

'I Am Who I Serve'—Community Health Workers In Family Planning Programs

By Rachel Benson Gold

For decades, family planning programs and other public health programs have utilized community health workers (CHWs) as a way to reach and serve disadvantaged populations, often immigrants leery of government-sponsored programs. CHWs—who are generally lay members of the same communities these programs are seeking to serve—provide a variety of functions, including outreach, counseling and education, and patient navigation. Despite decades of experience, however, and a substantial body of evidence documenting their effectiveness and cost-effectiveness, these efforts continue to be hampered by the lack of a dedicated funding stream—a problem now being addressed by individual states and potentially by a little-noticed provision in the federal health care reform legislation that could provide at least some funding nationwide.

Shared Roots

CHWs have been on the front lines of efforts to provide care to disadvantaged groups for decades. The umbrella term refers to a range of titles and job descriptions, including outreach worker (often referred to as promotoras in Latino communities), health educator, patient navigator, health advocate or peer advocate.

Both the CHW movement and the nation's commitment to providing access to family planning grew out of the antipoverty programs of the 1960s, and both trace their origins to the Johnson administration's Office of Economic Opportunity. Family planning efforts were seen as critical to the administration's "War on Poverty," because of their potential to increase economic well-being and self-sufficiency for

women and families, and by extension, communities. Efforts to promote the use of CHWs were part and parcel of broader strategies to reduce poverty by increasing access to health care, while providing employment in disadvantaged communities.

In fact, some of the earliest efforts to utilize CHWs in public health involved family planning programs. According to the first national workforce study on CHWs, conducted by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services from 2004–2007, early university-based research on CHWs was conducted at Tulane University in the 1960s and 1970s in partnership with Planned Parenthood of Louisiana; the study examined factors important to successful employment of CHWs. A study published in the *Journal of the American Medical Association* in 1974 found that a program operated by Denver General Hospital using CHWs to provide family planning services to a low-income urban community enabled women to avoid unintended pregnancy while reducing infant mortality. Since those early efforts, CHWs have been utilized in family planning and other public health programs nationwide, as well as internationally (see box).

Gaining Credibility by Building Trust

Although many health care professionals have cultural connections with their patients, being from the communities they serve is one of the defining characteristics of the CHW workforce, and is a critical factor in their efficacy and ability to establish trust. As Imelda Garcia of the Texas Department of State Health Services said, "a community health worker, a promotora, comes

Meanwhile, in the Developing World...

When the United States began experimenting in the 1970s with the use of CHWs to increase access to and enhance the quality of family planning services, similar efforts already were underway in the developing world. The movement began early that decade in Asia and spread rapidly to Latin America and Sub-Saharan Africa. The original impetus was the fact that in many countries, large distances existed between where most people lived and where it was practical to establish clinics. That reality led nongovernmental organizations (NGOs) providing family planning services to begin training field workers—nonprofessional, but trusted, usually married, women—to knock on doors in their villages and communities, raise awareness about family planning, provide basic information and offer temporary contraceptive methods, such as condoms, the pill and spermicides, along with referrals to clinics as appropriate.

CHWs, and their use both in community-based programs to distribute contraceptives and in broader health promotion programs, are now an integral part of the global effort to enhance access to sexual and reproductive health services more broadly.

Not only do they help overcome the geographic barriers that still exist throughout the developing world, but they are considered trusted members of the community who are critical in helping surmount sociocultural barriers associated with family planning, as they do in the United States. They are critical resources in answering women's questions or concerns about side effects and in helping them select the method that is best for them. And their responsibilities have grown along with the need for more comprehensive information and services to promote and protect sexual and reproductive health. For example, male CHWs are making great strides in increasing the acceptance among men of contraceptive use for their wives and in increasing men's understanding and role in preventing STIs including HIV.

Pathfinder International, a U.S.-based NGO, has relied heavily on CHWs for more than 30 years. With simple checklists, CHWs can identify a wide range of basic health risks and needs. For example, in the small town of Tuse, Ethiopia, Pathfinder trained Aman Buli, a farmer and father of three, to provide information and counseling on family planning, HIV

prevention, safe pregnancy and childbirth, nutrition and care of childhood illnesses. Buli, who had been selected by his neighbors for this role in 2001, also has provided basic contraceptive methods to thousands of clients over only a few years' time, distributing condoms and pills at weekly markets. In addition, he meets regularly with community and religious leaders, arguing vigorously in this very traditional society against harmful practices such as female genital mutilation.

Pathfinder subscribes to the view, now almost universally held among providers working globally, that CHWs play an essential role along the provider continuum—building strong community support, increasing awareness and increasing demand for health services that are then provided by CHWs themselves, where possible, or by trained professionals in clinical settings. As in the United States, the role of CHWs in developing countries is ever-evolving. However, both here and overseas the goal is the same: to make basic health care more responsive and more accessible—in every sense—to underserved people.
—Susan A. Cohen

from the community, looks like them, speaks their language, knows their problems." Or, as a report on CHWs in Massachusetts quoted one worker in the state, "What makes me different [from other health care providers]? I am who I serve." This is critical to establishing trust, especially in immigrant communities, where fear of being reported or turned in to police or immigration authorities is omnipresent.

It is critical that CHWs live in the community they serve, according to Penny Almeida, a family planning counselor who works with Action for Boston Community Development/Boston Family Planning (ABCD), a Title X grantee that has had an extensive CHW program for decades. "That's your community. You're familiar with the people, the customs, their fears, their taboos. I bump into people just walking around the neighbor-

hood. They know me. They feel that they can just come up to me in the grocery store and ask me questions. Or they just want to talk. Sometimes it can take a long time to do my shopping.”

Establishing that level of trust is an important contributor to CHWs’ success in reaching vulnerable communities. Part of developing that trust is knowing that for many clients, confidentiality is key. “I have to actually tell teens I work with that it’s okay if they don’t say hello when they see me, if they don’t want the person they’re with to see that they know me. I won’t be hurt,” says Almeida. “They’re afraid they’ll hurt my feelings if they ignore me when they see me on the street.”

Developing trust is especially pivotal when it comes to issues related to reproductive health, where there can often be a reluctance to talk about sexuality and, in some cases, a long-standing and deep-seated mistrust of the medical establishment. For family planning, says Patrick Gillies of the Texas health department, “if they’re not from the community, people aren’t going to be willing to trust them. They really are the face of the program out in the community.”

In the Boston program, many CHWs are former clients, an experience that gives them an advantage in reaching sometimes-wary clients. And, say program administrators, by building trust one client at a time, the program as a whole gains indispensable credibility with the community it is trying to reach and serve.

Multiple Roles in Family Planning Programs

HRSA’s national workforce study found that reproductive health issues were among those most commonly addressed by CHWs. More than four in 10 employers said that the CHWs in their programs addressed women’s health, pregnancy, prenatal care or HIV/AIDS; more than three in 10 said that CHW activities involved sexual behavior or family planning; and more than one in 10 cited lesbian, gay, bisexual and transgender issues. Although CHWs perform many roles in family planning programs, among the most common are outreach worker, counselor and patient navigator.

Outreach worker. One of CHWs’ strengths is their ability to reach into communities to provide basic information and let people know about available services and care. Doing so effectively frequently involves making an extended effort to help individuals in often isolated and largely disenfranchised communities feel comfortable coming in for services. The Title X program in North Carolina makes extensive use of this model by having family planning outreach projects in county health departments, which allows the efforts to be tailored to specific, local needs. In some counties, the outreach staff work with community colleges and school nurses and even run programs at workplaces, such as a local Walmart or even a large brick factory in the community.

In many counties throughout North Carolina, outreach staff work with the state’s large Latino community. Outreach workers go to community events and Latino grocery stores in the neighborhoods to connect with people who might need services. One county runs family planning outreach sessions out of the Hispanic Learning Center, a community center, and uses the local Episcopal Farm Worker Ministry as a site for programs to train teens to serve as peer health educators.

A program run by the Carolina Family Health Center, a community health center in the state, hires outreach workers to run programs to provide information on sexuality and family planning at migrant camps. Because the county is isolated and transportation is an issue, the program offers transportation to clients who otherwise would be unable to get to their appointments; outreach workers use the time in the car to talk about sensitive issues such as sexuality in a relaxed and unthreatening setting.

Counselor and patient educator. In many cases, CHWs are part of the team that works at the clinic site. At Unity Health Care, a Title X grantee in Washington, DC, CHWs called family planning care associates run group sessions and provide individual counseling. According to Mark Hathaway, medical director of the Title X program at Unity, the arrangement means that “it isn’t just a doctor saying it to you, it’s someone

who has perhaps used the contraceptive methods, knows the ins and outs of the various methods and can spend considerable time talking with and educating the client about all her options.” It allows the physicians to be able to reinforce the message, and not have to introduce it: “Now I’m often the third person to talk to them about contraception, not the first,” he says.

The ABCD program in Boston makes extensive use of clinic-based CHWs who can provide pregnancy and rapid HIV tests and do extensive one-on-one counseling with clients, says Joan Whitaker, who administers the effort. Appointments are usually scheduled for 20–30 minutes, far more time than a clinician would have to spend talking with an individual client. In some cases, the counselors will be brought in to work with clients who have come in to the clinic for a visit. In others, clients call and schedule an appointment with the CHW directly. According to the CHWs, about 60% of their appointments are scheduled, and 40% are walk-ins—often teens who come in for pregnancy tests or young men who come in for STI tests.

The CHWs emphasize that it is important to take full advantage of the opportunities that are presented. When a patient comes in for an HIV test, a pregnancy test or emergency contraception, it is a great opportunity to talk about contraception. Or, when they come in for contraception, it is a good time to talk about STIs. “That’s how what could be five minutes for a test becomes half an hour, or sometimes way longer,” says one of the CHWs who works with ABCD.

As part of the comprehensive effort, the CHWs run programs in neighborhood schools. At one high school, the administrators routinely invite the CHWs to introduce themselves to the incoming freshmen every year. “I tell them to call me anytime they just want to talk,” said one of the workers. “I get a lot of calls right after I go to the school. These kids just really need somebody to talk to.” According to the counselors, it is important that they run the programs at places like schools and housing developments out in the community: “You get to meet people, even before they have a need. Instead of telling

people they can call the clinic, you can tell them to call you directly. They feel like they know you, have a connection with you.”

Patient navigator. A third key role for CHWs is to help clients navigate what can be a maddeningly complex health care system—a function that can take many different forms. In North Carolina, CHWs help people fill out their Medicaid applications and walk over together to the right office in the health department building to submit them. At ABCD in Boston, the counselors, who work in primary care centers that have medical and social services available, can connect clients with services to address a range of issues in their lives, such as domestic violence, housing or substance abuse. Or if a counselor feels that a client needs to be seen by a clinician, she can get the client squeezed in, even if the schedule is officially full for the day.

Unity Health Care in Washington has what it calls a “warm line” for family planning clients. According to Hathaway, it is not quite a hotline with round-the-clock staffing. Instead, it is designed for someone who has an urgent, if not quite emergency, medical need; often the calls are from clients who are experiencing side effects from their contraceptive method, had unprotected intercourse or had a condom that broke. Clients can call after hours and leave a message. A counselor will call them back the next day, provide the counseling and information that is needed and, if necessary, immediately get them an appointment without their having to go through what can otherwise be a complicated scheduling process.

Securing the Effort

To maintain and grow, CHW programs across the country are finding that they have to grapple with two key, interrelated issues—credentialing and financing. Texas, for example, has put a special emphasis on credentialing workers, with community colleges running programs across the state. These programs provide 160 hours of training, with 20 hours in each of eight disciplines, including communication skills, interpersonal skills, service coordination skills and knowledge of specific topical areas, such as

reproductive health. After going through the training, a prospective CHW can be certified, at no cost, through the health agency.

ABCD in Boston has also developed an extensive credentialing effort. Prospective family planning counselors complete a seven-day course that covers a range of issues, including human anatomy and sexuality; communication skills needed for effective patient education and counseling about family planning; how to teach clients about birth control, STIs and pregnancy options; and techniques for counseling teens on family involvement and avoiding sexual coercion. At the end of the program, students must take and pass a 100-question take-home exam and be observed on-site by ABCD staff to be certified as a family planning community health worker. Although staff talk about the importance of the credentialing, and how proud graduates are of their certificates, they also note that the programs need to maintain a delicate balance. Although they want to make the certification something official, it is critical that the effort not become so formalized that it begins to lose the very grounding in the community that makes the endeavor successful.

Program staff in Texas hope that their credentialing efforts will give them a pathway to addressing the other critical issue of financing, by laying the foundation for reimbursement from third-party payers, such as Medicaid. Their hope is that building a critical mass of certified health workers will better enable them to make the case that their services should be covered like other health care services and be eligible for reimbursement through programs such as Medicaid.

Recently, Minnesota became the first state to do exactly that, in a move long championed by the state's Community Health Worker Alliance, a coalition comprising CHWs, representatives from state agencies, health care providers, educational institutions and health care payers. In a critical step in 2007, the legislature adopted a provision allowing direct hourly reimbursement for CHWs under Medicaid. Later that year, the federal Centers for Medicare and Medicaid Services (CMS), the federal agency that administers

Medicaid, approved the state's request for payment for CHW services. Specifically, CMS authorized payment for CHWs who have completed the state's certificate program and who are working under the supervision of physicians, advanced practice nurses, dentists, public health nurses and mental health providers.

Massachusetts, which has a long history of using CHWs in a variety of settings, including family planning programs, is taking a different approach to the financing challenge. According to a recent report issued by the health department's Community Health Worker Advisory Council, the group is leery of seeking direct, third-party reimbursement to individual CHWs for fear that it may inadvertently limit workers to a prescribed set of tasks, which could reduce their flexibility and ability to mesh in with larger health care and community-based settings. Instead, the group recommended continued support of these efforts through specific grants from the state health agency.

The passage of the federal health care reform effort may prove to be a pivotal moment in the effort to legitimize CHWs as health care providers. The legislation explicitly includes CHWs as part of the health care workforce, along with other health care professionals with direct patient care and support responsibilities. This designation is critical, because it will open the door for CHWs to be seen as part of the legislation's overall efforts to secure a health care workforce capable of meeting the nation's needs, especially for disadvantaged communities and vulnerable groups.

Moreover, taking an approach similar to the one being used in Massachusetts, the legislation establishes a federal grant program to support the use of CHWs to promote positive health behaviors and outcomes in medically underserved areas. The provision specifically authorizes the Centers for Disease Control and Prevention to make grants to states, health departments, clinics, hospitals, federally qualified health centers and other private, nonprofit organizations for programs using CHWs to, among other things, educate and provide out-

reach in medically underserved minority communities, provide guidance on strategies to promote positive health behaviors and discourage risky behaviors, and refer individuals in need of health care services.

This provision is clearly an important step toward the long-sought goal of promoting widespread recognition and utilization of CHWs and of securing a stable funding stream for the effort. In addition, it seeks to do so in a way that avoids some of the concerns voiced about a Medicaid-based approach. However, a grants program has pitfalls of its own. As ground-breaking as it was, the health legislation's provision does not directly provide funding; rather, it authorizes Congress to allocate resources. Even in these difficult economic times and faced with myriad competing demands, it appears that Congress may be willing to do just that. Legislation approved by the Senate Appropriations Committee for the coming year includes \$30 million for the CHW program, although final decisions will not be made until the fall, or later.

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