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Acceptability and trust of community health workers offering maternal and newborn health education in rural Uganda

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Abstract

When trusted, Community Health Workers (CHWs) can contribute to improving maternal and newborn health outcomes in low- and middle-income countries through education. Issues of acceptability of CHWs by communities were explored through experiences gained in a qualitative study that is part of a cluster randomized trial in East Uganda. Initially, focus group discussions with key community members and leaders were undertaken regarding preventative health and 40 CHWs were observed making home visits by supervisors during the initial 6 months of fieldwork of the trial in eight villages in the Jinja District in Uganda. The results were analyzed using the 5-SPICE framework. Observation of CHWs in the field identified a number of unanticipated issues including a general mistrust of the public health system by community members in areas that had an impact on maternal and newborn health. At the outset, CHWs often did not trust their own abilities and faced community expectations that they would provide curative rather than preventative care. Early community engagement, non-threatening home visits that enhanced friendship and supportive supervision improved the confidence of the CHWs and improved the trust and acceptance of the CHWs and the willingness of the community members to act on what was discussed.

Introduction

Role of Community Health Workers in maternal and child health education

Community Health Workers (CHWs), lay individuals who are trained in some aspect of health care, have been assisting in a variety of modalities in resource poor communities, particularly since the success of the Barefoot Doctors in China [1, 2]. In the 1970s and 1980s there was concern about CHW effectiveness due to high attrition rates, particularly when smaller programs attempted to go to scale [3]. A number of factors, including commitments by many countries to the Millenium Development Goals (MDGs) [4] in the 1990s, saw renewed interest in CHW programs. This interest will no doubt be continued as countries attempt to meet number three of the yet to be adopted Sustainable Development Goals which is to ensure healthy lives and promote well-being for all at all ages [4]. Diverse approaches to training, supervision and remuneration of CHWs were implemented in a number of settings with varying success [5–8]. CHWs, who work to educate, empower and mobilize the community, have played key roles to reduce morbidity and avert mortality in mothers, newborns and children [9–12]. An example is Rwanda where they will meet and exceed the MDGs 4 and 5, in part due to a strategy whereby 15 000 CHWs were trained to educate women and their families in maternal and child health issues [11, 13].

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Trust in the community

Making sense of contradictory health information from family members, neighbors and health professionals can be a challenge for families. It is important, therefore, that those providing evidence-based health messages are trusted and respected.

Because CHWs are usually residents in the community in which they work, it is assumed that they will automatically receive community support. They are, however, not always accepted and trusted when they begin to operate in the community due to history, past performance or other issues [14]. For example, they might only receive minimal training, at least in the initial stages, and may therefore not have significantly more health-related knowledge than that of their neighbors on whose good will they rely to support their activities. A society with low trust levels [15] may, therefore, be a difficult environment for a CHW to operate in. This can lead to demoralization of the CHW, attrition and ultimate failure of the program [14, 16–18].

Trust can be defined as 'the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests' [19] which can be based on either a calculated decision or an intuitive or affective response [19]. Trust includes components such as honesty, competence, benevolence and integrity. Trust may be related as much to 'motivations and intentions as to results' [20].

It has been suggested that when people do not trust the government, they distrust health workers who are perceived to be a part of the government system [21, 22]. This can have important implications for choices made around both maternal and child health. For example, because women from a number of countries including Malawi, South Africa and Nigeria [23–25] feel disrespected or inferior in a clinical setting, they may prefer birthing with a traditional birth attendant because she is kind or respects the beliefs of the laboring mother [25].

The role of supervision in gaining community trust

The World Health Organization, in a review of CHW programs conducted during the decade up to 1989, noted that challenges facing these programs could be attributed in part to overemphasis on training with little consideration for either the complexities of the cultural and political realities in which the CHW was working, or to supervision of the CHWs [26].

It has also been noted that 'CHW performance is a reflection of how they are supported, not their inherent abilities' and that 'if communities do not have an ability to supervise the CHW in some capacity, the communities demand and respect for the CHWs will suffer' [22].

Some groups have developed strategies and frameworks to facilitate evidence-based planning, improvement and scaling up of CHW programs [11, 22, 27–29]. Although each has particular strengths, the 5-SPICE framework (Fig. 1) lent itself as a means by which to think about and organize the learning of our small-scale intervention.

5-SPICE framework

The 5-SPICE framework has been proposed as a conceptual framework to guide discussions about CHW projects or to formulate hypotheses that will form the basis of a program's research agenda [22]. Engaging a large group of implementers and researchers, and the available literature, the 5-SPICE framework was developed and applied to a variety of CHW programs. Insights gleaned were summarized in a tabular format called '5 × 5 SPICE Charts'. This format provides a graphical representation of the myriad ways in which important CHW program elements interact. The framework describes the positive and negative interactions among supervision, partners, incentives, choice (CHW selection) and education—hence the acronym 5-SPICE [22].

Titaley *et al.* [22] further elaborate on the meaning of each category:

- Supervision—includes management plans and structure
- Partners—especially ownership and stewardship by national programs

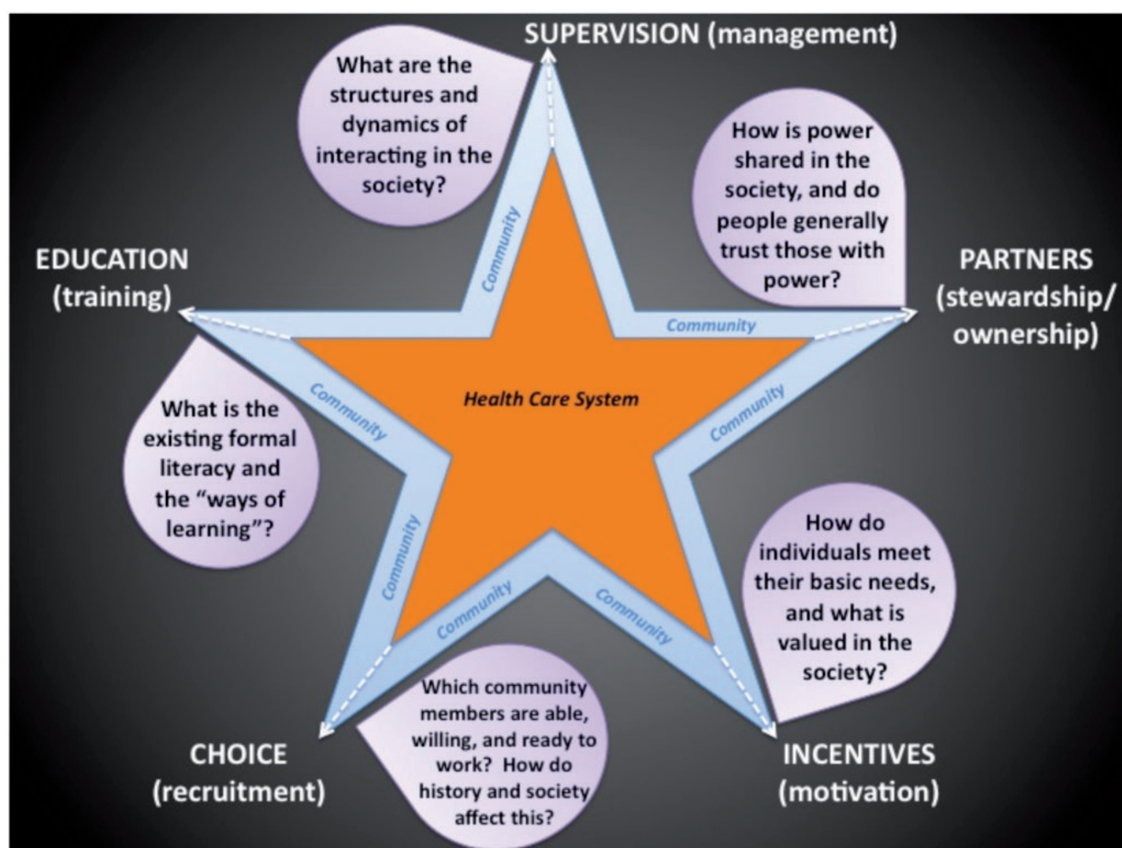

Fig. 1. 5-SPICE conceptual framework. Reproduced with permission of Palazuelos *et al.* [22].

- Incentives—which are a key part of the larger theme of motivation and performance
- Choice—both how CHWs are recruited to work, screened and selected, and why they choose to take the job
- Education—including what CHWs bring to their job and how they are trained

One potentially complex interaction is that of trust in the community. It might be anticipated, based on the 5-SPICE model, that when CHWs are poorly selected, educated and supervised, CHWs will find it difficult to gain the trust as well as the skills they need to function effectively.

Study setting

Budondo, Jinja, located in Eastern Uganda has 38 villages, in which a number of government- and non-governmental organization (NGO)-initiated CHW programs have operated since the late 1980s. The purpose of the government strategy has been to develop a human resource that would undertake prevention and first-line care for communities. The programs included the following: training on preventable health issues; campaigns to address specific health problems such as worms, schistosomiasis or family planning; development of Village Health Teams (VHTs) and Community Medicine Distributors (CMD) and training in Integrated Case Care Management (iCCM) [30]. VHTs—made up

of volunteer CHWs—were introduced in 2004 (personal communication with sub-county leader); however, most members have been minimally active or dormant since 2008 when the CMD program was rolled out. The iCCM, CMD and VHT programs have all faced challenges with lack of supervision, stock outs and inconsistent funding [30]. Despite these challenges training of CHWs remains a major public health strategy for Uganda [31, 32].

In some parts of Uganda maternal and child health educational services are provided by CHWs at village level and immunizations, antenatal care, deliveries and basic curative care begin in the Health Centre II (Table I). Although Health Centre IVs should have access to blood and surgical care, this is not the case in Budondo, and many other Health Centre IVs. Families therefore need to be financially prepared to travel 20–30 km to the Jinja Main Hospital in the case of obstetric emergency.

The purpose of this article is to explore some of the complexities and challenges facing CHWs as they begin the process of being recognized in the community and developing capabilities necessary to be both accepted and trusted in communities.

Methods

This article describes a qualitative study conducted in Eastern Uganda in 2014 as part of a mixed method cluster randomized trial that is currently underway. The article reports data collected from (i) focus group discussions (FGDs) in the intervention villages conducted at the beginning of the trial and (ii) the field observations of the 40 CHWs from the intervention villages from April to September 2014.

Cluster randomized trial

The cluster randomized trial focused on developing a model for empowerment of CHWs to improve maternal and child health outcomes that commenced in March 2014 and is currently underway in eight villages in Budondo. The trial began with 221 baseline household quantitative surveys with mothers of children under 5 years. The study then employed a cluster randomized design with randomization carried out within matched pairs of villages. Eight villages were selected with study villages separated from each other by a geographical buffer, of at least one village wide, to reduce the potential for intervention diffusion into control sites. Randomization of villages took place at the end of March 2014 after the baseline household surveys had been conducted. Each of the eight villages—four intervention and four control—have access to a Health Centre II in their parish, are located 2–5 km from a Health Centre III and at least 5 km from the nearest Health Centre IV, which is the best equipped government facility in the county. The CHWs made up of a group of 2–5 members per village is considered as the Health Centre I. The purpose of the trial is to compare motivation, retention and effectiveness of CHWs who receive monthly training alone ($n = 40$) versus those who receive the same training but are then supervised during home visits once a month in the community ($n = 40$) for ~3 h by a CHW supervisor. In the intervention group, a

Table I. *Hierarchical structure of the Ugandan Health System [33]*

Infrastructure level	Administrative level	Target population	Services
Health Centre I	Village	1000	Community-based healthcare prevention, CHWs
Health Centre II	Parish	5000	Preventative, Curative, Outreach
Health Centre III	Sub-county	20 000	Preventative, Curative, Outreach, inpatient, maternity, laboratory services
Health Centre IV	County	100 000	Preventative, Curative, Outreach, inpatient, maternity, laboratory services blood transfusion, surgical care

sex-matched male or female CHW supervisor works with two or three CHWs per visit.

Prior to commencement, the study protocol was approved by the Institutional Review Board at the School of Public Health at Makerere University, Uganda, and the Uganda National Council for Science and Technology and the Human Research Ethics Committee at the University of Sydney, Australia.

Members of the research team

In addition to the in-country researcher (D.S.), there were four research assistants, two men and two women. One of the research team had been the CHW coordinator in Budondo for 18 years, and was well known among the community leaders and members. The team conducted the household surveys, worked with the local leaders to recruit suitable FGD participants, conducted the FGDs with the in-country researcher present, organized meetings and CHW selection with the community, trained the CHWs and supervised them in the field and assisted with entering and analyzing the data. They will be referred to throughout the article as CHW supervisors.

Focus group discussions

Following the baseline household surveys, community leaders and key individuals in the four intervention villages were invited to one of the four FGDs. The 41 participants (22 female and 19 male) were recruited through community leaders who were visited by CHW supervisors. The FGDs comprised between 8 and 12 participants and included local chair people, representatives of women's and defense groups, CMDs, former or current CHWs, youth leaders and elders. Each participant was over 18 years of age and was given a participant information sheet in Lusoga, the local language of the Busoga region, and consented via a signature or thumbprint. FGDs were conducted in Lusoga.

Questions were centered on experiences with the former and current CHWs, as well as the potential role of CHWs, and included community perception of acceptability of CHWs, challenges previously faced, prevention versus cure and the most realistic role of the CHW. The FGDs were moderated by two of the CHW supervisors. Recordings were translated and transcribed by the other two CHW supervisors/research assistants within 3 days of the FGD. Participants were not remunerated but were provided with a snack during the FGDs.

Field observations

Following the FGDs, community meetings and CHW selection took place. Half of the CHWs were selected by the community and half were self-selected. Some had prior experience or were currently serving as a CHW and others did not. It was felt important to go through a re-selection process because many CHWs, while still identifying as a CHW, had been inactive for a number of years. They all completed a demographic questionnaire. After receiving training, the CHWs made home visits together with the CHW supervisors on a monthly basis. Through both observation and a reflection process, the CHW supervisors were able to see the progress made by the CHWs and the challenges they faced. The observations included formal monthly and quarterly assessments by the supervisors of the following skills and abilities of the CHW's: (i) confidence in introducing themselves and the program (ii) ability to discuss health topics with community members—men and women, and local leaders (iii) capacity to organize time to make home visits and ability to explain danger signs of pregnancy and newborns and (iv) capacity to examine a newborn baby and appropriately refer according to a check list. Immediately after each visit, the CHW supervisors reported their experiences to the in-country researcher, who transcribed direct quotations of observations.

Analysis of FGDs and field observations

Qualitative data from the FGDs and field observations were taped, transcribed and translated into English. The in-country researcher (D.S.) and two of the research assistants reviewed the data twice independently. Themes that emerged that

contributed to trust and acceptability of CHWs were categorized according to the 5–SPICE model into the areas of Supervision, Partners, Incentives, Choice and Education. To increase the validity of the findings, the other two researchers (R.C. and J.N.) reviewed the findings and classifications and suggested changes in some categories, which were discussed and agreed with D.S. Although the 5-SPICE model can potentially be applied to entire programs, for the purpose of this article it was used to consider the issues that contribute to trust and acceptability of CHWs of themselves in their role and by the community to provide education around pregnancy, birth preparation newborn care and hygiene.

Although 5-SPICE provides a useful acronym, we felt that the more logical order for this article was Partners, Choice, Education, Supervision and Incentives.

Results

The demographic data from the 40 CHWs were gender desegregated and analyzed using tallies and percentages that are presented in Table II.

There were similar numbers of male (52%) and female (48%) CHWs. The mean age of male CHWs was 43 years, while for female CHWs it was 38 years. Female CHWs had a lower level of education with 48% having attended some years of secondary school or higher compared with 76% of their male counterparts. Twenty-one percent (21%) were Muslims and 79% were Christians, compared with 13% Muslim and 87% Christian population throughout Uganda [34]. Ninety-five percent (95%) of the men were born in the village compared with 42% of women many of whom had moved after marriage. Twenty-four percent (24%) of men and 21% of women in the program had volunteered for 11–20 years as CHWs. Twenty-four percent (24%) of men and 42% of women had, however, no experience volunteering as CHWs. The qualitative data from the FGDs and field observations were analyzed using the 5-SPICE framework.

Partners: how is power shared in society and do people generally trust those in power?

In this setting, we considered there to be a partnership between the community and the CHWs.

It was clear from the FGDs that the history of the government CHW program in Budondo had created some mistrust among the CHWs. From 2004, there were 10 CHWs per village and then in 2008 the government selected 2 'CMDs', from among the existing CHWs, who although still volunteers were given provisions and training allowances. This then meant that the other CHWs lost motivation and felt unappreciated.

NGOs had also rewarded certain CHWs and given them bicycles and livestock, which had further reduced motivation of the other CHWs (personal communication with sub-county CHW supervisor and leader).

The FGDs revealed additional issues related to a lack of trust in the government's intentions with public health interventions.

> The challenge the CHWs face is that when we tell people to take their children for immunization people refuse, claiming the government wants to kill their children, hence they neglect the information we give them. (CHW in FGD)

The trust issues first mentioned by the FGDs were confirmed when the CHWs were operating in the community. The CHWs described that when they were given medications for distribution by the government the people feared using them. They described concerns about family planning methods and insecticide treated nets potentially causing infertility and fear of being arrested because of hygiene issues.

> There is another health related program of immunizing children against malaria so the people are misinformed that the program is going to kill their children so some are harsh with us when we go to them thinking we are also dealing with that same program. (Field observation CHW supervisor)

Table II. *Summary of CHW characteristics*

	Male		Female		Total	
	N	%	*N*	%	*N*	%
Religion						
Christian	15	71%	15	79%	30	75%
Muslim	6	29%	4	21%	10	25%
Age						
18–28	3	14%	4	21%	7	18%
29–39	8	38%	8	42%	16	40%
40–50	3	14%	5	26%	8	20%
Over 50	7	34%	2	11%	9	22%
Born in the sub-county	20	95%	8	42%	28	70%
Education						
Primary	4	19%	9	47%	13	32%
Secondary	14	66%	8	43%	22	55%
Post-secondary	2	10%	1	5%	3	7%
None	1	5%	1	5%	2	5%
No. of years of CHW						
0	5	24%	8	42%	13	33%
1–5	1	48%	5	26%	15	37%
6–10	1	5%	2	10%	3	17%
11–15	4	19%	1	5%	5	13%
16–20	1	5%	3	16%	4	10%

> The main fear was of ‘being arrested’ because of the condition of their pit latrines. (Field observation CHW supervisor)

Historically, from the time that Uganda was a British protectorate, it was not uncommon for people to be arrested or threatened with arrest because they did not comply with hygiene requirements (personal communication with James Mwami, director of the Busoga Trust, Jinja, July 2014).

Gaining insight into community expectations, experiences and history of CHW training and approaches made it possible to orient the training and supervision to ensure that these issues were addressed.

Choice (recruitment): which community members are able, willing and ready to work? How do history and society affect this?

Volunteerism is relatively common in Ugandan villages, while income is derived from other activities—often related to subsistence farming or having a small retail outlet.

As previously mentioned, in our study, five of the CHWs in each village were selected by the community members, and five volunteered themselves for a minimum of 5 h/week. We found that a number of community leaders were community selected, and while their endorsement of the study and health interventions was extremely helpful, they were less likely to have the time to make regular home visits. On the other hand, a group of five self-selected school teachers, who might also be expected to be busy, have been not only well accepted and trusted by the community but also effective in working at household level.

The following comment from a self-selected CHW indicates that, at times, however, self-selection may not lend itself to community trust and acceptability.

> One young man explained that he had a bad reputation in the area because most people had seen him grow up since childhood and did not

> think he was capable of being a CHW. They asked him for his certificate to prove he was qualified. The CHW coordinator suggested he move with an experienced CHW who was respected by the community. (Field observation CHW supervisor)

Education: what is the existing formal literacy and 'ways of learning'?

The CHW supervisors felt that a number of unrealistic expectations of CHWs were identified during the FGDs. The FGD participants expected that although CHWs had minimal training and resources available to them, they should still provide health care rather than preventative interventions.

> They don't get much medicine. The community wants the CHWs to get the medicine and to have the tetanus injections and work on the sick people. (Community member FGDs)

Based on the results of the FGDs, it was decided that CHWs would dedicate the first 2 months of implementation talking with people and introducing themselves and the program. A 2 to 3 day training for the CHWs covered topics such as undertaking a community mapping process, dividing the community into zones so that the 10 CHWs covered all homes in the village and generally strengthening friendships and developing trust among the community members. Each CHW was responsible for between 15 and 40 households. CHW tools included a story to share about 'what is health' and pictures illustrating how 75% of the illness burden in the community is preventable. Focusing on trust and friendship proved to be a useful strategy even though initially some of the experienced CHWs did not see the need for it. As discussed in the 5-SPICE model, there was a clear interaction between the 'Partners' perception of the CHWs and the need for 'Education' and 'Supervision'.

Supervision: what are the structures and dynamics interacting in society

Supervision provided the opportunity to address community experiences and issues of trust gleaned from the FGDs with the CHWs. Historically, supervision has been hierarchical and feared. We therefore included the idea of 'accompaniment' in the training rather than supervision and we explained that members of our team who went with the CHWs for home visits were there to learn with the CHWs. We do however refer to them, in this article, as CHW supervisors for ease of understanding.

Having a higher level human resource—the CHW supervisor—work alongside the CHWs in the field provided considerable insight into the challenges of acceptance faced by the CHWs. It also enabled the CHW supervisors to respond by reflecting on the issues with the CHWs and adjusting training according to the needs. Below are some of the areas identified and addressed by the CHW supervisors in collaboration with the CHWs.

The initial areas of discussion seemed to be critical. It was found that if topics were chosen carefully and were both non-threatening and engaging then people are interested in talking about health issues.

> I realized that those that feared us at first this time they could welcome us because of the friendship and trust pictures we shared with them so they realized we are not there to blame them but learn together with them. (Field observation CHW supervisor)
>
> At first the people they were not friendly to the CHWs, but now have become their friends after they visited them. The community members have started accepting the CHW's and have stopped running away from them. (Field observation CHW supervisor)

According to the CHW supervisors, many of the CHWs found it difficult to approach homes and introduce themselves to explain their roles as CHWs.

> The CHWs experienced fear of the community because it is their first time to reach the homes. They have a problem with (making) introductions yet it is very important. Actually this is a problem to all the CHWs including the experienced CHWs. (Field observation CHW supervisor)

Related to a lack of confidence, it was observed that the CHWs felt under tremendous pressure to show their knowledge and 'advise' community members. This resulted in CHWs talking 'at' the community members rather than engaging them with stories and pictures and allowing the community members to share their thoughts and ideas.

> . . . the CHW couldn't allow the community to say anything, she wanted to prove that she knows it all. The CHW talks without giving chance to the others. (Field observation CHW supervisor)

Initial reactions from the community further reinforced a lack of confidence in the CHW's that needed to be overcome with time with the help of the CHW supervisors.

> Some people asked me many questions because they had not known that I was one of the CHWs. Someone told me to get a uniform. I showed her the book (training materials) that proves that I am a CHW. (Field observation CHW)

Having an identifier may be important for CHWs gaining confidence. The response from some community members might also explain the repeated request for T-shirts, badges, gum-boots, umbrellas, bags and the like. In addition, CHWs frequently requested that the village leader or the CHW supervisor to go with them when they visited people.

Each month the CHW supervisors found that the CHWs were becoming more confident and that their presence enabled the CHWs to feel 'legitimized' in the eyes of the community.

Incentives: how do individuals meet their basic needs and what is valued in the society?

The CHWs receive $2 per month for transport. Other inputs have been training and accompaniment. The issue of community respect may be an important motivation for the CHWs.

> CHWs connect us very easily to the government call. . .for quick response. CHWs are the immediate health workers you can talk to. . .one CHW can cover a wider area and with more expertise than one (health professional) who is coming from a distant area. (Community member FGD)

Deeper analysis of the role of incentives in motivation will take place at the end of the cluster randomized trial.

Discussion

The purpose of this article was to examine the process of building trust and acceptance of volunteer CHWs to provide education related to issues that might impact pregnancy, newborn care and hygiene. While being a respected and trusted member of the community is often mentioned in selection criteria for CHWs [9, 11, 34, 35], there are few studies that look at the process of developing strong interpersonal relationships with community members [9, 35].

The 5-SPICE model has been applied to a large number of varying sized CHW programs and common themes and interactions related to supervision, partners, choice (CHW selection), incentives and education both positive and negative documented [22]. When examining some of the insights gained in the 5-SPICE process [22], we were able to demonstrate a number of consistencies between what was identified as important for building trust and acceptability of CHWs for health promotion and our own findings.

In this study, a partnership was established with the community leaders and members through initial FGDs, participation in community selection and development of components of the training materials based on the insights gained from community members. A common finding in the 5-SPICE model was that 'If the community mistrusts the government, it will be hard for them to trust a government-supported CHW (even if they choose them)' [22]. It was found that community members often found it difficult to distinguish among government, non-governmental and research interventions. Mistrust was directed toward all public health interventions,

no matter what the source. Integrating trust building into the training and the initial months of fieldwork of the program proved to be a worthwhile and necessary time investment.

Similar to other programs, it was found that community meetings to select CHWs were beneficial for trust building [22, 36, 37]. Although the community frequently chose respected individuals, such as leaders, those making the choice did not always give due attention to the amount of time an individual had available to make home visits. The presence of the community leaders at the trainings was helpful in improving the acceptability of the health interventions, although they often had little time to do home visits as CHWs. Self-selection of 50% of the CHWs was also included in our study and resulted in both positive outcomes and some challenges, depending on prior history of the CHW in the community.

Although community meetings and selection of CHWs were beneficial, they were not enough to gain acceptance of the community. Despite endorsement by community leaders and the presence of both leaders as CHWs and a respected CHW coordinator, people still ran and hid from the CHWs when they started to do home visits. The choice of the order of educational materials and topics for discussion was also important in the trust building process. Education and discussion related to hygiene, malaria prevention and family planning were sensitive because of fear that they may cause infertility or harm to children. Finding non-threatening and engaging topics to discuss with community members successfully built trust and prevented the CHWs from being rejected by community members over time.

Supportive supervision was found to be an indispensible tool in addressing community concerns, building trust in the community and in empowering CHWs as they transitioned from being a community member to a CHW [17, 22, 36]. This was particularly the case for women who were less likely to have attended secondary school, be from the area or have volunteered as a CHW in the past. It was found however, that as in other hierarchical societies, supervision was a threatening term. Accompaniment [37, 38] was more able to create an environment of trust between the CHWs and the supervisors. Through this process the CHWs were able to feel legitimized as they built confidence and skills. Having a person well-known to the community involved in the accompaniment also seemed helpful for the trust building process. Demands for uniforms, badges, bags and gum-boots could not be met because of financial limitations; however, the role of these kinds of identifiers was clear in the early part of the process [22]. It is Ministry of Health policy in Uganda to make these items available [32] and a number of NGOs working with CHWs will do so when funds are limited. Community recognition seems to be an important motivator in the process.

Study strengths and limitations

The number of CHWs in the study was relatively few; however, a number of the observations were similar to those of the 5-SPICE model, thereby increasing validity. The field observations were only undertaken in the intervention group. Although it would have been of interest for comparative purposes, field observations in the control group may have been interpreted as supervision, which would have undermined the purpose of the study. Having a non-Ugandan researcher may have affected some of the responses in the FGDs; however, having four Uganda research assistants overcame many of the cultural barriers. Having a CHW coordinator from the area was of particular importance as he was known and trusted.

Conclusions

Overall, no single factor was enough to create an environment of trust, rather the issue proved complex. Another insight from the 5-SPICE process, that we found to be true, was that 'building trust is iterative and happens through concrete actions and regular communication' [20]. CHWs are often expected to undertake health education in settings where the social determinants of health are complex with little preparation and training. Negotiating issues can be challenging and CHW training programs need to be aware of the realities faced by the CHWs and factor

in strategies, such as a supportive supervisory scheme, that will enable the CHW to build their own confidence and increase the trust of the community [9, 14, 15, 33].

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Conflict of interest statement

None declared.

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