



Health workers in Jigawa State, Nigeria (Credit Yagazie Emezi - Save the Children)

# OPTIMISING EQUITY IMPACTS OF COMMUNITY HEALTH WORKER PROGRAMMES IN LOW- AND MIDDLE- INCOME COUNTRIES

## POLICY BRIEF AND RESOURCE PACK FOR POLICY MAKERS AND PRACTITIONERS

Authored by Liana Chase, Kate Hampshire, Sonia Ahmed, Nasima Akhter and the REACH Team (Durham University 2021). The research was commissioned by Save the Children UK and supported by CARE International and AMREF Africa, as part of the GSK funded Community Health Worker portfolio.

## 1. THE RESEARCH

We systematically reviewed literature on how community health worker (CHW) programmes impact health in/equity in low- and middle- income countries (LMICs). CHWs are health workers who are based in communities, and who have received some training (up to two years) but are not considered health professionals. Health inequities are unfair and avoidable differences in health between groups, including those based on place of residence, social identity, socioeconomic status, gender, and disability, while health equity is the absence of such differences. Achieving health equity requires more than just providing equal care to everyone, because some disadvantaged groups may need extra support to reach the same level of health enjoyed by others.

Our study aimed to develop programme and policy recommendations to optimise the impact of CHW programmes on health inequities in LMICs. We reviewed findings of 167 studies on CHW programmes in 33 LMICs. We looked at quantitative findings to learn how well CHWs reach and improve health among the most disadvantaged groups compared with more advantaged groups. Analysis of qualitative findings then revealed key barriers and facilitators to equitable CHW service delivery and helped identify routes for CHW programmes to make a positive difference.

## 2. OVERVIEW OF FINDINGS

Today, many NGOs and governments rely on CHWs to bring healthcare access to the most disadvantaged communities and individuals. As expected, we found that **CHWs do a good job of reaching groups that experience barriers to accessing conventional health services**, including women and girls, the poor, people with limited literacy/education, and people living in rural/remote regions. Most studies found that **people in these disadvantaged groups received as much or more care from CHWs compared with more advantaged groups**.

However, despite the equitable reach of CHWs, **disadvantaged groups continued to have poorer health behaviours and outcomes in many communities**. This may be in part because people in disadvantaged groups were less able to follow through on CHWs' advice and referrals. For example, some found it impossible to follow CHWs' nutritional advice because they couldn't afford healthy food; others did not take up CHW referrals to the hospital because of transportation costs or fear of discrimination by hospital staff. This shows that equitable service delivery by CHWs is not enough to overcome health inequities within populations. **For CHW services to maximally benefit all members of society, we need to look at the wider context of health and address challenges faced by society's most marginalized**. Realising the full potential of CHW programmes may require taking steps to alleviate poverty, improve transportation, strengthen health facilities, or tackle social inequality. This resource pack offers recommendations on how CHW programmes can better reach and improve health in disadvantaged groups while also helping address some of the underlying causes of health inequity.

## 3. THE POTENTIAL

It is well known that CHWs reach individuals who have limited access to conventional healthcare because of their positioning within communities. For this reason, CHW programmes are often seen as a low-cost way to bridge access gaps in settings where healthcare resources are scarce. But our study suggests that well-designed CHW programmes can go further to actually address some of the root causes of inequity. They can contribute to social and economic empowerment by creating qualified employment opportunities in disadvantaged communities. They can support action on the social determinants of health by empowering CHWs to act as advocates and activists. And they can generate expertise about the health challenges faced by marginalized groups that can be used to improve health policy and programme planning. In all these ways, **CHW programmes can rise above serving as a temporary band-aid in settings of deep, existing inequity to play a role in catalysing social, political, and health system transformation**.

## 4. THE RISK

Unfortunately, without caution, CHW programmes may fail to address health inequities or even make them worse. This can happen when:

- (a) CHWs fail to reach the most disadvantaged individuals
- (b) The most disadvantaged individuals are unable to benefit effectively from CHW services, for example, because they are unable to follow health advice and referrals
- (c) CHW programmes are seen as a low-cost alternative to tackling complex structural and health system problems

- (d) **Poor working conditions for CHWs negatively affect their wellbeing and socioeconomic status, furthering social and economic marginalization**

## **5. RECOMMENDATIONS FOR OPTIMISING EQUITY IMPACTS**

In order to realise the full potential of CHW programmes in LMIC, we need to look at the wider social context of health. This is important to ensure CHW programmes reach and maximally benefit disadvantaged groups while also contributing to positive change in health systems and society. Here are 5 recommendations for achieving this.

### **(a) Proactively address barriers to care experienced by disadvantaged groups, taking affirmative action**

The main way that CHW programmes promote health equity is by extending access to healthcare to disadvantaged groups. However, simply recruiting health workers based in communities is not enough to achieve this. Measures must be taken to ensure CHWs are able to reach the most disadvantaged in their communities. This means considering possible barriers to service delivery, including distance and cost, as well as barriers to utilization, such as fear of discrimination or stigma. Beyond the reach of CHW services, we must also consider their impact in disadvantaged groups. Some individuals will face barriers to acting on CHW health advice and referrals, which means that CHW services may not benefit all community members equally. In this resource pack, you will find recommendations for **improving the reach and impact of CHW programmes in disadvantaged groups** based on available evidence. See Resource Packs C-F.

### **(b) Ensure good working conditions and fair pay for CHWs**

CHW programmes can contribute to addressing social and structural inequalities by creating qualified employment opportunities within disadvantaged communities. Adequately remunerated employment that is meaningful and impactful can be a pathway to improvements in health and wellbeing for CHWs from disadvantaged backgrounds, with positive spill-overs for their families and wider communities. It can also help address social inequalities and promote empowerment; for example, supporting gender equality by fostering women's financial autonomy, solidarity, and opportunities for leadership and educational development. Unfortunately, however, CHWs in many places report poor working conditions, including unstable employment, inadequate remuneration, unmanageable workloads, and discriminatory treatment. CHWs also often incur direct or indirect costs as a result of their work, that are not covered by employers, for example, the cost of mobile phone credit used to call patients. Careful attention to working conditions and employment practices is needed to ensure CHW programmes address, rather than reproduce, the social and economic inequalities that contribute to poor health. See Resource Pack A.

### **(c) Empower CHWs to act as advocates for change**

CHWs can play an important role in advocacy and activism to address social, structural, political, and health system problems that contribute to poorer health in disadvantaged groups. We suggest supporting this capacity in CHWs. This may require going beyond simply adding 'activism' to the list of CHWs' responsibilities; CHWs' advocacy roles should be clearly defined in operational guidelines and work environments structured to enable them to realize this potential. Ongoing training, supportive supervision, and mentoring can help CHWs develop the confidence and leadership skills required for advocacy work. Programme designs that make CHWs accountable to communities rather than health institutions (e.g. when CHWs are employed through village committees) may increase CHWs' willingness and ability to advocate for change within health systems. Performance-based incentives linked with biomedical service delivery may disincentivise CHWs from engaging in community mobilisation work, while consistent and adequate remuneration for all time spent, coupled with support for indirect costs such as childcare, can enable and empower CHWs to realise their role as agents of change. With appropriate support, CHWs can play a role in catalysing social, political, and systemic transformation for a more equitable society. See Resource Pack B

#### (d) Involve CHWs meaningfully all levels of decision making

Because of their placement in communities, CHWs have unique insights into health inequities that can be used to inform policy and programme planning processes. Research shows that CHWs are usually acutely aware of the structural barriers to achieving healthcare equity in their communities (including some of the less visible ones) and strongly motivated to address them. In this way, CHW programmes generate expertise that can be used to build more equitable health systems. We recommend recognizing and harnessing this by bringing CHWs into the heart of programme planning processes, from design to evaluation, as well as higher-level health system policy processes. CHWs may have ideas about new initiatives to respond to the challenges they encounter, which should be supported wherever possible. In short, we advocate **treating CHWs as partners in change**. See Resource Pack B.

#### (e) Make complementary investments in structural and health system improvements

It is clear that CHW programmes can only ever be a part of the solution, because of the limited range of services that they can realistically offer and because they cannot alone address the wider social and political determinants of health. Although CHWs are often conceptualized as links between communities and formal health services, in practice they have limited influence over many of the factors that impede people from accessing these services, including poor road conditions, long distances, and the cost and quality of care provided by health professionals. Providing basic health promotion, disease prevention and limited curative services is unlikely to be enough to change the health behaviours of marginalised populations in contexts of resource deprivation without complementary investments in poverty alleviation and transportation infrastructure. Moreover, when CHW programmes are implemented in the absence of access to adequate primary, secondary, and tertiary services, the result is a 'two class medicine', where marginalized communities receive healthcare exclusively from less qualified providers. For these reasons, it is important that CHW programmes are implemented **not as an alternative to, but as an integrated component of well-functioning health systems**. CHW programmes can support this by advocating for and investing in structural and health system improvements.



## RESOURCE PACK (A)

# 5 WAYS TO ENSURE FAIR WORKING CONDITIONS FOR CHWS

CHW programmes can contribute to health equity by creating qualified employment opportunities in marginalized communities, as long as fair and good working conditions are ensured. Poor employment practices and working conditions can damage CHW motivation and retention, and may inadvertently end up reproducing the very social and health inequalities they set out to address.

## 1 ENSURE THAT CHWS REPRESENT THE COMMUNITIES THEY SERVE

- Hire local CHWs wherever possible.
- Proactively seek to recruit CHWs from disadvantaged groups within communities (e.g. religious/ethnic minorities, single mothers, people with disabilities etc.).

## 2 ENSURE FAIR PAY

- Pay a proper living wage. No one should be excluded from becoming a CHW for financial reasons and CHWs should not have to undertake additional work to 'top up' their salaries.
- Include paid leave for maternity, illness and holidays.
- Ensure that CHWs are reimbursed for reasonable costs incurred in the course of their work; for example, transportation and mobile phone costs. Bear in mind that these may be disproportionately borne by those working in remote rural areas.
- Ensure adequate provision for indirect costs that CHWs may incur, such as farm labour or childcare

*In Ethiopia, female Health Extension Workers complained that remuneration was inadequate for the challenging work they did. This had a negative impact on their wellbeing and led many to resign and pursue other career opportunities. One explained, 'My family told me I've lost weight and colour in my face and they want me to run a shop now. It is not comfortable walking with all the rain and the mud. One pair of shoes lasts one or two weeks because there are no good roads'.<sup>1</sup>*

## 3 ENSURE MANAGEBLE WORKLOAD

- Ensure that the range of tasks is clearly defined, appropriate and achievable, to avoid burn-out.
- Factor in extra time for transportation for CHWs with large, dispersed or rural catchment areas.
- Be prepared to re-allocate and re-prioritise tasks at 'pinch-points', when workloads are high

## 4 PROVIDE ROUTES FOR EFFECTIVE CAREER PROGRESSION AND DEVELOPMENT

- Provide regular in-service training and professional development opportunities, with appropriate compensation for time and travel costs.
- Ensure regular, effective mentoring and supervision.
- Where possible, ensure that CHWs have stable contracts and clear routes for career progression. Where job stability cannot be guaranteed, be transparent about this and put in place training opportunities and mentoring to support career development beyond the current contract.

## 5 TACKLE DISCRIMINATION AT ITS CORE

- Proactively work to tackle discrimination against female CHWs and those recruited from marginal or disadvantaged groups / areas.
- Enforce equal pay for equal work. Regularly monitor and address gender (and other) pay gaps.
- Tackle discriminatory behaviour of other health ('higher status') professionals towards CHWs.

*A gendered analysis of Afghanistan's national CHW programme found that male CHWs generally had less demanding tasks yet were more likely to become supervisors and decision-makers.<sup>2</sup>*

## RESOURCE PACK (B)

# 5 WAYS TO ENGAGE CHWS AS PARTNERS FOR CHANGE

CHWs often have first-hand knowledge of the communities they work with and the barriers to health experienced by the most marginalized members. They are also well-placed and strongly motivated to identify solutions and advocate for social, political, and health system changes that can contribute to health equity. How can we ensure their insights, ideas and skills are captured and used most effectively to improve programmes?

## 1 INVOLVE CHWS IN PROGRAMME PLANNING AND DECISION MAKING

- Recognise and harness CHWs' first-hand knowledge by bringing them into the heart of programme planning processes.
- Ensure that experienced CHWs are meaningfully involved at each point of programme design, roll-out, monitoring and evaluation.

## 2 BE RESPONSIVE TO CHW FEEDBACK AND SUGGESTIONS

- Actively listen to and be prepared to act on ideas and insights from CHWs working on the ground, in order to improve programme outcomes.

*Grassroots volunteers in Tanzania noticed that their clients were not adhering to HIV treatment because they did not have enough food to eat. They successfully lobbied the NGO employing them to add food distribution to their portfolio of services.<sup>3</sup>*

## 3 EMPOWER ADVOCACY TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

- Recognise and value the skills and motivation of CHWs to act as advocates for patients and agents of social change.
- Consider training CHWs on advocacy skills, allotting paid work time each week for advocacy activities, and supporting the formation of CHW professional associations and groups.

*CHWs in South Africa expressed an interest in creating media that could be used in their work and to promote local social change. Through a participatory arts-based research project, they received training on media-making and decided on the social cause they wanted to address. They were provided with digital cameras and support to produce 10 media posters targeted at addressing gender-based violence.<sup>4</sup>*

## 4 ENSURE EFFECTIVE SUPPORT FOR CHW-LED INITIATIVES

- Ensure that CHWs are reimbursed for reasonable costs incurred in advocacy and other work to address structural barriers to healthcare equity – they should not have to draw on personal resources to meet additional expenses.

---

## **5 ENSURE THAT CHWS HAVE AN EFFECTIVE VOICE IN HIGHER-LEVEL HEALTH SYSTEMS PLANNING**

- CHW's expertise and insights are relevant not only for programme design, but also for health policy planning and implementation at national and international levels.
- Advocate for greater CHW representation in health policy and programme settings.

## RESOURCE PACK (C)

# 5 THINGS TO CONSIDER IN REACHING RURAL/REMOTE COMMUNITIES

CHW programmes often target rural areas and have been successful in extending services beyond cities. However, it can be challenging to reach the most remote rural populations, and to provide effective care for mobile and displaced populations.

## 1 ENSURE CHWS ARE PROPERLY EQUIPPED AND TRAINED TO WORK IN REMOTE AREAS

- Consider hiring CHWs living in rural and remote communities to serve those communities.
- Ensure that CHWs based in the most remote rural areas have adequate medical equipment/supplies to minimize travel to and from facilities.
- CHWs in rural and remote areas may require additional training, for example, in managing obstetric complications where emergency transport to hospitals is not possible.
- Ensure CHWs working in rural/remote areas have mobile phones and cover the costs of mobile credit & charging.
- CHWs in some settings may require additional equipment to work safely, such as torches or GPS technology.

*One CHW in Ethiopia recounted the challenges of serving an Afari community in the desert: "Once I assisted a woman whose labour lasted more than one day to get to the hospital. I walked 20 kms to get a phone signal to call the ambulance but when that didn't work I went home and we carried the woman for six or seven hours on a stretcher to the road. Then we called the...ambulance to come the last 40 kms".<sup>5</sup>*

## 2 FACILITATE MOBILITY OF CHWS AND CLIENTS

- Provide CHWs with means of transportation such as bicycles or motorcycles where appropriate.
- Provide stipends/reimbursements to cover CHWs' transportation costs where public transport is available.
- Where women's mobility is restricted, consider deploying male CHWs and/or CHWs in pairs or groups, including mixed-gendered pairs when appropriate.
- Facilitate patient transport to and from specialist services by providing transport stipends or financial incentives.
- Seek to establish linkages with free or low-cost emergency transportation services, such as ambulances

## 3 PLAN SERVICES TO ACCOUNT FOR GREATER DISTANCES AND TRAVEL TIMES IN RURAL AREAS

- Ensure CHW catchment areas are manageable in size and account for local transportation infrastructure and difficulty of terrain. They may not map neatly on to formally recognized 'districts', 'counties', etc.

- 
- Considering expanding CHWs' remit to include more direct service delivery in areas where referral to other services is not realistic for many. To avoid work overload, this may require additional staff deployment.
  - Ensure that additional travel time and costs are factored into CHWs' workloads and remuneration.
  - Consider deploying 'mobile CHW' teams to reach nomadic, homeless and other mobile populations.
  - Implement effective transfer-of-care processes to provide continuous care when people move or migrate.

## **4 ENSURE THAT CHWS WORKING IN REMOTE AREAS ARE NOT DISADVANTAGED**

- Make sure that CHWs in rural and remote areas have access to the same training, supervision and career development opportunities as those based in urban areas; this may require providing stipends and additional paid time for travel.
- Ensure that additional costs borne by rural CHWs (transport, communication) are covered or reimbursed

## **5 WORK WITH OTHER AGENCIES TO ADDRESS SYSTEMIC RURAL DISADVANTAGE**

- Where possible, make complementary investments in transportation infrastructure, emergency transportation service development, and strengthening the nearest referral facilities.
- Advocate for government investment in transportation, infrastructure, and health system strengthening.

# 5 THINGS TO CONSIDER IN ADDRESSING GENDER HEALTH INEQUITIES

CHW programmes are often successful at reaching women and girls. However, many women continue to face significant challenges within households in negotiating access to healthcare. Lack of financial and social autonomy, combined with risks of stigma, can limit access to care, particularly in the area of sexual and reproductive health.

## 1 CONSIDER GENDER WHEN HIRING AND DEPLOYING CHWS:

- Think carefully about the gender composition of CHW teams and strategically distribute tasks between female and male CHWs, appropriate to the social and cultural context.
- Consider matching the gender of CHW and client. Female clients may feel more able to discuss sensitive health topics with female CHWs, while male clients may be more comfortable talking with male CHWs.
- Consider deploying mixed-gendered pairs of CHWs for some home visits.
- Consider having male CHWs to cover night shifts, when women's mobility may be more restricted.

## 2 PROVIDE SAFE SPACES FOR WOMEN TO ACCESS HEALTH SERVICES DISCREETLY:

- Ensure all services are genuinely free of charge, to enable access for women who lack financial autonomy.
- Provide the option of home-based care/home visits where possible, especially where mobility is restricted.
- Use mobile phones to facilitate confidential consultations for women.
- Consider embedding family planning services (and other sexual and reproductive health services) within general medical outreach camps to minimise visibility.

*A programme in Southern Ethiopia aimed to increase access to diagnosis and treatment of tuberculosis by training community-based providers. A Health Extension Worker explained how the programme's home-based care approach improved access to care for women in particular: 'Previously, with regards custom, they [women] don't get out of the house. When she is sick, she is not given attention. There is also lack of awareness. But now the campaign goes from house-to-house. The other thing is women don't go far away for medical examination. Giving sputum at home is convenient for women'.<sup>6</sup>*

## 3 ENSURE THAT PROGRAMMES REACH THE MOST VULNERABLE WOMEN AND GIRLS:

- Recognise that gender can intersect with other factors (poverty, low education, adolescent motherhood, disability, etc.) to compound disadvantage for some groups of women and try to identify groups of women/girls who may be particularly vulnerable.
- Proactively work to ensure that interventions reach the most vulnerable women and girls. This may entail taking affirmative action and providing other forms of support (e.g. financial assistance, advocacy) to facilitate access.

---

## **4 ENGAGE MEN:**

- Consider having male CHWs to engage with men and act as ‘ambassadors’ and allies for women’s health rights and needs.
- Having male CHWs working alongside female CHWs can promote gender equity and normalise male care-seeking in contexts where health centres are seen as ‘women’s places’.

## **5 CONSIDER GENDER AND SEXUAL MINORITIES:**

- Be aware that some community members may be LGBTQ+ and may need to conceal this identity.
- Sensitization training may be needed to ensure that CHWs treat all individuals with respect, taking particular care not to ‘out’ or otherwise endanger people who may identify as LGBTQ+.

## RESOURCE PACK (E)

# 5 THINGS TO CONSIDER IN ADDRESSING SOCIOECONOMIC INEQUITIES

CHW programmes have often been effective in reaching socio-economically disadvantaged (poor) groups, but this does not always lead to improved health behaviours and outcomes. Addressing financial barriers to effective service uptake and utilisation, particularly when referral to other health facilities is indicated, is key to ensuring that CHW programmes make a difference for the poorest.

### 1 ENSURE THAT CHW SERVICES ARE GENUINELY FREE OF CHARGE:

- While most CHW services are provided free of charge, even small additional costs (e.g. for transport, medications, registration fees or other 'incidentals') can represent a significant barrier for the poorest.
- Ensure that all CHW services are genuinely available free of charge at point of use.

### 2 ADDRESS FINANCIAL OBSTACLES TO POORER CLIENTS FOLLOWING CHWS' HEALTH ADVICE:

- Ensure that CHWs' advice is realistic and achievable, even for the poorest.
- Where appropriate, consider providing additional material support (e.g. food parcels, vouchers, social welfare grants or cash).

*In Kenya, one CHW explained how lack of food interfered with uptake of nutritional messages: '...when you counsel someone on what to eat, sometimes they look at you funnily because you can see that they cannot afford what you are telling them'.<sup>7</sup>*

### 3 FACILITATE FINANCIALLY VULNERABLE CLIENTS TO TAKE UP CHW REFERRALS:

- When CHWs refer clients to other health professionals and facilities, the costs can be prohibitive, especially when hospitalisation is indicated.
- Consider empowering CHWs to provide 'fee-free referral vouchers', financial subsidies or cash incentives to low-SES clients in need of facility-based treatment.
- Explore possibilities of establishing links with free or low-cost transportation services (either dedicated services like ambulances or with commercial-sector taxi/minibus companies, etc.).
- Consider establishing CHW triaging systems to flag poor, high-risk patients to facility-based professionals for immediate attention (preventing need for costly overnight stay and repeat visits).
- Consider facilitating CHWs to accompany and advocate for poorer clients in interactions with health professionals in settings where they might feel uncomfortable or belittled.

### 4 MINIMISE TIME COSTS OF SERVICE USE FOR POORER CLIENTS:

- In addition to financial barriers, the time costs of accessing CHW and other health services can be prohibitive for some lower-income clients, who may be too busy just trying to earn a living.
- Consider adjusting clinic hours to fit in with clients' working schedules, and introducing effective appointment and/or triage systems to minimise waiting times.

- 
- Consider delivering home-based or workplace-based care.

## **5 ENSURE EFFECTIVE TARGETING AND DISTRIBUTION OF PRO-POOR MEASURES:**

- Undertake SES mapping to identify the most vulnerable/poorest groups, noting that poverty may intersect with other axes of disadvantage (gender, disability, limited schooling, adolescent motherhood, etc.)
- Proactively work to ensure that pro-poor measures are available to all vulnerable individuals and groups, especially those that might be less visible and less able to access support.
- Identify inter-sectoral opportunities to support sustainable poverty-reduction, e.g. through training and employment opportunities, etc.

## RESOURCE PACK (F)

# 5 THINGS TO CONSIDER WHEN WORKING DIVERSE COMMUNITIES

Most communities have some degree of ethnic, religious or other cultural diversity. In many cases, some groups are more powerful or have higher status than others, posing challenges for equitable delivery of CHW services. This may be compounded when minority groups are regarded as being 'ignorant', 'traditional' or 'uneducated'.

## 1 ADOPT APPROPRIATE CHW RECRUITMENT AND DEPLOYMENT PRACTICES:

- Proactively recruit CHWs from minority ethnic, linguistic and religious groups.
- Ensure that CHWs are acceptable and accessible to the community groups they serve. Depending on context, this may involve ensuring matching the gender of CHWs and clients where cultural/religious indicate this.

## 2 MAINSTREAM TRAINING ON CULTURALLY-SENSITIVE PRACTICE:

- Ensure all CHWs receive appropriate and regular training on culturally-sensitive practice.
- Avoid stereotyping and making assumptions about the needs and values of minority groups.

*In Ethiopia, one Health Extension Worker described an encounter with an elderly pastoralist who resisted advice to boil her milk: 'So instead of wasting time to this kind of people whose cultural issues are deep rooted, it's better to talk to someone moderate in the family who can at least understand what I'm trying to tell him/her.... For us, dealing with rural people is a hell on earth'. These dynamics eroded trust and led to lower perceived quality of care and utilisation.<sup>8</sup>*

## 3 RESPECT AND WORK WITH LOCAL PRACTICES AND PRACTITIONERS:

- Show respect for local healthcare practices and practitioners; for example, by involving traditional healers as partners in care.
- Adapt CHW services, messaging and materials as appropriate, to make them acceptable and accessible in the local context.

## 4 ENCOURAGE CHW ADVOCACY:

- Consider facilitating CHWs to accompany clients to health facilities to advocate on their behalf and prevent mistreatment.

---

## 5 ENSURE LANGUAGE CONGRUENCE:

- Communication is key for effective healthcare; difficulties communicating in the dominant language can lead to poor healthcare experiences or low health seeking in minority groups.
- Wherever possible, ensure that CHWs are fluent in minority languages spoken in their region.
- Consider use of interpreters where this cannot be achieved.

*A programme in Mexico established 'Casas' to provide healthcare for indigenous women who experience barriers to conventional care on the basis of their ethnicity, gender, and class. All Casas were staffed by women fluent in indigenous languages as well as Spanish. In a qualitative evaluation, staff considered language congruence the 'primary success' of the programme, enabling women to feel confident seeking health care and satisfied with care received. One woman using a Casa reported, 'I was happy with all of the care I was given... I got along well with the personnel because they spoke Tzotzil and I also speak Tzotzil. We have a good experience with them because you know, when we go to a hospital they don't treat you the same as here in the Casa, because they speak Spanish and here we don't speak Spanish. That's why...'*<sup>9</sup>

## BIOGRAPHY

1. Jackson, Ruth, Di Kilsby, and Assefa Hailemariam. 2019. "Gender Exploitative and Gender Transformative Aspects of Employing Health Extension Workers under Ethiopia's Health Extension Program." *Tropical Medicine and International Health* 24 (3): 304–19 (quote from p. 310). doi:10.1111/tmi.13197.
2. Najafizada, Said Ahmad Maisam, Ivy Lynn Bourgeault, and Ronald Labonté. 2019. "A Gender Analysis of a National Community Health Workers Program: A Case Study of Afghanistan." *Global Public Health* 14 (1). Taylor & Francis: 23–36. doi:10.1080/17441692.2018.1471515.
3. Corbin, J. Hope, Maurice B. Mittelmark, and Gro T. Lie. 2016. "Grassroots Volunteers in Context: Rewarding and Adverse Experiences of Local Women Working on HIV and AIDS in Kilimanjaro, Tanzania." *Global Health Promotion* 23 (3): 72–81. doi:10.1177/1757975915569514.
4. Lange, Naydene de, and Claudia Mitchell. 2016. "Community Health Workers as Cultural Producers in Addressing Gender-Based Violence in Rural South Africa." *Global Public Health* 11 (5–6). Taylor & Francis: 783–98. doi:10.1080/17441692.2016.1170867.
5. Jackson, Ruth, Fisaha Haile Tesfay, Tesfay Gebregzabher Gebrehiwot, and Hagos Godefay. 2017. "Factors That Hinder or Enable Maternal Health Strategies to Reduce Delays in Rural and Pastoralist Areas in Ethiopia." *Tropical Medicine and International Health* 22 (2): 148–60 (quote from p. 154). doi:10.1111/tmi.12818.
6. Datiko, Daniel G., Mohammed A. Yassin, Olivia Tulloch, Girum Asnake, Tadesse Tesema, Habiba Jamal, Paulos Markos, Luis E. Cuevas, and Sally Theobald. 2015. "Exploring Providers' Perspectives of a Community Based TB Approach in Southern Ethiopia: Implication for Community Based Approaches." *BMC Health Services Research* 15 (1) (quote from p. 5). BMC Health Services Research: 1–9. doi:10.1186/s12913-015-1149-9.
7. Avery, Lisa S., Elsbé Du Plessis, Souradet Y. Shaw, Deepa Sankaran, Peter Njoroge, Ruth Kayima, Naomi Makau, et al. 2017. "Enhancing the Capacity and Effectiveness of Community Health Volunteers to Improve Maternal, Newborn and Child Health: Experience from Kenya." *Canadian Journal of Public Health* 108 (4): e427–34 (quote from p. e432). doi:10.17269/cjph.108.5578.
8. Getnet, Fentabil, Abdiwahab Hashi, Sahardid Mohamud, Hassen Mowlid, and Eveline Klinkenberg. 2017. "Low Contribution of Health Extension Workers in Identification of Persons with Presumptive Pulmonary Tuberculosis in Ethiopian Somali Region Pastoralists." *BMC Health Services Research* 17 (1). BMC Health Services Research: 1–9 (quote from p. 6). doi:10.1186/s12913-017-2133-3.
9. Pelcastre-Villafuerte, Blanca, Myriam Ruiz, Sergio Meneses, Claudia Amaya, Margarita Márquez, Arianna Taboada, and Katherine Careaga. 2014. "Community-Based Health Care for Indigenous Women in Mexico: A Qualitative Evaluation." *International Journal for Equity in Health* 13 (1): 1–9 (quote from p. 5). doi:10.1186/1475-9276-13-2.