COMMUNITY HEALTH WORKERS

PROFILE AND TRAINING PROCESS IN COLOMBIA

INÉS DEL PILAR LÓPEZ QUIÑONES

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The IMCI (Integrated Management of Childhood Illness) strategy has emerged in recent years as the primary tool to achieve control of the illnesses and health problems that continue to cause a high proportion of the deaths in children under 5, especially in developing countries. The application of its components, both through health workers, families and the community, will make it possible to give children under 5 access to effective disease prevention, early diagnosis and adequate treatment, as well as care in the home compatible with prevention and health promotion.

The efforts countries are making to ensure that all children receive the benefits of this strategy have been directed toward three areas - the three components of the process of IMCI implementation: improving the skill of the health workers in child disease prevention and control; improving the health systems so that they offer high quality care; and improving the family and community practices with a view to the health of the children. This last component is considered essential to guarantee that the available interventions to improve child health conditions achieve their maximum coverage, with the consequent impact on general child health conditions.

The improvement of family and community practices related to child health in the home will require a broad mobilization of all the sectors, to transfer knowledge and practices to caregivers and for them to adopt the most appropriate decisions for health promotion, disease prevention and treatment within the context of their culture. In this process, health personnel and health services will perform an important role, but the protagonists will be the large number of people and institutions who, in one way or another can deliver information to the population, strengthening attitudes and practices that improve the quality of health care of the child.

The Community Health Workers (CHW), including all the institutional and non-institutional personnel that promote health will fulfill a crucial function in this framework, since they constitute the fundamental link between health services and the communities they serve. Through prevention, health promotion, and early detection and treatment of diseases in the community, the CHW ensure that many interventions arrive on time to many children that otherwise would not receive these benefits. Thanks to these actions, many children enjoy a better state of health, are disease-free, or many episodes of disease that could not be avoided are less serious thanks to the prompt care and adequate treatment they received, including timely referral to services, and greater problem solving ability of health workers.

The massive incorporation of CHWs within the process of IMCI strategy implementation, especially with regard to the third component directed to the community, is considered an action of profound importance. Within this framework, knowledge of the experiences existing in the countries for the education, supervision, and evaluation of the human resources in health can constitute a basis for identifying strengths and weaknesses and orienting activities in the most efficient way possible.

For this purpose, it is of great interest to know the situation of a country, such as Colombia, where an analysis of the experience in the formation and work of the CHW and of their role in child health care has been carried out. The analysis presented in this publication makes it possible to understand the principal forms in which the education and work of this important human resource are carried out. This understanding can contribute to the continuous transfer of knowledge, attitudes, and practices whose outcome
can be an improved state of health, especially for children. This is presented not only as a contribution to the description of the role that this personnel can perform in care and the way they do it, but also as a contribution to the identification of ways in their performance can be improved.

In the coming years it is expected that the role of these CHW will be strengthened, in particular in regard to the application of the IMCI strategy and to the achievement of the universal access of the population to it. In this way we hope to support the achievement of the proposed goal by the Director of PAHO, to reduce by 100,000 the number of deaths of children under 5 by the year 2002.

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INTRODUCTION

This document addresses the proposal regarding community health workers, delivered and endorsed by the Pan American Health Organization (PAHO) and the World Health Organization (WHO) in November 1998, the purpose of which was to determine the profile of community health workers in Colombia and outline their training process.

The proposal reflects the findings of the research conducted in six Colombian cities and is based on explanatory analysis of information obtained from private, public, national, and international entities that promote health activities using community health workers.

To promote programs in the areas of disease prevention and health promotion to prevent morbidity and mortality, particularly among women and children, requires an appropriate and effective approach that considers the realities of marginal urban and rural communities as well as the daily experience of families in the environments where children spend most of their time.

In this approach, based on the reality and daily life of communities, community health workers (CHW) represent a strong and decisive link, facilitating participatory management processes in health programs within the community dynamic.

Therefore, it becomes increasingly evident that the State, institutions of all types, and society as a whole have an increasingly important stake in taking advantage of, promoting, strengthening, and upgrading the role of community health workers in order to further the transformation of our daily health practices.

The objective of this study is to develop a comprehensive approach attuned to the reality of community health workers in Colombia and facilitate their training. In this context, the objective is to identify resources for promoting the design and implementation of policies for disease prevention and health promotion, as well as the design of informal educational programs that will have a real impact on society’s most abandoned and marginal communities.
BACKGROUND

In order to speak of community health workers in Colombia, we must first go back and review the framework of primary health care activities in the 1970s. At that time, official and private organizations were aware of their responsibility for solving the problems faced by some communities—communities where the concepts of development and well-being had practically no meaning whatsoever.

Primary health care is defined by the Declaration of ALMA ATA as "health care universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford. It forms an integral part of country's health system, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, and constitutes the first element of a continuing health care process." 1

Using this conceptual framework, the Declaration's strategy is beginning to be implemented in Colombia. As a result, different activities are under way in cities throughout the country, for example the collaboration between the city of Cali and the Universidad del Valle and Multidisciplinary Research Center (CIMDER), and that between Santa Fe de Bogotá and the Fundación Santa Fe and its Community Health Division, whose purpose is to promote the well-being of vulnerable populations through investigative, educational, and technical assistance activities. Hence, it has sought to address the health problems that most frequently affect families and communities.

These and subsequent activities have served as the basis for promoting development and strengthening primary health care, spreading to other cities of the country.

In the wake of this study, other groups, such as the FES, RESTREPO BARCO, CARVAJAL, and CORONA foundations, have begun to join this effort. These foundations adhere to the principles of strengthening, self-reliance, self-determination, and self-management as described in the Declaration of Alma Ata, as well as the principles set forth in the Ottawa Charter, in financing activities oriented toward the creation of groups of volunteer health workers. According to these foundations, such activities are important for strengthening the organizational processes and participation of communities throughout the country.

In Colombia, the selection, education, and training of community health workers have taken place in three distinct periods.

The first period spans from 1982 to 1992. During this time, efforts began in nine cities throughout the country, involving local residents motivated by a spirit of collaboration and solidarity and mobilized by the staff of local institutions, whose activities put an emphasis on disease prevention.

During the second period, from 1992 to 1995, the work spread to other cities. However, these activities included not only health volunteers but also members of the community with recognized leadership skills who were linked to local organizations. These individuals included community leaders, representatives of Community Action Boards (Juntas de Acción Comunal), and the heads of neighborhood and mothers' associations. The training process of these volunteers emphasized health promotion and the importance of participation and organizational processes as a means of involving their communities in the dynamic of health service decentralization under way in the country.

The third period began in 1995 and has continued into the present, as a result of the passage of Laws 10/1990 and 100/1993, passed during the reform of the social security health system. These laws establish three new players: Health Promoting Enterprises (EPA); institutional health service providers (IPS); and Administrators of the Subsidized System (ARS). Accordingly, these institutions recruit and train community health workers or coordinate training processes with them, adding a new dynamic to primary health care in Colombia.

The large number of organizations involved in Colombia's health sector reform process, representing differing levels of responsibility for disease prevention and health promotion, today has resulted in a wide variety of profiles and training processes for health workers.
METHODOLOGY

The planning and implementation of this study followed the proposal submitted to PAHO, which implied the review and analysis of primary and secondary information sources. The objective of the study was to compile an accurate profile of community health workers and their training in Colombia. Although instruments designed to provide both qualitative and quantitative information have supported the study, the resulting analysis shows a more explanatory than descriptive approach.

This document is the result of a comprehensive analysis of data obtained through field research. Its purpose is to provide a more in-depth profile of community health workers and the training processes currently under way in Colombia.

The study consists of four basic phases, overlapping at different intervals as the research was conducted.

The first phase consisted of a review of official documents, studies and articles on the situation of the country's community health workers. The main objective of this phase was to place the problem within a general framework and, ultimately, to get a preliminary idea of the dynamics and approaches to the training of community health workers, as well as to understand how institutions introduce and execute these programs.

As an essential component of this phase, two important impact assessments on the evaluation of community processes in Colombia were performed: the "Impact Assessment of Community Homes for the Well-Being of Families" and the "Evaluation of the Comprehensive Malaria Control Program on the Pacific Coast in Chocó, A Community Experience, CINDE". The analyses and summaries of these impact assessments relate to the objectives of this study, and their most significant elements are discussed in this document.

The second phase centered on the information gathering process, conducting surveys of institutions working in community education and health in different regions of the country, and on the formation of three focus groups made up of 21 community health workers linked to programs for health promotion and disease prevention at various health institutions responsible for CHW training.

These surveys were conducted by fax, mail, and in person, targeting representatives of public and private institutions, nongovernmental organizations (NGOs), mutual associations, family subsidy funds, Health Promoting Enterprises (EPS), institutional health service providers (IPS), and Administrators of the Subsidized System (ARS).

With regard to structure, the survey consists of 20 closed and 10 open-ended questions (see Appendix 2). The topics covered in the survey included general institutional information; the community health agent selection process and institutional connection with workers; areas of responsibility and functions; training; monitoring and assessment; interinstitutional coordination; and a section for comments. The latter proved to be very useful, especially in the case of organizations where the survey was administered in person, as it provided an opportunity to record information on areas of particular interest to this study.

It is important to mention that the first six questions pertain to general institutional information about the organizations surveyed. This information was used to compile a comprehensive directory of these organizations, whether through visits, airmail, e-mail or fax. The directory is included in Appendix 1 of this document.
The surveys were conducted in different regions of the country. Some institutions did not respond to the survey, while others chose not to answer some items they considered irrelevant to their area of work. A total of 101 surveys were sent by mail, to which 20 organizations responded. Seventy surveys were administered directly to organizations in the regions of Cundinamarca, Manizales, Pereira, Santa Marta, Pasto, and Bogotá. These surveys were administered to institutions that work in marginal, rural, and urban areas.

At the conclusion of the study, 90 surveys had been processed.

It should be pointed out that the surveys administered directly provided greater and more pertinent information, given that some items were left blank in the surveys sent by mail or fax. Moreover, the direct interaction with institutional representatives facilitated a more integrated approach to the processes, as well as the analysis of the documents needed to gain better insight into these processes.

The focus groups were formed to address the need for a comprehensive characterization and analysis of the practical knowledge of community health workers working in some rural and marginal urban areas. These included the town of Bosa in Bogotá, the rural zone of Cundinamarca, and the municipalities of San Juan de Rio Seco and Viani.

The focus group strategy was based on informal conversations, involving open and structured responses, in groups of six to eight persons, with the objective of uncovering new and relevant information for the study. This tool facilitated interaction among group members, generating honest responses and contributing new ideas. Moreover, first-hand insight was gained with regard to participants’ behavior, attitudes, language, and perceptions in areas of interest to the study (see Appendix 3).

The third phase of this study centered on the organization of information, both quantitative and qualitative, addressing the study objectives.

The survey data was entered into a database to facilitate efficient information management. This database consolidated quantifiable survey questions into general findings. In the case of open-ended questions, this information was subsequently analyzed and categorized to identify the principal thematic areas and get a better understanding of the training processes, as well as a more accurate CHW profile. Moreover, information obtained from the focus groups, even from transcripts of audiotaped interviews, was added to this characterization.

The organization of this information made it possible to develop categories that group the most significant findings in keeping with the proposal. These categories are:

1. CHW profile proposed by institutions;
2. CHW profile proposed by community health workers and the community;
3. Institutional connection and training process of community health workers;
4. Training program contents;
5. Training methodology;
6. Assessment and monitoring of CHW work;
7. Areas of CHW intervention; and
8. Organization of CHW activities.

The fourth and final phase consisted of drafting the final report, which involved organizing the information into a document analyzing the inputs obtained; the synthesis or explanatory reading of the information obtained in the study, designed to provide a profile of community health workers in Colombia and their training process; and a summary of the two impact assessments mentioned earlier.
ANALYSIS OF DATA

This chapter provides a quantitative and qualitative analysis of the study data in order to get a better understanding of the profile and training of community health workers in Colombia.

In order to facilitate their analysis, the responses have been grouped into the categories established in the process.

1. Preferred Profile

This category represents the ideal community health agent, as indicated by the institutions and organizations that work with them.

According to survey responses, the main selection criteria identified for acceptance into CHW training programs are: the candidate's educational level; social skills; knowledge and experience in health; the extent of association with the geographic work area; age; and to a lesser extent, affiliation with an organization working in the field of health.

Social skills, such as dynamic leadership, good community relations, and community appreciation, are the requirements emphasized the most. In this regard, the CHW is considered a community leader, as the agent's significance transcends the area of health. In this sense, association with and knowledge of the geographical work area also emerges as an important consideration.

With regard to educational level, survey responses indicate that the majority of training institutions require health workers to have a high-school education. However, a significant number of institutions require only that workers have completed primary education or have the ability to read and write.

The required proficiency level and experience in the area of health varies with the type of training institution. The institutional members of the Social Security Health System, Health Promoting Enterprises (EPA), institutional health service providers (IPS), and Administrators of the Subsidized System (ARS) demand a more advanced agent profile than do foundations, NGOs or mutual associations participating in these processes.

Age appears in almost all survey responses as a requirement for participation, pointing out that community health workers must be at least 18 years of age. However, the upper age limit varies significantly, ranging from 26 to 45 years of age in some institutions, and ignored in others.
2. Actual Profile

The actual profile is defined in terms of the significance of the CHW work to community health workers and the communities they serve.

According to responses of the community health workers interviewed, some of them included below, it is clear that they value and recognize the importance of their work, although they are "unaware" of the theoretical principles involved in their work:

"My work makes me a guide for my community";

"We serve the community, we educate it. Hospital employees only work the day shift, but we serve the community both day and night." ²

In the view of community health workers, their work is carried out under difficult conditions. One of the conditions of participation required by most institutions is that community health workers reside in their work area. These areas are generally marginal zones in urban areas or remote rural areas. The topography in these areas is also a problem, given their susceptibility to heavy seasonal rains and/or landslides. These areas are generally located in strata 1 and 2, are not easily accessible by conventional transportation, and lack communications infrastructure. Moreover, they are located in isolated regions where, in the exercise of their duties, community health workers may have to stay overnight.

Not only must health workers endure the difficult topographical challenges inherent in their work zones, but also the socioeconomic and political conditions of the region—factors influencing the degree of success health workers may achieve in their work.

Likewise, health workers hold that they lack the necessary supplies to perform their work in the community.

Whether working with his/her family or in the community, the task of the community health agent is not confined to fixed working hours. Although there are formal mechanisms for evaluating the work of the CHWs, the job requires independent management of time and location by the health agent. This can be observed in the following comment, made by a community health agent working in a rural area of the Viani region: "Promoting health is a very big responsibility."

The work of health workers has promoted a sense of appreciation among community members, because workers visit isolated areas where other institutions do not go. It seems that this strategy is somehow managing to counteract the notion of being "abandoned by the State," a sentiment common to some regions of the country.

With regard to the dynamic of community service, the work of community health workers fosters their personal development and raises their self-esteem and sometimes changes their aspirations. In other cases, the community service dynamic is merely a work alternative that does not imply a real social commitment, but rather an alternative livelihood motivated by economic gain.

With regard to the actual CHW profile, it appears that receiving economic compensation for CHW work generates tension and envy among other community leaders who do not receive this compensation.

² Declaraciones de los agentes comunitarios de San Juan de Río Seco y Viani
Community health workers affiliated with health institutions such as hospitals feel that their work is undervalued, and that they are treated differently than health workers or assistants, although they perform the same duties. However, this contrasts with the case of community health workers that are not directly associated with health institutions, but are involved with foundations or organizations, since they are responsible for developing educational health processes in their communities.

3. Institutional Connection and Training of Community Health Workers

This category contains the responses of the institutions and organizations surveyed, regarding their institutional connection to community health workers as well as aspects related to CHW training. These include: the area of the institution involved in training; the individuals in charge of training; the content and methodology employed; and the instruments used by community health workers in the exercise of their duties.

With regard to the type of connection institutions establish with community health workers, most are mixed, meaning the institutional connection to the agent is for both employment and training. In fact, survey responses indicate that 50% of these institutions have a mixed institutional connection with workers; 31% reported that their connection was strictly for CHW training; 6% reported their connection was confined to employment only, with no intervention in the training process; and 13% described their connection to workers in neither of these categories ("other"), either because they are only involved in selecting candidates for training in other institutions, or because they provide temporary consulting services to other institutions for short-term or special projects.

This information is shown in the following figure:

![Figure 1. Type of Institutional Connection with Community Health Workers](image-url)
The institutional connection with community health workers is either for employment or volunteer services. It should be noted that employment refers to a relationship in which the CHW receives economic compensation for his or her services, whereas a volunteer CHW does not. Most institutions hire community health workers on fixed contracts for periods ranging from six months to one year, or for the duration of a particular program.

Likewise, Figure 2 indicates that 45% of the organizations surveyed reported that their connections to workers are for employment and thus, the CHWs receive economic compensation for their services. According to reports provided by these institutions, salaries range from the minimum wage to two times the minimum wage (the current monthly minimum wage in Colombia is $234,000 Colombian pesos for a 48-hour workweek).

On the other hand, 40% of community health workers at institutions are volunteers, receiving no economic compensation for their services. Nevertheless, it is important to mention that workers may receive other forms of compensation or benefits, as they are called by the institutions and their community health workers, such as personal development, prestige, ongoing training, personal satisfaction derived from community service, etc.

Finally, 11% of institutions have another type of connection with community health workers. An important example is an academic connection for schooling, as in the case of schools offering nurses' aide training.

![Figure 2. Institutional Connections with Community Health Workers](image_url)
Institutional Areas Responsible for Recruiting Community Health Workers

With regard to the institutional areas responsible for CHW recruiting, the institutions surveyed most often described this activity under the category "Others" (see Figure 3).

This category includes areas such as management and administration, health services, human resources, research, recruitment and admissions, academic division, and special projects. Consequently, the area(s) responsible for CHW recruitment reflect each institution's level of complexity according to its nature—whether government, private, cooperative, mutual association, or educational institution—and the emphasis of its programs.

After the "Others" category, the most significant areas were health promotion, with 18%; disease prevention and community outreach, each with 12%; training with 11%; communications with 4%; and epidemiology with 3%.
Number of Community Health Workers by Health Zone

With respect to the number of health workers working in each institution, Figure 4 represents the information reported by the institutions surveyed. Accordingly, 55% reported that the number of health workers is too few to meet the health needs of the zone or region they serve; 35% reported that the number is sufficient to meet health needs; and 3% did not respond to this question.

FIGURE 4. Number of Community Health Workers and Satisfaction of Regional Health Needs

Among the most important factors contributing to an institution's dissatisfaction with its number of community health workers, in terms of the needs of the zone or region it serves are: lack of financial resources; program length; health agent seniority, and the health promotion and disease prevention policies developed by regional or local authorities, given that, in most cases, policies vary from one government administration to the next.
Community Health Workers’ Length of Service in Institutional Programs

With respect to the period of time health workers serve in institutional programs, the greatest number, or 37% of institutions, reported that this period ranges from 1 to 2 years; followed by 24% reporting a period of 2 to 5 years; 22% reported a period of less than 1 year; and 11% reported a period of more than 5 years. The following figure represents the above-mentioned information:

**FIGURE 5.** Community Health Workers’ Length of Service to Health Institutions

- No response 6%
- > than 5 years 11%
- 2 to 5 years 24%
- 1 to 2 years 37%
- < than 1 year 22%
- No response
Re:asons Why Community Health Workers Leave Institutional Programs

The most common reasons why community health workers leave institutional programs include: 33% voluntary separation; 21% terminated for poor work performance (lower percentage, but significant number); 16% resign or are terminated due to poor community relations; 15% for lack of financial resources to continue programs; and 10% for other reasons. With respect to the latter, these include: low academic performance of agent; agent takes another job that demands most of his or her time; and the agent leaves without notification. This information can be observed in Figure 6.

![Figure 6: Reasons Why Community Health Workers Leave Institutional Programs](image-url)
**Institutional Area Responsible for Training Community Health Workers**

With regard to the institutional areas responsible for CHW training, the most representative of survey responses was the health promotion area, with 26%. Following closely with 24% was the category "Others," which includes: woman and family; health projects; informal education; teaching section; Basic Health Care Plan (PAB); and technical coordination.

22% of the institutions surveyed gave responsibility for training to the health prevention area; 14% to community outreach; 9% to training; 2% to epidemiology; 1% to communications; and 2% of the institutions surveyed did not respond to this item. This information is presented in Figure 7.
Professionals Responsible for Training Community Health Workers

With regard to the professionals or staff in charge of the training process, they do not work independently but as a team made up of a variety of other professionals. According to the institutions surveyed, this team would consist of the following: 23% nurses; 18% physicians; 14% social workers; and 13% from the category "Other." With regard to the latter, this group of professionals would include: ophthalmologists; counselors trained in psychology; nutritionists; dentists; bacteriologists; physical therapists; environmental advisers; and attorneys, followed by 9% educators; 7% health workers and nurses' aides, respectively; 6% psychologists, and finally, 3% sociologists. This information is presented in Figure 8.
4. Training Contents

One of the main objectives of this study is to identify what training processes for community health workers are designed and implemented. Accordingly, the information provided in the following table is very important, because it makes it possible to identify and categorize the contents of these processes. Institutional responses have been grouped into the following 16 thematic areas:

<table>
<thead>
<tr>
<th>Community Health Worker Training Program Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Disease Prevention and Health Promotion</td>
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<tr>
<td>2. Social Security Reform in Colombia</td>
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<tr>
<td>3. Organization for Community Participation</td>
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<tr>
<td>4. Leadership</td>
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<tr>
<td>5. Malaria</td>
</tr>
<tr>
<td>6. Teaching Methodology</td>
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<tr>
<td>- Communication</td>
</tr>
<tr>
<td>- Educational Techniques</td>
</tr>
<tr>
<td>7. Leprosy</td>
</tr>
<tr>
<td>8. Health Education with the Gender Approach</td>
</tr>
<tr>
<td>9. Project Development/Administration</td>
</tr>
<tr>
<td>10. Practices with Families</td>
</tr>
<tr>
<td>11. Breast-feeding</td>
</tr>
<tr>
<td>12. Business Management, Management Structure</td>
</tr>
<tr>
<td>13. Human Resources Management</td>
</tr>
<tr>
<td>14. Home Vegetable Gardens</td>
</tr>
<tr>
<td>15. Compassionate Health Care</td>
</tr>
<tr>
<td>16. Record and List Management</td>
</tr>
</tbody>
</table>
Moreover, it is necessary to break down thematic areas 1, 2, and 3 by subject, given that within each area there are more than five subjects areas related to the objectives of this study that need to be examined. These areas are listed in the following table, in order of importance, according to the frequency health institutions discussed them in training events.

### 1. DISEASE PREVENTION AND HEALTH PROMOTION

<table>
<thead>
<tr>
<th>Subject Areas</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.1 Rights of the Child</td>
<td>1.17 Growth and Development</td>
</tr>
<tr>
<td>1.2 Domestic Violence: (sexual abuse, child abuse; affection, self-esteem, violence against women)</td>
<td>1.18 Public Health</td>
</tr>
<tr>
<td>1.3 Health Education and Information</td>
<td>1.19 Education on Old Age and Death</td>
</tr>
<tr>
<td>1.4 Vaccination (immunizations)</td>
<td>1.20 Treatment for Parasites</td>
</tr>
<tr>
<td>1.5 Family Planning</td>
<td>1.21 Auditory Screening</td>
</tr>
<tr>
<td>1.6 TB, AIDS</td>
<td>1.22 Accident Prevention</td>
</tr>
<tr>
<td>1.7 Primary Prevention</td>
<td>1.23 Diabetes</td>
</tr>
<tr>
<td>1.8 Pregnancy: healthy pregnancy, healthy baby, maternal and perinatal care</td>
<td>1.24 Hypertension</td>
</tr>
<tr>
<td>1.9 Nutrition: feeding the child up to 7 years of age</td>
<td>1.25 Tuberculosis</td>
</tr>
<tr>
<td>1.10 First Aid</td>
<td>1.26 Alcoholism and Smoking Prevention</td>
</tr>
<tr>
<td>1.11 Mental Health</td>
<td>1.27 Tropical Diseases</td>
</tr>
<tr>
<td>1.12 Health in the Home</td>
<td>1.28 Environmental Sanitation</td>
</tr>
<tr>
<td>1.13 Oral Health</td>
<td>1.29 Breast Cancer Prevention</td>
</tr>
<tr>
<td>1.14 ARI</td>
<td>1.30 Osteoporosis Prevention</td>
</tr>
<tr>
<td>1.15 Acute Diarrheal Diseases</td>
<td>1.31 International Humanitarian Law IHL</td>
</tr>
<tr>
<td>1.16 Vaccine-preventable Diseases</td>
<td>1.32 Theory and Stages of Child Development</td>
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<tr>
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<td>1.33 Visual Health Education</td>
</tr>
<tr>
<td></td>
<td>1.34 Health Education with Gender Approach</td>
</tr>
</tbody>
</table>
2. SOCIAL SECURITY REFORM IN COLOMBIA

Subject Areas

2.1 What does the reform consist of?
2.2 Contributory and subsidized systems
2.3 User rights and duties
2.4 Beneficiary selection process under the System for the Identification of Beneficiaries (SISBEN)
2.5 Compulsory Health Plan (POS) and Basic Health Care Plan (PAB)
2.6 Social Security System disease prevention and health promotion programs

3. ORGANIZATION AND PARTICIPATION

Subject Areas

3.1 Organization for community participation
3.2 Mechanisms for community participation, Laws 134/94 and 130/94
3.3 Opportunities of participation:
   • Health Oversight Committees
   • COPACOS
   • User Alliances
   • User Associations
3.4 Legal framework for social participation in health
3.5 Ethics committees
5. Training Methodology

Concerning the techniques and methodologies employed in the training of community health workers, the most widely used is hands-on training, concentrated in a specific place and during a given period.

Training sites and periods vary from institution to institution, depending on the specific training policies, the availability of health workers to relocate to a particular place during a specific time of the year, and the institutional structure. In the latter case, for example, if training is directed to a state school of nursing or the National Training Service (SENA), training programs are curricular, established by the institution and conducted at headquarters. However, in the case of foundations, NGOs, or other institutions outside the "formal school," these events may be held on-site, or as in many cases, in the health workers' homes to promote attendance. Accordingly, sponsoring institutions and health workers work together to establish training periods and schedules most convenient for all.

The training methodology consists of workshops or seminars. Worthy of mention in this regard are training programs developed by CINDE, the Colombian Institute for Family Welfare (ICBF), the Fundación Social Asociada de Campesinos (FSAC), Profamilia, Convida, Health Promoting Enterprises (EPS), and the Township of Santa Rosa de Cabal in Risaralda, which employ the following methodological techniques:

<table>
<thead>
<tr>
<th>Training Techniques and Methodologies</th>
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<tr>
<td>Research-Action-Contemplation-Action</td>
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<tr>
<td>Adult Education</td>
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<tr>
<td>Community Education</td>
</tr>
<tr>
<td>Sharing Knowledge</td>
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<tr>
<td>Learning to Teach</td>
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<tr>
<td>Learning to Learn</td>
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<tr>
<td>Learning through Play</td>
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</tbody>
</table>

These methodological techniques help workshop participants to learn by drawing on their everyday experiences, motivating research and assessment through learning techniques such as field visits, practical exercises with families, and practical exercises and observations at the health services.

Also particularly noteworthy are the experiences of GONAWINDUA TAYRONA, an NGO made up of the indigenous peoples of Sierra Nevada de Santa Marta. This organization conducts cyclical training program that employs the "traditional western dynamic"—meaning that workshop content and facilitators are selected by the Ministry of Health or the departmental health system. Once the workshop is over, GONAWINDUA TAYRONA members adapt the Compulsory Heath Plan (POS) and Basic Health Care Plan (PAB) to their own communities in four two-month cycles, without the presence of Western physicians or facilitators.

Fundación Santa Fe advances community-training processes by conducting CHW training directly in marginal urban sectors. Accordingly, this foundation's training methodology uses knowledge of the daily practices, customs, habits, beliefs, and ethics of health workers as a primary tool for CHW work with children, families, and the community.
Tools Used by Community Health Workers

The tools or materials used by workers in their outreach activities with the community can be grouped into five categories:

1. Field Diary/Community Portfolio
2. Family/Community File
3. Community Agent’s bag containing:
   - sphygmomanometer, scale, MHQ (Multi-dimensional Health Questionnaire by Wm. Snell, PhD), multivitamins, parasiticides, gauze, alcohol, bandages, facemasks, thermometer, sealants, flashlight, phonendoscope, contraceptives, latex gloves 4. Teaching Materials: folding charts, pamphlets, posters, wall charts, games, flannel boards, transparencies for explanations, materials for educational talks
4. Audiovisual Materials: videotapes, overhead projector
5. Some institutions provide materials that identify workers to the community, such as a backpack, baseball cap, vest or identification button

It should be noted that CHW tools might vary, depending on an institution’s objective or priorities. For example, institutions whose main objective is the protection of children and the family will use tools that facilitate assessment of the child, such as a comprehensive file. Therefore, the processing of this file is essential for assessing each child. Consequently, the file constitutes the basis for programming the priorities of CHW activities in order to advance the objectives of child health.

In remote and marginal areas, CHW tools are more oriented toward assistance activities.

Continuing Education

With regard to continuing education, analysis of the data indicate that 69% of the institutions surveyed have continuing education programs in place as part of their CHW training process, while 24% do not.

Gaps in the pedagogical component of both CHW training and performance can be noted and need to be addressed in order to achieve a long-term impact. Thus, while greater emphasis is placed on content and short-term solutions, work is needed to develop strategies that will facilitate structural transformations, including community habits, beliefs, and attitudes about health.

FIGURE 9. Continuing Education for Community Health Workers

A pie chart showing:
- 69% Yes
- 24% No
- 7% No response

Profile and Training Process in Colombia 21
6. Assessment and Monitoring

Periodic monitoring of CHW activities varies from institution to institution. Factors affecting monitoring periods include program objectives and length, and whether the work relationship between the institution and its health workers is temporary or permanent.

The study indicates that 43% of the institutions surveyed conduct monthly monitoring of CHW activities, followed by 20% reporting "Other" monitoring periods, as can be observed in Figure 10. With regard to the latter, 6% report weekly monitoring; 6% monitoring according to the program; 5% semiannual monitoring; and 3% ongoing monitoring. Moreover, 13% of the institutions surveyed offered no response to this question, either because this component is not included within the institutional structure or monitoring activities are not conducted at all. For the remaining institutions, 12% conduct quarterly monitoring; 7% annual; and 5% daily.
Activities and Mechanisms Used to Monitor Community Health Workers' Work

Monitoring activities conducted by institutions that provide training can be grouped into five basic categories. In some institutions, two or more of these activities may overlap, while in others they remain separate.

a. Monitoring through Periodic Reports and Registries
   
   This formal monitoring mechanism is the most widely used by institutions that provide training, allowing them to maintain an organized registry of CHW activities at a low cost. Accordingly, this mechanism supports monitoring by providing forms for CHW activities which workers are required to complete. This facilitates the organized identification of monthly coverage indexes and registries. This mechanism offers real advantages with respect to the organization and planning of institutional activities, provided that it is linked to other complementary monitoring strategies, and it is widely used by institutional members of the social security system.

b. Institutional Forums: Periodic Assessments, Meetings, and Workshops
   
   In this regard, successful monitoring is directly related to the institution. Some institutions provide for periodic assessment of activities. One important advantage of this mechanism is that it provides a forum for health workers to share experiences with one another, learn from other health workers’ experience, and voice opinions concerning shortcomings and problems with people that can understand their situations.

c. Direct Monitoring of Field Activities
   
   The objective of this mechanism is for the evaluator to provide direct monitoring of the work of health workers in the field through home visits and in workshops, directly observing the work of the CHW.

d. Monitoring Activities through Community Beneficiaries
   
   This mechanism is related to direct monitoring. However, its approach involves seeking the opinion of those who benefit from CHW activities regarding the impact of community health workers on the community. These activities are carried out through home visits, meetings with community representatives and municipal health and administration officials, among others. This mechanism is very important, since the objective of CHW work is to serve the community. Consequently, this mechanism helps to provide insight into the influence that the health agent has in the community health culture and how the community perceives the work of its health workers.

e. No Monitoring
   
   This category includes institutions with no monitoring mechanisms in place. In this case, the number of institutions is not representative.

   With respect to formal mechanisms for monitoring CHW work, the study reveals that institutions use a variety of materials including:
Materials Used in Monitoring the Work of Community Health Worker

- Performance Evaluations
- Daily Activity Registries
- Monthly Progress File
- HTA Screening Formats
- Forms for confirming the number of beneficiaries served
- Field Diary
- Timetable of Activities
- Consolidated Educational Diary on Work in Disease Prevention and Health Promotion
- Agent Supervision File
- Activity Schedules
- Collection of Anecdotes
- Monthly Planner
- Registry of Participants at educational sessions
- Periodic Reports (weekly/monthly).

The monitoring activities of institutions with CHW training programs can be grouped into five basic categories. In some institutions, two or more of these activities may overlap, while in others they remain separate.

7. Intervention Areas: Disease Prevention, Health Promotion, and Health Care

With regard CHW interventions, the study reveals that 21% of activities are conducted in health promotion and disease prevention; 13% in census activities; 12% in environmental sanitation; 9% in diagnostic, reference and "Others," in equal proportions; and 5% in treatment.

The item "Others" represents activities of a different nature, such as: assistance activities; interinstitutional coordination as a basic strategy for the work of community health workers; epidemiological surveillance; marketing, including recruitment of new workers; administrative activities; and social welfare, as seen in Figure 11.

8. Organization of the Activities of Community Health Workers

This category of analysis contains responses concerning financial resources and interinstitutional coordination. Specifically, it refers to the type of support offered by other institutions in which the CHW is not directly involved, but are nonetheless related to the CHW’s work.
An important consideration in the recruitment, training, and monitoring of community health workers is the financial aspect. To a great extent, financial resources determine the success or failure of the CHW’s work. Access to adequate financial resources is the means to ensure the enforcement of Law 100/1993 called for disease prevention and health promotion. The government passed this final law in order to transform health conditions in Colombia.
According to the institutions surveyed, 60% report having financial resources to employ workers; 33% do not have these resources and must resort to agreements, or co-financing and/or alliances with other institutions. This is the case for most foundations and NGOs, whose objective is to promote the educational, cultural, social, and technical development of the country, and to improve the quality of life for disadvantaged populations.

Moreover, organizations that do not have the financial resources to employ health workers offer other types of support—logistical, operational, training, delivery of educational materials, or the updating of different contents—, depending on the needs of the groups they serve.
Institutions with which Community Health Workers Coordinate their Activities

A fundamental component of the activities in health and health education is interinstitutional coordination. This requires the ability to coordinate with other groups engaged in the same activities or same work area, and with institutions whose objectives overlap with those of the community served by health workers with the objective of promoting favorable health conditions. This is especially true for the populations most at risk, such as children, pregnant and nursing mothers, and the elderly—the family in general.

Analysis of this information reveals that 41% of health workers involved with the institutions surveyed, carry out coordination activities with public institutions; 27% with private institutions; 18% with NGOs; and 11% with other organizations, such as cooperatives, churches, and professional associations.

CHW coordination helps these organizations provide support in the following areas: 37% operational support; 33% logistical support; 14% financial support; and 10% in the form of design and contribution of educational materials, which facilitate community education programs. Of the institutions associated with the latter, the Foundation for Health Education Development in Colombia (FUDESCO) is the country’s leader.

This information is presented in Figure 14.

![Figure 14. Types of Institutional Support](image-url)
SUMMARY OF IMPACT ASSESSMENTS

During the course of this study, the results of two impact assessments carried out in Colombia were released. One is known as the "System for Assessing the Impact of Community Welfare Homes. First Survey: Children Aged 0 through 6"³, conducted by the ICBF in 33 departments of the country; and the other, "Evaluation of the Comprehensive Malaria Control Program on the Pacific Coast in Chocó"⁴, conducted by CINDE.

For the presentation of these impact assessments, the pertinent aspects of these studies have been selected, which include:

- Background;
- Objectives;
- Conclusions; and
- Recommendations


Background

The program for Community Welfare Homes has been defined as "a series of state and community actions designed to facilitate the psychosocial, moral, and physical development of children under the age of 7, from sectors living in extreme poverty (strata 1 and 2), through stimulation and support for their socialization, as well as an improvement in their nutrition and living conditions."

This program was conceived in 1986 as a human development strategy based on what was then the new approach to comprehensive care for the most disadvantaged population.

Since this endeavor was a government-sponsored social policy program involving health care for children and families, the ICBF was responsible for drawing up the regulations for the program and establishing the technical and administrative guidelines for its operation.

With regard to the program's health care model, its central concept is education and child development, grounded in family and community participation.

Mothers from the community, who act as community educational workers (hereafter known as "community mothers"), carry out program activities in their own communities. This community mothers care for up to 15 children of up to 7 years old in their homes, five days a week, where they give them affection, protect them, feed them, and lead them in educational activities.

The families of the children participating in the program are responsible for its administration and operation. These families form parents' associations or other types of community organizations. Once an organization has been legally recognized by the ICBF, it signs a support contract with this institution, empowering the organization to administer 3% of the resources generated from monthly payroll taxes of
public and private enterprises, which are distributed by the national government. Each parents' association operates between 10 and 25 Community Welfare Homes.

Although the program has been evaluated several times over the past 13 years, these studies have not been conducted at the national level, and there is no evidence to suggest that institutions have followed the recommendations offered during the period.

**Objectives**

The objectives presented below have been selected on the basis of their relevance to this study:

- To assess the impact of the Program for Community Welfare Homes on preschool children in areas of direct ICBF interventions—nutrition and psychosocial development—as well as indirect ICBF interventions—child protection and health care.
- To examine, for the first time, the determinants of child well-being indicators as they relate to the work of the Program for Community Welfare Homes with regard to:
  - Compliance with standards; and
  - Degree of child well-being.
- To measure the impact of external factors on the program in terms of the well-being of participating children.
- To characterize the nutritional, health, and psychosocial development status of participating children, from the perspective of the community mothers, children, parents, and the community where the program is being implemented.

**Conclusions**

The conclusions presented here facilitate an overview of the findings of this impact assessment in two specific areas. On the one hand, this involves findings concerning the impact of the Program for Community Welfare Homes on the improvement of child health conditions and well-being. On the other, to assess the impact of community mothers as dynamic community workers in a process that seeks to join the family and the community in the care and protection of children.

- Community Welfare Homes are fulfilling their objectives with regard to the protection and identification of children from the most disadvantaged population groups.
- Community Welfare Homes do not satisfactorily meet ICBF standards.
- To some extent, the performance of parents' associations influences that of Community Homes. Moreover, the performance of the ICBF local centers affects the operation of parents' associations.
- Community Homes have a limited impact on the well-being of children, in terms of their nutritional status, psychosocial development, and health conditions.
- A child's background, family characteristics and behaviors, and sanitary conditions of their dwellings have a clear effect on child welfare. Moreover, these factors have a greater impact than that of Community Homes, particularly in areas pertaining to health.
Recommendations

The recommendations submitted by the investigators responsible for this impact assessment have been made pursuant to the interests of this investigation. This involves the community agent, in this case community mothers or fathers (community mothers are the norm in Colombia, with only isolated cases of zones where fathers act as community workers), and parents.

With regard to community workers:

Community Mothers:

- To improve the profile of the community mother as an educational agent;
- To broaden the community mother's knowledge base with regard to procedures related to the child psychosocial development and conditioning factors in order to reduce malnutrition, and to combat the different causes of morbidity present in the children participating in the program.
- To promote positive changes in the community mother with respect to her attitudes toward children's behavior and improve their relations.
- To improve food preparation and presentation.

Parents:

- To strengthen parents' education concerning the following:
  - Pre and postnatal check-ups;
  - Adequate stimulation;
  - Child health care;
  - Psychosocial health and development;
  - Environmental sanitation;
  - Nutrition and eating habits;
  - Breast-feeding; and
  - Role of parents in supporting the efforts by community mother.
2. "Evaluation of the Comprehensive Malaria Control Program on the Pacific Coast in Chocó"

Background
In 1978, the International Center for Educational and Human Development (CINDE) began implementation of a program known as "PROMESA," to improve health, education, and environmental sanitation, for the control of malaria in four Pacific communities in the municipality of Bahía Solano on the Pacific coast. The main objective of this program, known as PROMESA, was to improve environmental sanitation and thus promote the healthy development of the children.

This program, based on a biopsychosocial approach, is grounded in the concept of integrated action, which promotes eradication of malaria as the end-goal. It uses the presence of the disease as an opportunity to mobilize the community to solve this problem. This approach can be applied by the community to solve all the other problems its faces, thus improving the community's living conditions and attaining higher levels of human and social development.

It should be noted that ongoing assessment is an essential component for the effective development of this comprehensive malaria control program.

Objectives
With respect to this impact assessment, the following objectives are the most relevant to this study:

- To promote better understanding among program participants with regard to program realities and the transformations they are carrying out;
- To systematically reconstruct the experiences of program participants, incorporating a component for contemplation on their experiences, in order to reorient actions;
- To assess the level of progress made by communities with regard to decentralization, management, education, organization, and community participation;
- To compile and interpret children's drawings before and after the program has been implemented; children express their feelings and opinions about the processes they have undergone in drawings, thus documenting their experience as program participants; and
- To characterize the most significant elements that emerge from children's letters, drawings and stories, thus permitting evaluation from a very important perspective—the viewpoint of communities that have benefited from the program.

Conclusions
The conclusions of this impact assessment are diverse and affect each level of the program's implementation. Accordingly, the objectives presented below have been selected on the basis of their relevance to this study:

- Education significantly improved;
- Community members trained in diagnosis and treatment (community nurses, environmental health assistants, community leaders, teachers, mothers);
- Better quality in health treatment;
- Lower morbidity; mortality reduced to zero;
- Structured comprehensive program for malaria control in the area;
- Increased awareness and mobilization toward interinstitutional coordination as an element of community self-management/reliance;
Improved awareness and redefinition of the role of the community leader as a catalyst for changing community processes; and

Development of skills for disease treatment and the search for solutions to social problems.

Comments

Although the Program for Community Welfare Homes has had a positive impact in Colombia, the findings of this impact assessment clearly indicate that problems still affect the integral development of the children in Colombia.

This is a very significant program. In fact, few programs addressing the needs of disadvantaged communities and children under the age of 7 have 13 years of experience. Consequently, any changes made to the policy for child health care deserve careful examination.

Currently, there are approximately 70,000 community health workers working in Colombia (community mothers), located in all of the country’s 33 departments. These health workers are responsible for overseeing the socialization and development process of 14 children, on average. Consequently, this means that trained community workers, who are supervised by state institutions and NGOs participating in this process, are caring for approximately 980,000 Colombian girls and boys.

In view of this fact, the question arises: Will a strategy be developed to monitor the activities of these community workers, given the ever-shrinking state structure and capacity?

The results of these two impact studies seem to suggest that smaller-scale local programs (i.e., neighborhood, municipal, district, and ethnic communities), developed through community participation, are more effective in transforming customs and habits about health.

Although it is very difficult to generalize about leadership skills, it is important to highlight the differences between the leadership of health workers involved with the ICBF and that of the health workers in Chocó. On the one hand, these impact assessments reflect the need to strengthen and to improve the profile of community mothers. On the other, however, the impact of the malaria control program has indeed strengthened the role of community leaders in Chocó.

Nevertheless, in general terms, these two impact assessments on community experiences in Colombia can be summarized as follows:

- Because community health workers as residents and civic leaders in these regions assume greater risks with regard to disease and death, they should be supported in their activities by the institutions responsible for this area of development.

- Training, as a product of consensus building between the community and the institutions that serve it, should be a flexible process in constant evolution and adapting to the dynamic of each community.

- If assessment is not a permanent element in the programs—taken into account before the processes are implemented—progress may be made toward meeting specific tasks, but no progress will be made in transforming living conditions.

- According to the impact assessment, parents are either unaware of or indifferent to the potential risks their children face during their development. Consequently, health education must be a priority and should be given the importance it deserves with respect to training of CHWs and parents.

- In order for community workers to secure external resources through their own efforts, the objective of CHW training should focus more on skills development than on the accumulation of knowledge.

- Impact assessments on health care and health promotion programs for children should be performed in each step of the program implementation.
CONCLUSIONS

This research on the profile of community health workers and their training in Colombia, which has covered the institutional and community aspects of the CHW's work, leads to the following conclusions:

- Given the variety of approaches being put forward to advance social security reform in Colombia, as well as the methodologies and educational techniques applied in the training process, it is not feasible to speak of a single community health agent profile. On the contrary, it is more accurate to speak of multiple community health agent profiles, in diverse categories, including health workers, health managers, health volunteers, and community mothers. Nevertheless, there are certain characteristics they have in common:

<table>
<thead>
<tr>
<th></th>
<th>Age: Over 18 and less than 50 years of age</th>
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</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>Female</td>
</tr>
<tr>
<td>Place of residence:</td>
<td>Workplace</td>
</tr>
<tr>
<td>Educational level:</td>
<td>Primary school, with a tendency to require high school</td>
</tr>
<tr>
<td>Leadership</td>
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</table>

- In their training and while performing their work, community health workers have come to internalize the institutional message with regard to health promotion and disease prevention. However, this does not necessarily mean that the message is put into practice, as they do not "live" the message;

- With regard to the training of community health workers, most of these programs employ a behaviorist approach based on rote learning, set within the parameters of traditional curricular education. However, it is important to mention that CHW training programs at foundations and NGOs do not fit this profile;

- Training processes do not take workers' "traditional knowledge" into account and consequently, assign them a different status from that of their facilitators. This occurs because training processes are not designed collectively;

- Some formal training schemes being used do not address the priorities of the population;

- Community workers attach considerable value to the support materials supplied to them by institutions, which are deficient for the needs of health workers;

- Once initial CHW training is completed, there are too few programs in place to supplement and update the information that workers have learned during the process. In this regard, alliances and interinstitutional agreements have a key role to play in guaranteeing the continuity of the training process and the rational management of resources;
• CHW training emphasizes that workers are not qualified to provide health care. However, workers must contend with an inadequate health care infrastructure that can lead to unfortunate consequences. Consequently, efficient and timely communication channels need to be established among these levels, especially in cases where the institutions that provide training are foundations, NGOs and other organizations that do not have the necessary infrastructure to provide health care;

• Training contents vary widely with the priorities of each institution, and they have no health education programs in place;

• Just as there are different approaches to the definition of the CHW profile, the same occurs with respect to CHW training: while some organizations use a clinical approach to training, others use a social approach, considering aspects such as abuse and domestic violence;

• With regard to social approaches to training, the subjects considered in these are very significant. Accordingly, social approaches tend to be more developed by foundations and NGOs that embrace a social vision that transcends health considerations, unlike government institutions that are exclusively health-oriented;

• It is found that programs do not contain the investigative component and elements needed for planning;

• A recurring issue noted in survey responses is the lack of continuity in training;

• Monitoring tends to place more emphasis on judgment and control than improvement of CHW work. In this regard, the problem does not lie in the strategies employed, but in the way they are conceived and put into practice;

• The volume of the population to be served exceeds the capacity of workers;

• Given the short duration of programs, partisan political maneuvers can dilute their impact. Generally, programs are transformed or disappear from one administration to the next; especially those carried out by public institutions;

• The issue of the hierarchy of relationships between health professionals was also mentioned; and

• Community health workers need to develop their social skills, including the ability to establish clear and open communication with others and to develop expressive and entertaining teaching skills, and expand their knowledge base.
RECOMMENDATIONS

- To emphasize the participatory "research-action-contemplation-action" methodology, in a comprehensive approach to problems, in order to detect and identify the health concerns of the population;
- To promote and strengthen interdisciplinary teamwork among community workers and health professionals;
- To identify the dynamics of the society in order to begin investigative action;
- Health care processes that employ integrated action and decentralization reach more people by adapting to their beliefs, habits, and customs;
- Progress in the area of health with regard to the socialization and education processes requires establishing adequate CHW training conditions, including:
  - Consensus-building;
  - Participation;
  - Flexibility;
  - Integration;
  - Culture (as an element that promotes new knowledge); and
  - Customs.

The conditions in communities where workers work vary from region to region, from town to town. Consequently, CHW training facilitators cannot lose sight of certain factors. For example, in hot climates nutritional and environmental conditions make it impossible for workers to work full 8-hour days, while there are other considerations affecting agent performance in marginal urban areas.

Moreover, additional considerations need to be included in training contents, such as an agent’s knowledge of and attitude toward the community and his or her knowledge of the community’s myths and beliefs about disease and health. Not all institutional concepts are incompatible with community beliefs, nor are all community beliefs contrary to institutional concepts. Consequently, basic knowledge of community culture and ethics are requisite for the work of the community health agent.

Currently in Colombia, CHW training is focused on equipping community workers with instruments to perform their tasks. Consequently, health workers spend most of their time processing forms, family files and records to feed into the information systems of their employers. However, there is a need to redefine the way work is presently carried out, in order to design and develop programs that address the needs and the morbidity and mortality concerns experienced by the population, and not merely those that the institution thinks that need to be addressed.

Accordingly, CHW training programs need to be designed and implemented with contents that focus more on developing social, managerial, organizational and promotional skills, rather than those related directly to treatment. In short, training should concentrate more on these needs without increasing the length of the course.
Entities such as the PAHO/WHO, the Ministry of Health and health secretariats need to reassert their leadership role with regard to the CHW association and training processes, so that the current emphasis on "instrumentalization" can be replaced by health education.

Finally, communication must be included as an essential part of the educational process promoted by health workers in the community, as well as in the training of CHWs, facilitators, and trainers.

Community health workers are armed with knowledge that no professional can match: an intimate knowledge of their own culture.


CINDE. "La planeación participativa con visión de futuro y enfoque de género: base para el desarrollo humano". CINDE. Colombia, 1997.


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