

Model of a Community Health Worker



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The Community Health Worker
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The views expressed in this text are the authors' own and not necessarily those of Combat Poverty Agency.



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Foreword

In response to an invitation to tender by the Combat Poverty Agency, CAN/NICHE was engaged to prepare a publication on the model of a Community Development and Health Worker. While led by CAN/NICHE, it was agreed that this work be undertaken by the Action Learning Group¹ within CAN. The Action Learning Group forms part of a wider action research programme on tackling health inequalities through using community development approaches. It includes representatives of Cáirde, CAN, Fatima Groups United (FGU) and NICHE (Northside Initiative for Community Health).

It was proposed that the preparation of the publication would be grounded in the experiences of the four projects in developing the role of a Community Development and Health Worker in various settings. It was based on analysing the learning from these experiences and on capturing the insights and reflections of key players, in a number of different sectors, on the development of the role. The exploration of this model of Community Development and Health Worker was set within the context of the broader Community Health

Worker (CHW) role that encompasses a wide variety of forms.

The methodologies employed in the preparation of this document include documentary research, consultation, critical reflection, dialogue and analysis. Each of the four projects in the Action Learning Group that employ CHWs were facilitated to reflect on their experience of the role within the project and within the community. The CHWs from the three projects, CAN, FGU and NICHE, along with other project workers, came together to explore and discuss the challenges and potential of the role. In addition, the Action Learning Group hosted a meeting of HSE personnel, specifically focused on the CHW role within community development settings.

This publication is the result of these reflections, explorations and analyses. It will assist the Combat Poverty Agency in illustrating and promoting the model of a Community Development and Health Worker which draws on learning from projects in the current Building Healthy Communities Programme.

¹ The Action Learning Group was established early in 2005. It is hosted and facilitated by CAN. The Group provides a reflective space for a number of community projects involved in tackling health inequalities using community development approaches. The action research programme on Community Development and Health is supported by the Combat Poverty Agency (CPA) 'Building Healthy Communities Programme' and the Health Research Board (HRB) 'Building Partnerships for a Healthier Society'.



Introduction

The concept of Community Health Worker (CHW) is widespread and a variety of names are used to describe the role. There are a number of operational models in Ireland and many more in other Western countries (notably the US) and in Majority World countries. Internationally, community health workers have been a part of the wider health system for nearly a century. There is a huge diversity of activities undertaken by CHWs in a wide variety of contexts. However, there are fundamental core elements that characterise the role of the CHW and that differentiate it from other actors in the community health arena. These are captured in the World Health Organisation (WHO, 1987) definition of the CHW:

“Workers who live in the community they serve, are selected by that community, are accountable to the community they work with, receive a short defined training and are not necessarily attached to any formal institution.”

This is a comprehensive and useful definition that encompasses the basic characteristics of the role as reflected in different settings, countries and levels of

development. However, it is the contention of this document that a CHW model as operationalised, to date, in the Republic of Ireland adds a number of other dimensions that significantly enhance its capacity to address health inequalities. At this relatively early stage in the evolution of the role in this country and in the light of the changing health structures it is imperative that these dimensions are identified so that the analysis informs future developments in this country.

What are these dimensions that hold out the possibility of effectiveness over the long term? While closely interrelated they may broadly be categorised as follows:

- They have the explicit objective of tackling structural health inequalities across physical, economic, social and cultural arenas in addition to improving access to, or enhancing the delivery of, health services within a community context.
- They operate within an unequivocal social model of health and address the social determinants of health. These recognise the range and the complexity of factors that affect health

and health inequalities and the variety of sectors that need to be involved if health issues are to be effectively addressed.

- They embody a community development approach, whereby the community collectively decides on a course of action to address issues that are affecting their health. The CHW acts in a supportive capacity to facilitate that community in identifying and defining these and in deciding on desired outcomes.

It is this model of a 'Community Development and Health Worker' that is the focus of this document. There are other models of community-based health workers that operate within a community context – some in Ireland and many more internationally. These have various designations, including health promoter, peer health educator, cultural mediator, lay health worker, health auxiliary, barefoot doctor, health agent, health volunteer, village health worker, community health aide, promotora². In some situations the concept of the CHW has been firmly incorporated into Primary Health Care. This is a very different model of CHW to that operating within a community development context. This document is based on the practical experience of community development projects that are developing the CHW role on the ground and are prepared to share their learning of this process and of the evolving model.

While not very prevalent within the Irish health arena, this model of CHW has been systematically developed over several years by non-governmental organisations and in a number of settings. The most well-

established of these is NICHE (Northside Community Health Initiative) in Cork. NICHE has been a pioneer in this field for a long period. However, two other organisations that form part of the CAN Action Learning Group (ALG) are also developing the CHW role. These are Fatima Groups United (FGU) and Cáirde. In addition, and separate from the ALG members, the Primary Health Care for Travellers Project (PHCTP) offers a national model that has been operating effectively now for a considerable period. Details of this are also elaborated throughout the document.

² an outreach worker (originally in a Hispanic community) who is responsible for raising awareness of health and educational issues



Developing the CHW Role

A closer look at these four projects captures the importance of the core dimensions of the CHW role, the diverse ways it has developed and how the concept is operationalised within the specific community context.

NICHE - Northside Community Health Initiative:

The focus of NICHE is on improving both community and individual health and well being in Knocknaheeny/Hollyhill in Cork city, using a community development approach. This involves recognising and building on the strengths that exist within the community as well as acknowledging the barriers that prevent individuals and groups from availing of health-enhancing options. Its current three-year strategic plan is to institutionalise a holistic, social model of health within the area.

NICHE has been extremely innovative, in the Irish context, in establishing a community health model, an essential element of which is the development of the CHW role. In its first phase of project development, NICHE piloted a range of initiatives aimed at enhancing the health and well-being of the community. Its Strategic Plan 2004-2007

recognised the achievement of the Project in meeting one of its key objectives, namely: 'to develop innovative health promotion initiatives in conjunction with local people through the use of Community Health Workers, whilst acknowledging and drawing on existing resources' (NICHE, 2005:4). NICHE employs five part time CHWs, mainly recruited from the locality and funded by the HSE Southern Region. It is firmly committed to the development, promotion and documentation of this role in the field of community health (NICHE, 2007).

Fatima Groups United:

The regeneration of Fatima Mansions in Dublin 8 provides the driving force for much of FGU's activities. The adoption of a holistic approach to health is seen as critical to the success of the whole regeneration process. Those involved in the regeneration recognise the important role played by both health and community development in ensuring successful outcomes.

In 2001, a needs assessment was carried out (Collins and Lyons 2001) to inform a health response for the regeneration. FGU and the Health Promotion Dept of the HSE (South Western Area) worked together on

developing community health initiatives in response to this needs assessment. In 2004/2005, FGU, in partnership with the HSE and CAN, provided training on Community Development and Health to ensure that local people would be included in the community health area. As a follow on, it received funding from the Combat Poverty Agency and the Fatima Regeneration Board to employ Community Development and Health Workers. The Fatima Health Initiative was then established as an FGU Project with four Community Development and Health Workers. This has produced a significant health team within a community development organisation that has now put health way up on the community's agenda (FGU, 2007).

In addition, the Fatima Regeneration Board (within which FGU plays a strong role) has been working on a community health strategy for Fatima and the wider area. A Community Health Co-ordinator was employed by the Regeneration Board in Summer 2007 to work with the health initiatives in the Rialto area and the Community Health Forum and to influence the development of the Primary Care Strategy, which is being rolled out locally.

Cáirde:

Using a community development approach, Cáirde works to reduce health inequalities amongst ethnic minority communities. The publication of a strategy for the health of minority ethnic communities by the HSE Eastern Region in 2004 and the commitment to support community development approaches in delivering the strategy, provided Cáirde with the opportunity to build on its ongoing work. During the previous years Cáirde implemented a range of

capacity-building initiatives with community leaders and ethnic minority community groups, seeking to realise the potential of applying community development approaches to health issues in marginalised communities.

Cáirde successfully persuaded the HSE to initiate a pilot programme to demonstrate interventions that would support the participation of minority ethnic communities in the Primary Care Strategy. This led to a Community Development and Health Programme (CD&H) within Cáirde. This aims to build the participation of ethnic minority communities in Primary Care at a local, regional and national level. Four distinct phases are identified in moving towards this goal and the capacity building phase and health needs assessment phase have been completed (Cáirde, 2006).

The need for the ethnic minority community health needs assessment emerged from the work of the Ethnic Minority Health Forum, also facilitated by Cáirde. Documenting the issues and experiences of ethnic minorities living in Ireland was seen as critical in developing appropriate actions and a solid evidence-base to inform the work of the Forum and as a tool for negotiating change with policy makers.

Pavee Point:

Primary Care, pursued within a community development framework, is the focus of the Primary Health Care for Travellers Project (PHCTP). A joint partnership was established between Pavee Point, a national Traveller Support Agency and the (then) Eastern Health Board in 1994 in response to a proposal from Pavee Point. Preceding by many years the National Primary Care Strategy³, the approach was to work 'with'

³ The National Health Strategy was published in 1994. It made a commitment that a special programme would be implemented to address the needs of the Traveller Community.

the Traveller community in order to develop a Traveller Health Promotion Service. This would be based on the Traveller Community's own values and perceptions and would have long-term positive outcomes. A group of Traveller women had already received training in basic health issues and had the personal skills to engage in peer health-care support.

The project was undertaken on a one-year pilot basis in one community care area in Dublin. It set out to use community development strategies to involve Travellers in identifying priority health care needs and the barriers they experienced in accessing core health services. A baseline survey was conducted by the CHWs. This formed the basis for prioritising needs and for dialogue with health service providers and resulted in an agreed set of priorities and a wide range of interventions. There are now Traveller Primary Health Projects in existence throughout the country (Pavee Point, 2005).

Despite these four very different settings and contexts there are similarities in the CHW model depicted. These have implications for its wider development in the field of community health in Ireland:

- Community Health Workers work from a social model of health, address the social determinants of health and tackle environmental, cultural and socio-economic influences on health.
- Community Health Workers use a community development approach at all stages of the work – in the prioritising, planning, developing, implementing and monitoring of activities.
- Training is a central component and there is a commitment by the projects

to ensure that the ongoing training and supports required are in place.

- The community ownership of the programmes is explicit and reflected in the way the projects are structured and operate.
- In addition to developing community-driven programmes, the CHWs play a vital role as links between other services, service providers and the community. However, they are not an arm of statutory provision.
- Community Health Workers operate within the context of the organisation's Strategic Plan - the end product of a community planning process. The work of individual CHWs is defined by this.
- Community Health Workers have documented and disseminated information on the operation of the CHW role and actively promote CHWs as valid actors in the field of community health.
- While the programmes are financially supported by statutory agencies, the CHWs are recruited, trained, employed by and accountable to the community organisation.

In essence, this CHW role is focused on the collective dimension where community organisations work together in identifying issues of concern and in organising appropriate responses. This distinguishing characteristic is unlike other CHW models which focus on individuals; or on points of access to services; or on responding to the needs of service providers in their attempts to reach or relate to different groups.

Diversity of the CHW Role

A huge variety of activities are undertaken by CHWs in Ireland. These range from: advocacy and lobbying to programmes for specific groups in the community; and from undertaking health needs assessments to delivering agreed services, in partnership with health services personnel. However, it is not so much the visible activities that define the CHWs but the process by which these are undertaken and the context within which they are decided upon:

- They are set in the context of the Social Determinants of Health with the focus of activities on structural influences as well as on personal issues.
- The concern is with collective change in health status and with the empowerment of the group as well as addressing the problems and interests of individuals.
- There is community participation at every stage of the activity – in the assessment of the situation, in defining the issues, in establishing priorities and in implementing, monitoring and evaluating.

While marked by these characteristics, the activities of CHWs vary from one setting to another and there may be a difference in emphasis between settings. For example, the job description for the CHW in the PHCTP includes such tasks as:

- accessing and disseminating health information to the Traveller community
- contributing to the development of

health education materials

- developing an advocacy role in their community
- identifying the health needs of Travellers
- facilitating dialogue between providers and the community
- contributing to relevant policy initiatives (Pavee Point).

The job description of the CHW in Cáirde covers areas relating to developing health services information, playing an active policy role, networking and working in partnership with relevant statutory agencies and supporting people from ethnic minority communities to access health and health related services. In Cáirde the job description signals a major role for the CHW in supporting and developing the Ethnic Minority Health Forum (Cáirde, 2007).

While the breadth of the role is captured in such job descriptions, the focus of day-to-day activity is reflected in the broad division of areas of work undertaken by each of the five CHWs in NICHE:

- Young Mothers and Families Support/ Primary Care
- Information and Access
- Environment/ Support to Men's Health Groups
- Pre-development Support/Mental Well-Being
- Physical Activity/Young People/ Schools.

CHWs in the Fatima Health Initiative provide opportunities for local people to look at their own and their children's health. The Fatima Health Initiative links with activities of other community groups to provide a health focus within their work as well as developing specific activities of its own. These include:

- Holistic Therapies
- Women's Group
- Working with Men
- Parenting Groups
- Providing access to support networks and community and health services
- Young People and Health
- Ensuring there is always a health element in the events and festivals held in Fatima.



Promoting Community Participation

Virtually all the health strategy documents of the current decade emphasise the importance of community participation in health. *Quality and Fairness: A Health System for You* (2001), for example, claims that a priority will be participation of the community in decisions in relation to health and personal social services (Action 52). The 2006 HSE *National Service Plan* points out that the aim of social inclusion services is to address inequalities in health between social groups and enhance the participation and involvement of socially excluded groups and local communities in the planning, design, delivery, monitoring and evaluation of health services (HSE, 2005:4.7.1)

While there is much lip service paid to the concept, there is little guidance as to how community participation is to be operationalised in different contexts and the structures required to facilitate it.

Within the community development context, maximisation of community participation is a major goal for the CHWs. The projects demonstrate, in some detail, how this is pursued and the gains, at a number of levels, in the resulting enhanced capacity:

*In a context where community ownership of programmes is emphasised, the development of local roles and skills creates a cohort of staff who are not just instrumental in delivering the project but are part of the process. There is net gain for the community in terms of local skills and investment. During the eight years since NICHE was established the CHW role has evolved. In the beginning the CHWs were primarily involved in supporting individuals to engage with the project and become involved in group activities. It is now a complex role, which encompasses all stages of development and partnership formation. **NICHE; 2007:2***

*The process of facilitating community participation in the 'Project' has resulted in the empowerment of Travellers and led to them taking more control of their health situation. Their attitudes to the health system have changed through the provision of information, training and resources. This, in turn, has brought about a change in their ability to access the system. Travellers are making greater demands on the health services and have greater expectations that they be provided in culturally appropriate ways. **Pavee Point, 2005:21***

Cáirde's approach to the research (health needs assessment) placed participation at the centre of the design of the methodology, whereby ethnic minority communities were actively involved in all aspects of the research, starting from the process of identifying priority areas for the research, designing the research process, conducting the research itself, and finishing with analysing the results and planning responses. A critical goal in this participatory approach is for the community to build its own capacity by developing skills, applying research results to improve their lives and planning for future health related needs. Cáirde, 2006:15

In NICHE, the work of the CHWs in promoting participation draws strongly on community development practice. This is highlighted in the three identified stages of: pre-development, development and empowerment (NICHE, 2007). In the pre-development stage the focus is on interaction and engagement with the community through supportive methods such as outreach. Information is spread and awareness raised through newsletters, accessible information talks and local venues. Specific groups are targeted to come together in a safe environment that supports their needs. Local knowledge and expertise is core to the pre-development work as new participants are encouraged to join the project. The CHW also has a role in progressing participants, not only to NICHE activities, but to other education and training initiatives. Because the CHWs are immersed in the local culture they create an ease that is a natural attribute.

At the development stage, people have moved to participation and involvement

in activities and programmes. They are contributing ideas, developing confidence and identifying and naming needs and supports. The CHWs adopt a facilitative role in the development stage but support is still a key factor for participants. CHWs provide support and create spaces where participants can find their own value and worth and take control over their own needs.

At the empowerment stage, participants have the ability to stand alone with little or no support. Emphasis is placed on action and active engagement and sustainable development. The focus is on identifying solutions, encouraging others and working in partnership with other people and agencies towards a common goal. The CHW's role at this stage is a challenge as progression is crucial to the participant's own empowerment. Here, sustainable development is a core principle and it is the CHW's role to guide and gently support but not to control.

As NICHE emphasises, in each of these stages, there is a particular focus on the needs of the individual or group. Stages may well overlap and people do not simply move to the next step. The work of the CHW means moving back and forth between the stages. It is, therefore, crucial that they have an understanding of a social model of health and of community development practice and are adequately supported to work with the local community through these stages.

To define the CHW role, therefore, strictly in terms of activities gives a very limited view. The CHWs not only provide activities but also attempt to create a supportive environment for people to participate. The core element of the role is the process

through which CHWs address the barriers that prevent participation through the gradual practice of welcoming, supporting and facilitating more vulnerable members of the community to get involved in activities. This element of the role requires an investment of time and energy to build relationships with vulnerable members of the community and facilitate their participation. (NICHE, 2002:4).

One of the characteristics of the CHW internationally is the wide variety of settings within which they work. While the vast majority operate within a community framework the actual setting may be very different. This is illustrated in the four projects involved in the Action Learning Group where all employ CHWs but within very different contexts.

As is apparent from the earlier descriptions, NICHE focuses on improving both community and individual health and well-being in an urban area. It does this through a very broad range of activities that are determined through a comprehensive community planning process. The CHWs are at the core of all these activities and operate at a number of different, and increasingly complex, levels.

In FGU, the regeneration of Fatima Mansions itself is a health project set in the context of the social determinants of health. Strong residents' involvement in the regeneration also facilitates participation in the Fatima Health Initiative. The adoption of a holistic approach to health is seen as critical to the success of the whole regeneration process.

Cáirde works to develop a model of community participation in primary care among disadvantaged minority ethnic

communities. To date, capacity building and the undertaking and publication of a community health needs assessment have been central to developing the CHW role. It is intended to move to the further two phases of 'Actions' and 'Mainstreaming' in the Community Health Initiative.

Training and Development

Training is core to the development of the CHW role and is specifically named in the WHO (1987) definition of the CHW. If that role is within a community development context, training and development assumes an even greater significance. There is a strong rationale for ensuring that it is prioritised and covers a range of issues:

- The need for training that enhances skills, is empowering, and promotes the capacity of the community to engage in effective collective action for social change
- The development of training that is accredited and improves progression opportunities for local people and for CHWs in pursuing education, employment and further training objectives.
- An interface between training and the community development project as the structures and systems are put in place to ensure CHWs are provided with ongoing training and support.

Training in relation to the CHW role is not a one-way process. There is also a need for capacity building for statutory health personnel, in order to promote real participation, an understanding of the factors that impact on the health of the community and appropriate actions to address these.

Training as a Strategy for Social Change:

Participation in an accredited Community Development and Leadership training programme⁴, designed and delivered by CAN, was the stimulus for the four different health-related projects coming together in the CAN Action Learning Group. This course was delivered individually to the projects. Two new modules (on community development and health) were also piloted and developed by CAN. (CAN Comment, 2006.)

In CAN training, community development principles and practices are pursued. The training engages participants in a way that mirrors the community development approach in action. There are a number of key stages reflected in the training process. These have been elaborated in the CAN Comment: *Community Development is Good for your Health?* (2006) and may be summarised as follows:

- It begins by honouring the lived experience of each person who has experienced inequality and/or a denial of rights.
- Creating the learning group is an opportunity of linking individuals together and creates a shared understanding of how inequalities are experienced as well as a sense of solidarity and identity within the collective itself.
- Subjecting this shared experience to scrutiny through the process of social

⁴ FETAC Level 5 Community Development and Health



analysis allows the group to see the interconnection between the personal, social, cultural, political and economic dimensions of the issues.

- Learning skills in planning for collective action, group dynamics and leadership that are linked to a vision of a more equal world gives groups power to take action on their own behalf.
- Networking within and across communities through visits, placements and using mentors all help to reinforce the need for and the value of strategic alliances.

Encouraging the practice of learning by doing is central to each stage of the training and the training is often changed significantly as a result of the joint reflection and evaluation. Participants learn that their views do count and that they can influence change. Such community development training is always located within a specific context and is sensitive to the stage the individual or community is at.

The CAN Comment identified a number of challenges relating to such training, including appropriate funding mechanisms; progression routes for trainees; support needs because of the previous failures of the educational system for many; and a lack of appreciation by many state agencies

of what is involved in 'up-skilling' people regarding community development.

An external evaluation of the NICHE training programme and the follow-up on participants documents in considerable detail the whole process and its outcomes, at both individual and community levels. This evaluation will be published later this year by CAN.

Training also formed the backdrop to the piloting of the PHCTP in the mid 1990s (Pavee Point 1995:13). The CHWs recruited to the 'Project' had participated in a number of training courses over the previous three years. The skills and experiences gained on these courses provided a foundation and were crucial to their successful development as community health workers.

“The 'Project' included a training course, which concentrated on skills development, capacity building and the empowerment of Travellers. This confidence and skill allowed the community health workers (CHWs) to go out and conduct a baseline survey to identify and articulate Travellers' health needs. This was the first time that Travellers were involved in this process. In the past their needs were assumed”

Pavee Point, 2005:18

Ongoing Training and Support

In addition to the initial accredited training, ongoing support and accommodating organisational structures are fundamental to this model of the CHW:

“A supportive organisational structure is essential for the CHW concept to be successful”

NICHE, 2007:2

The CHWs come from the community. They have experienced, and may continue to experience, inequality and exclusion in the wider community. They are also affected by the underlying factors that impinge on the health of the local community.

In NICHE very clear structures are in place to ensure there is ongoing support and supervision (NICHE, 2007:2):

The CHWs work from individual, clearly defined work-plans. These are the end product of a planning process in which the community, management and staff are all involved. The process begins with Community Health Planning to identify and prioritise local issues. This, together with in-depth internal evaluation is used to inform a Strategic Plan which covers a three year time-scale. Based on this, annual work-plans are set out and from this the individual work plans for CHWs are devised. The CHWs have a clear vision of what they need to do, why that particular action is appropriate, what outcome is expected and why.

Day-to-day support and supervision is provided by the Assistant Project Manager who works with the CHWs on the implementation of their work plans and on addressing any problems or issues that arise. She also supports them in meetings

with other agencies and organisations. Through a structured supervision process support is provided in defining boundaries, recognising limitations and sustaining themselves in a situation where they live and work (very visibly) in their own community. This supervision also provides them with an opportunity to reflect on and analyse their work ... Team meetings are held regularly and are part of the on-going work-plan. Training needs of the CHWs are reviewed annually and individual and team training needs addressed.

The CHWs place a huge value on teamwork. They see this as essential for the effective working of the project and make dedicated time for team meetings. They are all familiar with each other's work and ready to step in and assist their colleagues when needed. This also needs to be seen in the context of the diverse skills and experience that the CHWs bring to the project. For these to be complementary rather than conflicting, the team building and support is essential.

NICHE, 2007

Within the Travellers Health Project, meeting ongoing training requirements is seen as an important but difficult area. In the first instance, funding is not always available for specific training needs and secondly, training and work need to be balanced. However, the PHCTP maintains a focus on training – group training, team training and individual training (to develop both personal and technical skills) – in order to give CHWs the best opportunity to achieve their potential. (Pavee Point, 2005:37)

There is a widespread recognition of the importance of ongoing training and support for an effective CHW role. Internationally,

the analysis of many programmes has yielded clues to their success or failure. The International Medical Volunteers Association, for example, concludes:

“*In general CHWs are more likely to be effective if they are truly representative of the community, are chosen by the community, and are well supported ... Important elements of support include a good initial training, good supervision, regular continuing education, and access to further information whenever needed...*”

IMVA, 2007

Partnerships and Bridging Alliances

Partnerships, alliances and collaborative ventures are integral to the concept of the CHW. These are forged with other agencies, both statutory and voluntary, as well as through links with service providers, whether in the health sector or with other sectors that impact on the health of a community.

Once the group of CHWs was established, NICHE was clear that the appropriate way for it to consolidate and build on its success was to enter into a broad range of alliances with other organisations working in the area (NICHE, 2004:11). For example, CHWs now play a significant role in the Environment Forum, providing support to local representatives on the Forum, working in partnership with groups and agencies (such as the city council and RAPID) represented on the Forum and organising training for local people on environmental issues.

In NICHE, the CHWs also work with statutory agencies to ensure that the health information they are disseminating locally is appropriate. The mental well-being programme involves working with a variety of service providers, local groups, complementary therapists and a support group. A CHW supports youth groups and schools to identify health issues and makes the links with appropriate service providers to address these.

Staff of statutory agencies also value working with the CHWs in NICHE. They see them as making it possible to work more effectively in the community at a level that was previously not possible. They gain an

understanding, from the CHWs, of local issues and barriers as well as potential solutions to those barriers (NICHE, 2007).

In NICHE, the CHWs have described their work as 'building a healthy community within community and working with agencies.' They see themselves as a bridge for two-way communication and for dealing with and managing conflict which may arise between agencies and community. (NICHE, 2007)

The interlinking of work among the various community groups and services is central to the work of the Fatima Health Initiative. For example, the project is managed jointly by FGU, CAN, Fatima Regeneration Board and the HSE. Working on the ground, the CHWs continually engage with relevant other community projects and services. At present, the men's work involves a joint team consisting of workers from the Rialto Community Drug Team, the Fatima Youth Initiative and the Fatima Health Initiative. Increasingly the CHWs are being drawn into the programmes of other agencies, either as collaborators or to deliver a component of a programme specifically related to health.

In the PHCTP one of the immediate ways identified of improving Traveller health status was to improve access to and uptake of local services. A very good working relationship was established between the local health service providers and the CHWs which resulted in improved access to and uptake of services. This is evident in relation to audiology, speech and language therapy,

dental services, the Well Woman Clinic and Breast Check. In areas where there is a Primary Health Care Project, public health nurses are engaged in the delivery of health promotion/prevention services in partnership with the CHW. (Pavee Point, 2005:20)

The different strengths and resources of the statutory and voluntary sector are brought together in a constructive way on an agreed agenda. Each partner brings different skills:

“ *Pavee Point provides the channel of communication and established trust with Travellers; an arena for Traveller participation and a community development approach to working with Travellers. The Health Board provides the funding, the health knowledge and the health professionals... A crucial ingredient for this partnership has been willingness to engage as equals while respecting each others roles, responsibilities and ethos.* ”
Pavee Point, 2005:16

By contrast, in national health programmes there is often little room for ‘engaging as equals’ and there can be tensions between the top-down and bottom-up approaches. This may be evident in strategies such as those relating to Alcohol, Drugs, Suicide, Smoking, Men’s Health, and Obesity. On the one hand, having an infrastructure on the ground makes it possible to draw down resources and to use them positively within the community context to enhance health and well-being. However, there may well be differing views as to how to do this in a way that allows for a pace suited to the community while, at the same time, meeting government targets and ‘indicators’ of effectiveness. The absence of a supportive framework for community participation in health initiatives means that

there is, at best, a weak interface between community involvement and such national health strategies.

Strengths and Challenges of the Role

As part of the preparation of this document, individual and group consultations were undertaken with CHWs and project workers in NICHE, Cáirde and FGU. These explored, among other issues, what works well from their perspective and what are the challenges in relation to the CHW role as it currently operates. In the process projects identified both strengths and challenges of the CHW role.

From the Ground Up - What Works Well

- Being from the community; Known to people; See 'people as people' in the complexity of their whole lives and not as clients/customers/patients; Can connect with the reality of people in the community; Are aware of issues and of the barriers facing them.
- Familiar language and easy communication; Shared understanding of cultural issues and a common background; Experience, and more trust and credibility as a result.
- Informal approaches to engaging people; Being present where people gather; Providing information door to door; Word-of-mouth dissemination and targeted proactive approaches for 'hard to reach' groups.
- Attitudes of CHWs; Not judging but accepting people; Hearing peoples' suggestions and following through on these in a realistic way; Using positive processes that are openly evaluated with the group.
- The 'group work' approach in promoting participation; Encouraging participation at all levels - 'real participation' from planning to delivery to evaluation; Motivating people and bringing a health agenda to the community.
- Working with service providers and statutory agencies towards a more friendly, accessible and appropriate community service; Making an effort to get to know statutory personnel; Creating effective partnerships and bridging gaps.
- Having a number of CHWs working in a project, i.e. the potential impact of a 'critical mass'; Opportunities for reflection, teamwork and complementarity in the work.
- Having ongoing support, supervision and evaluation; Acquiring community development skills; Networking with other community development and health projects.
- Operating from a social model of health with scope to move across issues and sectors in addressing the root causes and not just the consequences of health inequalities.

From the Ground Up - What are the Challenges?

- Ensuring that 'being local' does not result in a downgrading of the position. While it is a professional position like any other, peer experience, understanding, empathy and analysis of the community is very important. It is crucial that the worker brings their own life understanding and experience to the work and that this experience is respected and valued.
- Maintaining boundaries between public and private life, where one lives and works in the same community
- Securing the training and information needed at personal levels
- The attention that is required to policy work, lobbying and advocacy rather than concentrating solely on the work on the ground
- Not getting 'boxed into' a Primary Care setting and operating in other arenas also. There is also a danger of community development itself being sidelined in Primary Care and the agenda and direction being driven by PHNs or other health service providers.
- Ensuring that resources are available to community groups to organise and mobilise around health and not getting pushed into services provision, solely
- Dangers of some forms of professionalisation in community health. Community development projects are 'using health' to get resources for workers but the workers then employed are not local but third level graduates.
- Staying true to community development principles, while facilitating progression when highly skilled CHWs move on from the project to avail of other opportunities. The very complex role which they perform so competently will not be fulfilled, in the short to medium term, by a newly recruited CHW.
- The need to behave and to speak appropriately in the face of real, difficult facts and inequalities. CHWs get angry at how the local community has been treated and at what they see as an inappropriate use of resources. However, given their position and the need to work with the agencies, in question, they have to be restrained in their criticism.

Being local is a core characteristic of the role of the CHW in many contexts. In Cáirde however, the CHWs are not 'local' in the geographic sense but they are from the community in that they are also members of ethnic minority groups and have experienced inequality.

It is not surprising that being part of the community with which one works emerges as both a strength and a challenge for those on the ground:

“*Being part of the community has enhanced their ability to create places/spaces for community members to express feelings, discuss issues and process them. Local people appreciate and value the CHWs knowledge and understanding of these issues and the empathy with their feelings. There is a huge element of trust and an ease of communication*”

NICHE, 2007

Project staff report how, in the early days of the programme, this unique position of CHW created tensions for them as they grappled with the dual role of being professional and being local. However, as the projects developed they felt more comfortable in their position and more accepted by outside agencies and their staff with whom they developed close links.

The issue of living and working in the same community is a very real one for the CHWs. They have to be aware of their boundaries and deal with situations where people may call to their houses in the evenings or at night or expect their support outside of the project. Maintaining these boundaries can be challenging. There is also a related issue where CHWs sometimes feel that their personal life styles and that of their families are subjected to scrutiny and judgement by others, particularly in terms of health related behaviours.

Employing Community Health Workers

In the projects examined in this discussion document, all CHWs are employed by the community projects. This is central to the model of the CHW that is elaborated. However, the funding for the positions comes from a wide variety of institutional sources from the HSE to Combat Poverty and from programmes for health promotion, social inclusion and labour market insertion.

NICHE, initially funded through the EU programme URBAN, is now mainstreamed and supported fully by the HSE (Southern Area). NICHE made a clear and early decision not to use labour market schemes in the employment of CHWs. The remuneration for the CHWs is linked with the child care worker salary scales.

In FGU funding for the CHWs comes from several different sources – Combat Poverty; Community Employment (CE) scheme, J1 and the HSE (through Dolphin Development Association). When the HSE (South Western Area) funded a dedicated post in health promotion, based in Fatima, it was interested in developing the concept of peer health education and the community health worker.

Cáirde is funded from a variety of sources. However, the Community Development and Health programme (CD&H) is funded by the HSE (Northern Area) under the Eastern Regional Health Strategy for Ethnic Minorities. In the absence of securing dedicated resources, its two CHWs are currently funded through a Community Employment (CE) scheme. Funding was also

secured from FÁS for the initial training programme that was at the core of its capacity building phase.

The engagement of a range of funding agencies or, indeed, different programmes within the HSE, can be seen as a strength, given the variety of sectors that need to be involved if health issues are to be effectively addressed. However, while the actual funding sources may vary the funding mechanism used is very important. It is essential that it provides adequate remuneration and security of funding over the medium term and facilitates the development of the dimensions that are at the core of the CHW model. This, for example, is seldom feasible in relation to labour market measures such as short term CE schemes, which are also very specific in terms of eligibility criteria.

What is important is that the necessary resources and supports are available within the organisation concerned regardless of whether it is a Community Development Project, a Family Resource Centre, a Primary Care Team, a Regeneration Project or a Community Health Initiative project. This is not simply payment for the CHWs but support for the infrastructure that will promote their effectiveness. Adequate infrastructural resources have to be given if there is a commitment to community development. It cannot be done otherwise.

Cáirde emphasises how funding for CHWs must include such resources:

“ Community Health Workers are members of the community, and are people who have participated in training in community development and health and are ideally located to play an active role in bringing the issues affecting their community forward to health service planners and providers and other related services. However, the role requires ongoing support, and funding secured for the employment of community health workers has to include resources for such support ”
Cáirde 2007

In the *Review of Travellers' Health using Primary Care as a Model of Good Practice* (Pavee Point, 2005), the issue of equality in relation to the employment of CHWs is raised. It emphasises that the role of the CHW needs to be carefully defined in the service delivery model to ensure equality outcomes. Community groups and organisations who choose to engage in service delivery for the state need to give serious consideration to the terms and conditions of employment of local CHWs, to their career path options and to how their personal and professional development needs will be met. It warns of dangers:

“ Inequalities can be generated and reproduced when local community health workers are not respected for the experience and expertise they have acquired, and for their commitment and work in advancing the health and well-being of their communities.

At the same time, inequalities are generated for the workers and their communities if they are not facilitated as part of their employment to acquire the skills and knowledge and the credentials that would enable and allow them to have equality outcomes from employment

opportunities and to provide quality health services to their communities in community-based health initiatives.

Community Health work is considered low-paid service work and provides an equality challenge for the workers (mainly women); for the organisations engaging in the service delivery; for the community to whom the services are delivered; and for the community sector that advocates for the highest standard of service delivery to already deprived communities. ”

Pavee Point, 2005:22/23

Evaluating Effectiveness

There is little written on the CHW role, either in Ireland or in other western countries. There is even less in relation to how the role is operationalised on the ground in community development settings and virtually nothing on evaluations of its effectiveness. Where the CHW role is evaluated it is frequently in relation to a single dimension or issue and notably in terms of access to, or take up of, existing services (Swider, 2002:19). Here the CHW role is less complex and more of a 'paraprofessional' who supports health and social service providers by assisting people and communities to access services (Community Voices, 2003:3). However, even in this context the limitations of existing evaluations in terms of learning are readily recognised:

“ Little is known about specifically what CHWs do that produces the desired outcome. Further study into the process of CHW work and what elements are necessary for a CHW to be effective would be helpful for future program development ”
(Swider, 220:19)

It is notable that in the relatively early stages of the development of the CHW role in Ireland so much is known precisely about these aspects of the role. The role of the CHWs as they operate within a community development context is well documented thanks to the work of the projects that have pioneered this model and that continue to develop it within the evolving health structures. This document is a further contribution to sharing the learning to date.

There is clearly scope to further document, analyse and evaluate the effectiveness of this model of CHW. This could be done by taking a medium to long-term timeframe, using community development approaches, based on appropriate indicators developed within the specific community context.

Conclusion

In this document a number of core characteristics have been identified in respect of the CHW model within a community development context. These are drawn from the experience of a number of projects that have operationalised it and are trying to develop the role within the Irish context.

They may be summarised as follows:

- 1** The location is within an explicit community development setting. The actual type of project is not so important. It may be Women's Projects, CDPs, Housing Rights Projects, Regeneration Projects, Family Resource Centres, Primary Care or Community Health Initiatives. However, these must have the infrastructure to support the model and allow its organic development.
- 2** The diversity in activities and settings is positive and necessary, given the range of factors that impact on health and the differing community strengths and resources. Despite the diversity there are clear common denominators that underpin a strong concept of the role.
- 3** The CHW is not only community-based but community led. While it may be the HSE who funds the position, management is best effected through the community project or through community management at a local level. This facilitates community ownership and the ongoing development of the role as appropriate to that specific community.
- 4** Training and development are central to the CHW role. While accreditation is important there is scope for flexibility and variety in the training programmes – depending on the context, the type of project and the stage of development of participants. Ongoing training and support are critical to the effective development of the role. The skills required by a Community Development and Health Project can be found within any community once there is a commitment to providing the required support and training.
- 5** Employment needs to be on a secure footing and CHWs need to be properly remunerated and work in a team context. This employment basis is essential in terms of the status attaching to the role as well as to gender equality issues, given that the vast majority of CHWs are women.

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