RECOGNIZING THE DIVERSE ROLES OF COMMUNITY HEALTH WORKERS IN THE ELIMINATION OF HEALTH DISPARITIES: FROM PAID STAFF TO VOLUNTEERS

Andrea Cherrington, MD, MPH; Guadalupe X. Ayala, PhD, MPH; John P. Elder, PhD, MPH; Elva M. Arredondo, PhD; Mona Fouad, MD; Isabel Scarinci, PhD, MPH

The community health worker (CHW) model has been successfully used to promote health and reduce adverse health outcomes in underserved communities. Although there is a general consensus that involvement of natural helpers from the targeted communities is a promising approach in the elimination of health disparities, there is less agreement on their responsibilities, scope of work, and reimbursement for their services (ranging from paid staff to unpaid volunteers). These differences in pay structure stem from philosophical differences, programmatic needs, and financial realities. Based on our experience with both the paid and volunteer approaches, we provide some lessons learned on how the CHW model can be integrated in our efforts to eliminate health disparities. (*Ethn Dis.* 2010;20:189–194)

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From School of Medicine, University of Alabama at Birmingham (AC, MF, IS) and Graduate School of Public Health, San Diego State University (GXA, JPE, EA).

Address correspondence to Andrea Cherrington, MD, MPH; Department of Medicine; Division of General Internal Medicine; 725 Faculty Office Tower; 1530 3rd Avenue South; Birmingham, AL 35294-3407; cherrington@uab.edu

INTRODUCTION

In response to documented health disparities, researchers and practitioners rely increasingly on community-based intervention approaches to improve health outcomes among underserved populations. Pre-eminent among these are approaches that include community health workers (CHW).[1–3] The CHW model is based on community empowerment, where natural helpers from within a community receive training and then spread health promotion messages to many others in a manner that is understandable and accepted by individuals in their communities.[4,5] The CHW model's strength lies not only in the CHWs' ability to provide community members with culturally relevant health education, social support, and a connection to services in their community, but also in their ability to serve as ambassadors to the healthcare system and to policy makers and to advocate for their community.[6–8]

Recent research and practice efforts designed to integrate the CHW into disease prevention and management systems have brought forth several questions that merit consideration, including whether the CHW program ought to involve paid staff or volunteers.[9–11] This commentary addresses the debate between those who hold that CHWs deserve to be paid and those who argue that receiving a wage is contrary to the very nature of lay health advising. This tension is complex and literature addressing potential benefits and drawbacks of each model and the subsequent impact on CHW roles is lacking. The purpose of this article is to share our collective experience and provide some insights on the use of both approaches. It is not the authors' intention to advocate for either model but rather to discuss the merits of each and consider the contexts that may favor one approach vs the other.

COMMUNITY HEALTH WORKERS: PAID STAFF TO VOLUNTEERS

Often described as an innovative approach to eliminating health disparities, the involvement of CHWs in public health is not new and has a lengthy history both in the United States and internationally.[6] In the United States, this model emerged in the 1960s in the midst of a political movement to end poverty and to improve related health outcomes.[6] Attempts to formalize and provide financial compensation for a CHW workforce were undertaken to extend health care services to marginalized populations.[6] Although enthusiasm for this effort waned somewhat during the '80s and early '90s, growing recognition of disparities in health care outcomes led to resurgence in the use of the model over the last decade.[12] CHWs are being

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referred to as a new profession emerging in response to the challenges brought by an aging and diverse population with multiple chronic diseases combined with a shrinking pool of resources and rising health care costs.[3,13]

It is estimated that more than 120,000 CHWs are functioning in the United States; approximately three quarters are paid and the remainder are volunteer.[3] Volunteer CHWs tend to be engaged by programs with limited budgets, most typically, grassroots organizations or university- or clinic-based outreach programs. Paid CHWs are typically employed in short-term positions with low pay and often are not recognized by other health care professionals.[13] Consequently, there is growing interest in formalizing the CHW role and securing permanent funding for the position.

Advocates for the paid model contend that CHWs deserve fair compensation for the work that they perform just as any other employee does and that failure to pay exploits the very communities that programs aim to serve.[3,13] Conversely, there are concerns that standardizing the role and incorporating it into the healthcare system may stifle CHW autonomy and creativity by placing restraints on their actions.[9] There is also the risk that CHWs' allegiance could shift from the community to the healthcare system or organization, decreasing CHW effectiveness by influencing trust and community connections.[6,12,14]

LESSONS LEARNED FROM NATIONAL AND INTERNATIONAL EFFORTS

In our studies with Latinos and African Americans in the United States and one study in Indonesia, we have used both paid and volunteer CHW models with varying degrees of success. In the following section we present examples of each form and then discuss observations regarding differences as applied to both the scope of work as well as issues related to sustainability.

Secretos de la Buena Vida (Paid Staff)

Secretos de la Buena Vida was a randomized controlled trial in which CHWs were trained to work with women from their community to encourage and promote dietary changes to reduce risk of cancer. The CHWs were recruited from existing networks of women involved in previous CHW efforts and were paid staff of the university. Each CHW worked with approximately 30 women, assigned to them consecutively, over a 12-week period, conducting weekly home or telephone visits. The CHWs were trained to collect extensive process evaluation data after each home visit to examine intervention fidelity and to better understand the processes of change. The CHWs achieved immediate improvements in the women's dietary intake[15] and longer-term changes in behavioral and psychosocial correlates of diet,[16] which were explained, in part, by the number of contacts with the CHWs.[17] Upon study completion, research staff assisted the women in seeking employment on other studies.

Friendship Circles for Health (Paid Staff)

Friendship Circles for Health is a group-randomized trial designed to promote primary and secondary prevention of cervical cancer among Latina immigrants that is currently in the follow-up phase. CHWs were recruited and received extensive training on relevant content as well as cognitive behavioral strategies. The CHWs worked full time for the university, and were responsible for delivery of a cognitive-behavioral intervention, documentation of all activities for process evaluation, and recruitment and retention efforts for two years. The CHWs delivered six group and two individual sessions for a total of 56 groups of approximately 8 women and also logged each contact they had with participants, including duration and content. Participants displayed a high degree of satisfaction with the program. The primary challenge was the amount of resources needed to train lay individuals on such an intense intervention, and securing additional funds to maintain the staff employed once the research program is completed.

We contrast the above studies to several completed and ongoing studies that involve a volunteer model.

Sowing the Seeds of Health (Volunteers)

The Sowing the Seeds of Health study is designed to promote screening for breast and cervical cancer among Latinas. Volunteers from within the target audience are recruited and trained as CHWs. The volunteers then decide what activities should be implemented based on their knowledge of community needs. Their involvement in the program is limited to 2 hours per week on average and their role is limited to gathering the participants, talking to them about the importance of breast and cervical cancer screening and then supporting women's efforts to get screened. University staff provides the education and arranges the screenings. During feedback sessions, the CHWs reported feeling empowered through their participation in development of the community action plan. They also endorsed the volunteer position as it means they are not required to perform documentation, complete paperwork, or interact directly with the healthcare system to arrange screenings.

The Deep South Network for Cancer Control (Volunteer)

This network was established to create a sustainable community infrastructure to promote cancer awareness among African Americans in Alabama and Mississippi through partnerships with the targeted communities. Over 500 natural helpers from within their respective communities were recruited

and trained as volunteer CHWs. As a part of the study's developmental phase, a discussion group was conducted among 12 of the CHWs. Discussion centered on whether CHWs in the program ought to be paid, and how that decision might impact their roles. The CHWs felt that, compared to a paid position, a volunteer position would provide an increased level of autonomy/creativity, more flexible hours, and preserve loyalty to the community. They pointed out the need for non-monetary forms of compensation, such as formal recognition within the community, as well as availability of community resources to enhance program sustainability. All 500 CHWs are still active members of the network, with activities ranging from community events to promote cancer awareness and screening to nutrition education and letter writing campaigns.

Familias Sanas y Activas (Volunteer)

Familias Sanas y Activas is a train-the-trainer intervention to promote physical activity among community residents in south San Diego County. Volunteer CHWs were recruited through formal and informal networks in the community and were then trained to offer free physical activity classes at least two times a week for one year. They were also encouraged to share information on community resources to community residents. However, they were not required to maintain one-on-one contact with study participants, nor were they required to ensure that a standard dose was received by study participants. To enhance retention of the volunteer CHWs, the program provided professional development support for the volunteers as well as formal recognition. Close to half of the volunteer CHWs have been retained in the program, with evidence suggesting that greater support and more opportunities for recognition were associated with retention.[18]

Kader in Indonesia (Volunteer)

The importance of non-monetary compensation also resonates internationally. The developing country of Indonesia has one of the regions' highest infant and child mortality rate; providing professional health care to all or even most citizens is not economically or logistically feasible. Therefore, as many as one million volunteer CHWs, known as health cadres (kader), are appointed by village heads to provide basic maternal and child health care. However, high drop-out rates among the kader have been observed. Qualitative research examining this issue showed that kader would have liked to have been paid, but barring that, would at least have appreciated more recognition by community residents, many of whom never thanked or even acknowledged them for their work.[19] These data suggest that while volunteer kader can have an impact on community members' health, sustaining such efforts requires strategies that reinforce the volunteers for their work, even if non-monetary. A subsequent effort showed radio spots to be effective methods for getting villagers to acknowledge and reinforce the work of their kader.[20]

Caminando con Fe (Paid Staff and Volunteers)

Though this study was originally designed using a paid CHW model, a natural evolution towards a combined model occurred. Caminando con Fe examined the impact of a faith-based multi-level intervention on Latinas' physical activity. The paid CHWs, recruited through the church network, were responsible for organizing all physical activity programs and for conducting motivational calls. They also documented program attendance as well as contacts with community members. In addition to the paid CHWs, five women from the church expressed interest in volunteering their time to assist with program implementation. Following six months of intervention activities, three of the five volunteers dropped out of the study. Although formal process evaluation was not conducted to understand dropout, staff members and church leaders concurred that additional strategies were needed to extend volunteer involvement. These strategies included offering the volunteers tangible incentives, providing additional support, and recognizing their efforts publicly.

CONCLUSIONS AND RECOMMENDATIONS FOR PRACTICE AND RESEARCH

The objective of this commentary was to explore the potential differences between the paid and volunteer CHW models. After reflecting on our own experiences, the differences we observed can be grouped into three main areas: 1) activities and perceived allegiance, 2) scope of work and flexibility, and; 3) support and compensation. (Table 1) Each of these areas of potential difference has implications for the CHW roles, program implementation and sustainability.

We observed differences between activities of paid and volunteer CHWs. For programs implementing a paid model, CHW activities were more explicitly defined by the employing organization in terms of both content and dose, while for volunteer-based programs activities were often determined by the community, the CHWs themselves, or collaboratively with an organization. Thus, paid CHWs may have more of an obligation to adhere to the priorities as set forth by the organization. To the extent that those priorities may diverge somewhat from priorities of the community, the CHW is at risk of appearing to have a greater allegiance to the organization than to the community. Such perceptions may have an impact on trust and therefore programmatic reach and effectiveness. In fact, the potential for shifts in CHW

Table 1. Observations regarding differences between the paid and volunteer community health worker model

Program component	Paid worker/staff	Volunteer
Activities and perceived allegiance	Assigned defined tasks	Choose own tasks
	Required to complete assigned tasks	Encouraged to completed assigned tasks
	Agenda set primarily by the employer	Agenda set primarily by the community or collaboratively
	Commitment to the job/organization	Commitment to the community
Scope of work and flexibility	Restricted schedule	Flexible schedule
	Required number of hours	No required hours
	Intervention fidelity	Autonomy/creativity in intervention delivery
Support and compensation	Paid by the hour or task	Incentives and non-monetary reward system
	Sustainability based on availability of funds	Sustainability based on the community resources and will of the volunteers

allegiances has been raised in the literature and was suggested by CHWs themselves in the Deep South Network.[6,12,14,21] This risk may be mitigated in settings where the organization/health systems works directly with the community to negotiate a shared set of priorities. To our knowledge, CHW loyalties and community perceptions regarding those loyalties have not been scientifically assessed in head to head comparisons of the models.

In all cases discussed, the scope of work considered reasonable for a volunteer was substantially less than that for paid staff. For example, volunteers may not be able to maintain the same level of record keeping because they are not paid for administrative time. Though this may seem obvious on the surface, no literature examines where the line between reasonable and unreasonable lies. Among the challenges facing programs utilizing the CHW model are high dropout rates.[9] The extent to which scope of work might contribute to dropout is currently not known. By definition, expectations for CHW activities depend on whether or not they will be paid and should influence both the intensity of planned intervention and CHW training. Hence, programs with intense intervention or significant data collection requirements may be better suited for the paid model. If the volunteer model is selected, alternative strategies, such as paid administration or research staff, should be devised for those activities.

Issues related to flexibility arose in multiple contexts. Perhaps most obvious was the need for flexibility with scheduling of volunteer time. Volunteers must be allowed to adapt intervention delivery to fit other obligations rather than when and where it is convenient for participants. Hence, program activities must not only be tailored to the target audience's schedule but must also take into account the volunteers' schedules. This flexibility relates not only to the number of hours or time of day volunteers are able to participate, but also relates to the inherent ebb and flow of volunteers' engagement/enthusiasm. For example, there may be times when volunteers cannot participate due to their own set of life circumstances. In those instances, programs must have the flexibility to allow for periods of disengagement followed by options for reengagement. Flexibility was also raised in a separate context relating to CHW activities; it was felt that volunteers needed to be given autonomy and creativity during implementation to keep them engaged. Thus programs testing a specific intervention dose may not be well suited for the volunteer model.

Finally, issues related to support and compensation were raised for both models. It is clear that both the paid and the volunteer models will require financing to some degree if they are to be implemented effectively and yield the full impact of which they are capable. For the paid model, the specific CHW role(s) in health care must be more widely agreed upon, training standardized, and certification put in place so that more permanent funding may be secured – as has been done in Texas and Alaska.[3] For the volunteer-based model, funding is needed to support infrastructure and administration, as well as incentives and other non-monetary forms of compensation given that volunteer commitment may be related to the level of support and recognition they receive from staff and affiliated organizations. As mentioned previously, high dropout rates were problems observed in several of the volunteer programs described here. Insofar as compensation reflects how a person is valued, non-monetary forms of compensation for volunteers should be carefully considered. Clearly, formal recognition and appreciation is of great importance. Future studies should assess how compensation – both monetary and non-monetary – affect CHW retention for both models as well as potential effects on recruiting.

The coordination of community-based efforts with health systems/organizational interventions is an understudied critical area. Several years ago, Wagner and colleagues proposed a care delivery model based on the premise that effective disease management programs are delivered in partnership with health systems and communities.[22,23] Although parts of the model have been successfully implemented,[24] integration of the community component is often challenging; few studies describe imple-

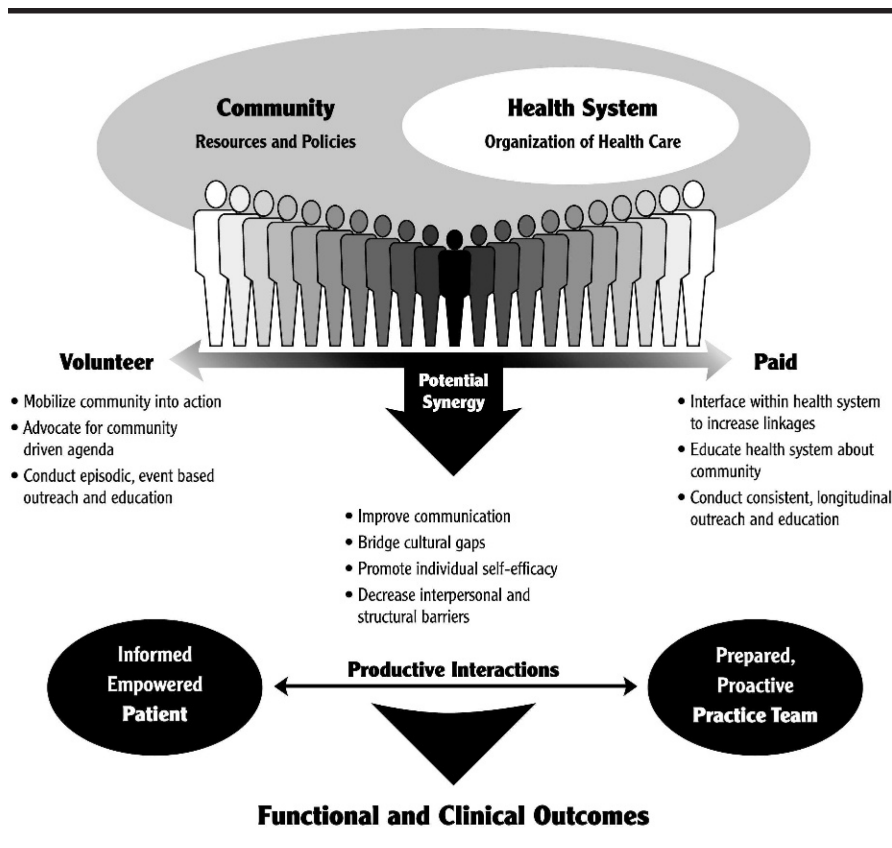

Fig 1. Conceptual model depicting full CHW continuum, with the full-time, paid CHW on one end of the spectrum and the volunteer CHW on the other

mentation of the full model.[25,26] To assist with this integration, we previously proposed placing the CHW at the interface between communities and the health care system, where CHWs bridge multiple components and facilitate the development of sustainable and culturally appropriate interventions.[9] Here, we extend that conceptual model to include the full CHW continuum, with the full-time, paid CHW on one end of the spectrum and the volunteer CHW on the other. (Figure 1) We believe there is the potential for great synergy through a combination of the paid and volunteer models; such a combined model may bring together strengths while overcoming limitations inherent to either model alone. For example, paid CHWs may be able to provide standing infrastructure for longitudinal outreach efforts that provide volunteers with opportunities for participation when their own life schedule will permit.

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In conclusion, we submit that there are legitimate arguments for utilizing both the paid and the volunteer models; selection must depend on context, community needs and program goals. Future efforts to advance the science of eliminating health disparities using the CHW model should include formal process and outcome evaluation aimed at teasing out the differential and/or synergistic benefits associated with each model.

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AUTHOR CONTRIBUTIONS

Design concept of study: Cherrington, Ayala, Elder, Arredondo, Fouad, Scarinci
Acquisition of data: Cherrington, Scarinci
Data analysis and interpretation: Cherrington, Ayala, Elder, Arredondo, Fouad, Scarinci
Manuscript draft: Cherrington, Ayala, Elder, Arredondo, Fouad, Scarinci
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Supervision: Cherrington