Assessment of Knowledge, Practice, and Satisfaction of Health

Care Services Rendered by Community

Health Workers among Health Care Consumers

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**Contents**

[Abbreviations 3](#_Toc15830320)

[Introduction and Background 6](#_Toc15830321)

[Research Rationale 9](#_Toc15830322)

[Research Objective 10](#_Toc15830323)

[Significance of Research 10](#_Toc15830324)

[Literature Review 11](#_Toc15830325)

[Research Methodology 13](#_Toc15830326)

[Study Area 13](#_Toc15830327)

[Study Population 13](#_Toc15830328)

[Study Duration 13](#_Toc15830329)

[Sampling Method 14](#_Toc15830330)

[Sample Size 14](#_Toc15830331)

[Study Tools 15](#_Toc15830332)

[Data Analysis 15](#_Toc15830333)

[Observations and Findings 15](#_Toc15830334)

[Discussion and Conclusion 16](#_Toc15830335)

[Salient Recommendations 17](#_Toc15830336)

[Summary 19](#_Toc15830337)

[References 20](#_Toc15830338)

# Abbreviations

|  |  |
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| **Abbreviation** | **Word** |
| CBO | Community-Based Organization |
| CHC | Community Health Centre |
| CHW | Community Health Worker |
| CPHC | Comprehensive Primary Health Care |
| DOH | Department of Health |
| DOTS | Directly Observed Therapy |
| DSM | Diagnostic Statistical Manual |
| GP | General Practitioner |
| HiAP | Health in All Policies |
| HIV | Human Immunodeficiency Syndrome |
| ID | Identity document |
| IDP | Integrated Development Plan |
| KII | Key Informant Interviews |
| NGO | Non-Governmental Organization |
| NPO | Non-Profit Organization |
| PHC | Primary Health Care |
| PTSD | Post-Traumatic Stress Disorder |
| RDP | Reconstruction and Development Programme |
| SDH | Social Determinants of Health |
| VCT | Voluntary Counselling & Testing |
| WHO | World Health Organization |

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Abstract

Community health workers are placed in a unique position to bridge gaps between communities and the health care sector. The strength of their relationship with both the community they serve and the healthcare department only boosts their level of motivation and performance. This study aims at the assessment of knowledge, practice, and satisfaction of health care services rendered by community health workers among health care consumers in the post-Katrina city of New Orleans, Louisiana. The study shows a complex interplay of the influence of trust and the relationship community members have with community health workers. Furthermore, it aims to analyze how useful their efforts were in rehabilitating the healthcare infrastructure in a post-hurricane New Orleans. This was a cross-sectional survey. It employed the use of multistage sampling and used a mix of quantitative and qualitative methods. The quantitative data obtained was analyzed using XL Stat while qualitative data was analyzed in a thematic manner.

# Introduction and Background

Navigating healthcare systems in challenging, especially with patients with lack of information about their ailment, language barrier, or various other problems (Osae-Larbi, 2016). This includes ways to understand and manage chronic diseases like diabetes, cancer, or heart diseases. Collectively known as health literacy, it improves patient’s knowledge about disease management, management of prescription drugs and how to prepare for appointment (De Wit et al., 2018). In order to improve health literacy among patients, healthcare centers often collaborate with community health workers.

The community health workers serve as a bridge between primary healthcare providers and healthcare consumer (Javanparast, Windle, Freeman, & Baum, 2018). In this instance, the primary healthcare providers are the doctors and the nurses that tend to your issues at a primary care facility, with the patients and their families serving as the healthcare consumer (Javanparast et al., 2018). Research has shown has hiring community health workers to be a part of community health care teams helps overcome a number of challenges, which leads to better access to care, increased compliance, increased quality of care and reduced costs (Mohajer & Singh, 2018).

This history of community health workers in the USA goes way back. It is long, varied and has served to be a rallying voice with the American Public Health Association, back in the 1970s (APHA, 2018). It is an old, reliable, and robust institute that often serves as the backbone of the healthcare services being provided by these workers in the community. They have contributed to the system in diverse ways, making it more efficient and effective. They have brought more individuals into the fold by allowing more individuals to have access to the care they need just where they need it and how they needed it. The operations undertaken by community health workers have made the jobs of both the primary health care providers, as well as the families of patients easier. Community health workers offer insight, along with services that address the scope of the health care model.

The activities undertaken by community health workers include a wide variety of areas that require attention. It includes creating a more effective and positive linkage between the communities as well as the healthcare system. They are tasked with impact health education, along with information, to various parts of the community. These messages are imparted in a culturally appropriate way which resonates with their ideals and moral values of the community. Attention to such small details makes it easier for the community to absorb the information being relayed by the community health worker, increasing the chances of the advice being followed. Such programs, according to another study, reduce the need to see costly specialists and lead to a nationwide cost savings of around 60 billion dollars.

With most people still unaware of what universal health coverage entails, a community health worker is tasked with organizing and mobilizing communities to help them look after their own health. They have a vital role in universal health coverage by making it more accessible to the masses. This promotes the idea of better health within the community and enables the preventive measures that keep them healthy. This is done through the intake of nutritious and healthy food options. They make preventive measures possible for the members of the community which keeps the need for a cure at bay (Mohajer & Singh, 2018). This exhibits that the issues of promoting health and preventing diseases in a community are key in community health services and first-line curative services. It allows a basic streamlining of the process at hand so that the time of a healthcare provider is properly utilized. It gives them room to focus on people requiring special care and attention while the community health workers ensure that the community has measures in place to deal with such ailments (Allen, McBride, Balcazar, & Kaphingst, 2016).

One of the finest examples of how fruitful community health workers proved for New Orleans, Louisiana following the devastating affects of Hurricane Katrina. Hurricane Katrina was the single most catastrophic natural disaster in the history of the USA (FEMA, 2006). It ushered in a storm of such magnitude that the state of Louisiana and its healthcare system has yet to recover from its devastating effects (Mammoser, 2017). However, no city was hit worse than New Orleans. The population is mostly African American, and the city had one of the country’s highest percentage of uninsured individuals among the population. These people relied on the Charity Hospital System for care (Rudowitz, Rowland, & Shartzer, 2006). When Katrina devastated the New Orleans healthcare safety net, it completely changed the healthcare landscape of the city. It left many without access to healthcare for over a year, with local officials struggling to rebuild the city (Rudowitz et al., 2006).

According to the Census held in 2000, Louisiana is the poorest of all US states. It has the largest percentage of population with incomes that is rather low than the federal poverty level, i.e. $16,090 for a family of three. This percentage includes 22% of the population of the entire state of Louisiana, 23% of which is concentrated in New Orleans alone (Morial, 2007). Furthermore, about 25% of the population in Louisiana did not have access to health insurance, even prior to Katrina. This number is equivalent to 900,000 residents of the state and is considered equal to about 15% population of California. Couple that in with low-rates of employer-sponsored coverage, most people do not seek medical assistance until its to late. This also showed the deplorable state of Louisiana in terms of healthcare network available to the masses (Morial, 2007).

This system was reformed by community health workers, giving healthcare to those caught in the middle of unprecedented devastation and urgent need of healthcare. The hurricane left more than 1,577 people dead in Louisiana alone, with even more suffering from direct physical health problems as a result of the hurricane. To make the situation even worse, countless were unable to access medical care they needed or the prescription drugs they required to deal with pre-existing conditions, or new conditions that formed as a result of hurricane (Huelskoetter, 2015). Two years after the storm, a survey by FEMA discovered that the people still present in the area suffered through a weakening of their physical and mental health. As compared to adults, children were four times as likely to be implicated by the after effects of the disaster. While more care is needed to this day to improve the situation and make it better than what it was before (Griffies, 2010), community health workers were nothing short of being heaven-sent for the residents of the area. They worked alongside first responders and helped wherever they can, in just about every possibility that they possibly could (Wennerstrom et al., 2011).

# Research Rationale

Community health workers were a huge support in dealing with Post-Katrina New Orleans. Not only did the help the healthcare providers with the patients, but they also allowed the healthcare system to vastly improve in short among of time. They not only physically helped the people but also helped them improve their mental health but getting them the care they needed (Wennerstrom et al., 2011). Thus, this study aims to understand the role played by community health workers in the development of healthcare in post-Katrina New Orleans and assess customer satisfaction regarding the care they are being provided.

# Research Objective

The primary objective of this research is to access the knowledge held by and the perception of healthcare consumers regarding the healthcare services provided by the community health workers in their community. It seeks to understand the ways in which hospitals can integrate community health workers into their system and see how beneficial this integration be, especially given their unique relationship with the community they serve. For the purpose of this study, the focus will be on the assessment of knowledge, practice, and satisfaction of health care services rendered by community health workers among health care consumers in New Orleans, Louisiana.

# Significance of Research

Community healthcare workers serve as the frontline public health worker that is an integrated part of the said community and has a deep and personal understanding of the community it serves. They are not physician extenders, however, they can certainly serve as an intermediary body that can listen to your issues and refer your case to the right specialists, so that you may get the care that you need.

Thus, the significance of this research lies in its objective which is to see how useful community health workers have proven to be by enabling the communities to implement measures that have the potential to improve their well-being and reduce the need for hospital visits. Furthermore, their presence can smooth-line the entire process, making it easier for poverty-stricken communities as well as the minority groups to seek the help that they need.

Additionally, this study can also serve as a tool for assessment of how well the present healthcare provisions put in place in the state of Louisiana are doing. It will record how the healthcare is still at work providing relief to those affected by Hurricane Katrina years ago, especially with regard to community health workers and the communities that they work for (Wennerstrom et al., 2011).

# Literature Review

Community health workers have a unique position. They not only worked with their communities in an integrated manner, but they also improve the health care system by adding to the provided care. According to research (Kok et al., 2017), community health workers are rather optimally placed to benefit the community and its health sector by shaping factors that enhance client satisfaction. The measures they employ not only improve the quality of life for community members but also reduces the frequency of hospital visits.

Earlier, it was believed that community health workers can only be highly effective in low- and middle-income countries (Javanparast et al., 2018). However, the measures employed by a community health worker in an urban high-income situation, it has the potential to be just as valuable and useful. Household satisfaction was seen as an important indicator for measuring the quality of the care provided by a healthcare system. In various countries, such as Brazil, primary health care serves at household levels are provided using community health workers (Masango Makgobela, Ndimande, Ogunbanjo, Bongongo, & Nyalunga, 2019). This has led to an improvement in their healthcare system and enables them to provide care to households in a better manner.

CHW roles and responsibilities are often outlined in government or NGO protocols for a CHW program or in documents that summarize the features of CHW programs across multiple countries (George et al., 2012; Kayemba et al., 2012). The role of the CHW includes (but not limited to) identifying the sick child, assessing danger signs, treating the child with the correct drugs, arranging follow-up visits, completing patient registers, maintaining medicine stock records, and storing medicines correctly (George et al., 2012).

CHW’s responsibilities into four domains of performance: building community relationships, providing care, managing commodities, and reporting. The domain of building community relationships concerns the relationships a CHW has with the people in his or her community; building awareness and confidence among community members and cultivating a sense of trust and approachability so that community members are willing to utilize the CHW’s services. Managing commodities concerns a CHW’s ability to keep and maintain the supplies and equipment necessary for their role, such as behavior change print materials, drugs and diagnostic tests, and scales or measurement devices. A CHW’s ability to manage a stock of drugs will depend on supply chain functioning, but CHWs may also play their own role in restocking drug kits. Providing care concerns the provision of care itself; for example, assessing, classifying, and treating sick children, and counseling caregivers. Some CHW programs, such as health promotion programs, do not require the delivery of clinical services, but nonetheless require CHWs to provide technical counseling and advice, or assessment and referral. Reporting concerns the paperwork that a CHW undertakes to document his or her activities, such as sick child forms, referral forms, patient registers, and monthly reports. Reporting is different to the other domains in that it does not directly contribute to the delivery of services, though arguably reporting does contribute to program effectiveness by providing policy makers and program managers with data to make more informed implementation decisions.

Articulating performance in this way helps to distinguish between CHW performance, and the performance of a CHW program as a whole, given other health system, community, and contextual factors. Whereas a program-centered term such as “quality of care” relies on both CHW performance in delivering care, and health system performance in making drugs available for the CHW to prescribe, the term “providing care” in the framework refers only to those actions within the control of a CHW, such as the correct assessment and treatment of sick children.

Uganda, according to some studies, has the highest percentages of child mortality globally. This high rate of child mortality has been attributed to the reduced presence of care and need for improving access to care. Community health workers are more than capable of reducing this epidemic, especially in rural areas by providing people with access to better care. They have been successfully able to do so by educating people on the matters of self-care, preventive measures, and a good diet to ensure that mothers are taking good care of themselves. This has not only improved child mortality rates but also has changed people’s outlook on the healthcare system (Wanduru et al., 2016).

Furthermore, Denver health study has shown that the integration of community health workers in healthcare programs have saved $2.28 for every $1 invested. Similar results were obtained by MHP Salud’s Community health worker-led cancer prevention program, which had a return in investment of about $3.16 on every dollar that was spent (Salud, 2019). Integration of community health workers has also proven rather beneficial for a Baltimore Health Program (CDC, 2016). It showed a 38% drop in emergency room visits and 30% drop in hospitalizations, leading to a reduction in Medicaid costs of 27% (Kumar, Mawson, Lavigine, & Dove, 2018). Since they know the culture, the language and particular challenges faced by the community they serve, community health workers are uniquely suited to build bridges between patients and healthcare professionals.

One such intermediate measure is CHW performance. The performance of CHWs is sometimes described in terms of quality of care or utilization (Cardemil, 2012; Miller et al., 2014). These measures are important as population-level indicators of program performance. To improve quality of care and utilization, we need to consider the physical and cognitive tasks that CHWs are asked to undertake. For ministries of health, understanding which tasks CHWs have been asked to perform, and how well they are performing at these tasks, can clarify program expectations, help to identify gaps in health system support, and inform performance improvement strategies. At the health-facility level, performance metrics can help supervisors of CHWs to identify strong or weak competencies in individual CHWs and set appropriate benchmarks.

Recent evaluation efforts have shown that many large-scale CHW programs are not impacting health outcomes as expected - not because the underlying CHW strategy is necessarily flawed, but because program implementation has been insufficiently strong to achieve success (Amouzou, Kozuki, & Gwatkin, 2014; Bagonza, Kibira, & Rutebemberwa, 2014; Hermann et al., 2009; Miller et al., 2014). For this reason, program managers and evaluators are beginning to pay increasing attention to intermediate measures of program performance (Callaghan-Koru et al., 2013; UNICEF, 2014). Evaluators need data on program processes and outputs to identify barriers to implementation and develop strategies to overcome these barriers, and program managers need similar data to inform real-time decision making and resource allocation (Hazel, Guenther, Marsh, Swedberg, & Bryce, 2014; Mitsunaga et al., 2013).

# Research Methodology

## Study Area

New Orleans is a consolidated city-parish in Louisiana. The landmass has an area dimension of 349.85 sq. mi. i.e. 906.10 km squared. It is located alongside the Mississippi River and considered to be a major port city in the country. New Orleans was one of the most severely affected areas as a result of Hurricane Katrina on 29th of August 2005. The event flooded more than 80% of the city and caused the death and displacement of thousands of people around the city. Community health workers were a huge help to the population stuck in the area in response to the epidemic.

## Study Population

An approximate total population of New Orleans, Louisiana is 391,006 people as of 2018, which makes it the most populous city in the region (U. S. Census Bureau, 2018). The city is well known for its unique cross-cultural and multilingual society. Hurricane Katrina displaced more than 800,000 people, however, between 2010 and 2015, the city drew by 12% on an annual basis, which means an addition of 10,000 to the city’s population annually. This increase in population will also be a part of the study in order to understand and access the community’s response to community health workers in the area.

## Study Duration

For the purpose of the study, the sample population comprised of individuals that were already in the city when it was affected by Hurricane Katrina. Those individuals that moved into the city a long time after Hurricane Katrina were also enrolled in the study for comparative analysis. The study duration will be from 2006, when Katrina actually hit, to 2018 i.e. 12 years from when the disaster first struck.

## Sampling Method

The study designed for the purpose of the research was a cross-sectional survey. Data collection in this study was carried through a mix of quantitative (client exit interviews) as well as qualitative methods, which includes the discussion of the focus groups. There will be four primary focus groups. The first group will include individuals that were in the city when Katrina struck and didn’t relocate following the hurricane. The second group will include people that relocated as a result of hurricane Katrina, but later returned to the city after its rehabilitation. The third group included individuals that moved into the city post-Katrina. The fourth group will comprise of individuals that belong to a well-developed city, with an extensive and successful network of healthcare, such as Florida or California. Given the income of tourists in the area for Mardi Gras, it would be easy enough to find and interview the required population. The purpose of group two and four will be put into place for comparative purposes, which will enable the assessment of group one and three.

## Sample Size

The sample size for client exit interviews was determined by talking to various patients coming to see a community health worker, as well as the doctors involved in situations where community health worker plays the role of a mediator. The anticipated response rate for this study was 90%, with an adjustment being made to cover for non-response rate. The sample was divided using a factor *f*, which was estimated as the response rate by dividing the total population with the 0.9 for 90%. Apart from the interview, questionnaires were also distributed among the sample population. It was made sure that all the samples being distributed were filled and later analyzed.

## Study Tools

For the purpose of research, a pretested standardized semi-structured questionnaire was used to obtain information on the socio-demographic characteristics of the client. This also yields the knowledge of the client on the basis of equality of care, along with the delivery of care as well as its frequency among the masses in terms of prompt attention, customer’s level of satisfaction and the quality of care being delivered. This will yield the data needed for quantitative analysis on the basis of close ended questions in the responses. Furthermore, they will also be interview of one of one basis to get a better understanding of their history as well as their experience as a result of hurricane Katrina. The open-ended questions in the questionnaires and the interview will serve as the basic material needed for qualitative assessment of the obtained responses.

## Data Analysis

Quantitative data was then analyzed using XL Stat and frequency distributions of all relevant variables were presented in tables. The calculated means, along with standard deviations were determined, with statistical significance analyzed using correlation matrix. On the other hand, the qualitative means of assessment were subjected to intense scrutiny and then subjected to thematic and comparative analysis of the responses based on the groups the people had been divided into.

# Observations and Findings

The observations and findings collected as a result of review of literature have relayed some fact, which reflect the various ways the healthcare system may be improved in New Orleans, and the entire state of Louisiana as a whole. The review of literature on the subject explain how devastated Post-Katrina New Orleans was, especially in terms of healthcare and the need for it in the city. However, the situation was already deplorable to begin with. According to the Census held in 2000, Louisiana is the poorest of all US states. When Katrina devastated the New Orleans healthcare safety net, it completely changed the healthcare landscape of the city. It left many without access to healthcare for over a year, with local officials struggling to rebuild the city (Rudowitz et al., 2006). However, it wasn't doing all that well in terms of healthcare Pre-katrina as well. The state of Louisiana in terms of healthcare network available to the masses (Morial, 2007). Community health workers were a huge support in dealing with Post-Katrina New Orleans. Not only did the help the healthcare providers with the patients, but they also allowed the healthcare system to vastly improve in short among of time.

# Discussion and Conclusion

The data obtained on the subject shows certain limitations with regard to the services offered by community health worker services, especially in a city like New Orleans. Thus, this study was based on the views of the service provides, the customers seeking healthcare and the community health workers themselves. However, it limits the understanding of the study’s weaknesses, especially given the involvement of the user’s perspectives. Additionally, the policies in place that dictate the sort of services that should be provided overlooks the needs of poor households and what they need in terms of these services. A wide range of successful models would have provided a better understanding on the subject than the one that is available at present. Another limitation was the choice of city. Choosing a more urban city would have yielded more data and a better set of results, however, it would not have made for an excellent study or given me something to compare the materials up against.

Despite the limitations, the methodology adopted in the study would enable an in-depth understanding of the experiences of a community health worker in the efforts to ensure that the communities they are working with not only have access to a wide range of services, but the basic services that they definitely needed as well. It also gives a change to look into the methods employed by community health workers to reach out to poor communities. This allows the study to dissect the finer components of the issue at hand and potentially contribute to the ability of a community health worker to negotiate the circumstances faced by poor households.

It motivates that to strengthen of the capacity of community health workers in the health system, it is crucial for those in authority to prioritize their training, their supervision and the level of institutional support provided. The study further asserts that poor communities, where CHWs often have to provide their services, need other multifaceted development services which will enable CHWs to provide more effective services to improve the health and wellbeing of marginalized communities. Furthermore, the study indicates that while inter-sectoral action is regarded as a macro level function, providing services that work across sectors while facilitating inter-sectoral action through outreach services at the community level.

The study is aimed to examine the extend of community health worker’s contribution to the rehabilitation of New Orleans by participating in various community events and working with factors that enable the provision of such outreach services. It is supposed to analyze the given literature in supplementary perspective and add to the known facts in a superlative manner.

# Salient Recommendations

Given the already available material on the benefits of using community health workers to collaborate with basic healthcare services has shown that how crucial it is to absorb the community health workers into the health system. This will show the sector’s capacity to not only sufficiently support these workers, but also enables the society to build effective and personal network of healthcare. It will also exhibit a more effective use of finances and the resources being put into the healthcare system by saving a physician’s time and leading healthcare workers to exactly where they need to be at the time. Furthermore, this study emphasises the importance of institutional relationships, including the nature of such relationships in implementing community-based interventions in poor communities. While my study acknowledges the role of the health sector in motivating and guiding other sectors to appreciate the importance of inter-sectoral action, it highlights the greater need for a state-wide’ approach of central government.

# Summary

The community health workers serve as a bridge between primary healthcare providers and healthcare consumer (Javanparast, Windle, Freeman, & Baum, 2018). In this instance, the primary healthcare providers are the doctors and the nurses that tend to your issues at a primary care facility, with the patients and their families serving as the healthcare consumer (Javanparast et al., 2018). Community health workers offer insight, along with services that address the scope of the health care model. The activities undertaken by community health workers include a wide variety of areas that require attention.It ushered in a storm of such magnitude that the state of Louisiana and its healthcare system has yet to recover from its devastating effects (Mammoser, 2017). This system was reformed by community health workers, giving healthcare to those caught in the middle of unprecedented devastation and urgent need of healthcare. They worked alongside first responders and helped wherever they can, in just about every possibility that they possibly could (Wennerstrom et al., 2011). This study aimed to understand the extend of community health worker’s contribution to the rehabilitation of New Orleans by participating in various community events and working with factors that enable the provision of such outreach services. By using both qualitative and quantitative analysis of the data obtained, the issue with the understood and addressed on a grander scale in hopes to understand the assessment of knowledge, practice, and satisfaction of health care services rendered by community health workers among health care consumers.

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