GLOBAL HEALTH INITIATIVE SEMINAR

COMMUNITY HEALTH WORKERS: PROMOTING HEALTH FROM THE BOTTOM UP

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ICAP
COLUMBIA UNIVERSITY
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# My Experience with CHWs/Peers

<table>
<thead>
<tr>
<th>Dates</th>
<th>Title</th>
<th>Issue</th>
<th>Nature of project</th>
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<tr>
<td>1983-1984</td>
<td>Crisis Intervention Services Project</td>
<td>Gang violence</td>
<td>Services, research</td>
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<td>1997-2000</td>
<td>Consumer Services Research Project</td>
<td>Community mental health</td>
<td>Research</td>
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<td>1996-2000</td>
<td>Pathways to Completion</td>
<td>LTBI treatment</td>
<td>Services, research</td>
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<td>1998-2004</td>
<td>Harlem Adherence to Treatment Study</td>
<td>HIV treatment</td>
<td>Services, research</td>
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<td>2001-2006</td>
<td>TB Adherence Partnership Alliance Study</td>
<td>LTBI treatment</td>
<td>Services, research</td>
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<tr>
<td>2005-2011</td>
<td>Peer Advanced Competency Training</td>
<td>HIV peers</td>
<td>Training, technical assistance</td>
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Why Use CHWs?

• “When I was diagnosed I felt like nobody could possibly understand what I was going through. I would have given anything to have another HIV+ woman to talk to right away. When I finally did meet another HIV+ woman, she gave me hope. She had information. She gave me courage. Now we can give other women what we only dreamed of before.”

Rebecca Denison, founder of WORLD

Anna Jackson and Sylvia Young, Peer Advocates at WORLD
Who is a CHW?

- Not working as a licensed clinical professional
- Who shares key characteristics with target population such as:
  - Community membership, gender, race/ethnicity
  - Disease status or risk factors
  - Salient experiences, e.g. former drug use, sex work, incarceration
- Who uses shared characteristics/experiences to act effectively as a:
  - Trusted educator
  - Mentor for adopting health behavior
  - Role model
  - Empathic source of social and emotional support
Qualifications for Being a CHW

- Targeted condition ("infected or affected")
- Familiarity with target community
- Commitment to helping others
- Good communication skills
- Specific requirements (e.g., being adherent to medications, not currently abusing drugs)
MODELS OF CHW PROGRAMS (MACRO)

1. **Assist HC providers:**
   - CHW works with MD
   - Rural and urban settings

2. **Replace HC providers:**
   - No providers available ("barefoot doctor")
   - Mostly rural settings

3. **Advocate with HC providers:**
   - HC system isn’t accessible/responsive
   - CHW pushes HC system on behalf of patients
   - Mostly urban settings
MODELS OF CHW PROGRAMS (MICRO)

A Continuum:

**Natural Helper:**
- Identified as a leader
- Generally not paid
- Operates independently

**Paraprofessional:**
- Part of a treatment team
- Paid or volunteer
- Institutional support/obligations
CHW COMPETENCIES

HIV CHWs:*

• Emotional support
• HIV care and treatment support
• Harm reduction and behavior change
• Care referrals (“navigation”)
• Other roles (e.g., disclosure, setting boundaries)


* Tobias et al. J Cmty Hlth 2010. 35:609-617
What do CHWs do?
Communicating with Providers

CHW: “A lot of times they have issues with their doctors so I sit in with the doctor, like a case conference. … It helps them because they understand it more, when I break it down to them what the doctor’s saying. And I’ve been told they feel safer when I’m there talking to their doctor.”
Educating Clients

Client: “Now I may have heard it a different way but when I hear it from my peer it's like, wow, okay, that's an easy way to remember it you know. Because he's not using them doctor terms but he's keeping it straight with us.”
Motivating Clients

Client: “Every morning she see me first thing she says, “did you take your medicine?” I said yeah. She says, “Good then, baby, okay then you’re set because the most important thing you’re supposed to do today was get up and take your medication.” …. It feels good when somebody outside of your family is concerned about you.”
Being a Role Model

“I like seeing the clients come in and reach a different level when they leave. The clients looked at the peers and saw how they lived—that they stopped using drugs, they were working, they were taking their medication. They saw how much better the peers were getting, and they would say ‘I want to be like that’.”

Jackie Howell, HATS peer, Harlem Hospital
CHW: “Well, I’ve never been an alcoholic, I’ve never been a drug addict, but I have been mentally ill and also a compulsive overeater. Believe me, if you eat a whole Entemann’s cake, you know that food is really like a drug, for me it is. And I’m still in recovery for that addiction.”
Use of Personal Experience

A Continuum:

- **Non-disclosure**: sensitive to stigma, trying to escape stigmatized role
- **Partial disclosure**: when away from agency or in safe environments (e.g., support group)
- **Full disclosure**: CHW: “I share everything. . . . I share my experience in illness and recovery. So it gives strength and hope. Not only that, but when I share my negative experiences, other consumers might actually get more comfortable, because first of all they see I’m being real, second of all they can relate to it . . . and the next thing you know it’s a whole beautiful discussion with all of us growing at the same time.”
The Tension between Personal Experience and “Professionalism”

- CHWs are valuable primarily because they share their clients’ life experiences.
- CHWs are expected to use their personal experience in order to relate to clients in their environment.
- But are then often accused of not being “professional” (crossing boundaries).
- The response of some professionals: “give them more training”.
- BUT at what point are you stifling the qualities that led you to use CHWs?
Moving from Ad Hoc Programs to Routine

• are CHW programs an “emergency” response or a permanent program?

• Ad hoc programs:
  – Spirit of voluntarism, community
  – Flexible, quick to adapt
  – Cheap

• Routinized programs:
  – Performance standards (job descriptions, etc.)
  – Accountability
  – Requires financial support
Why Should We Move toward Routinization?

• The danger of ad hoc programs:
  – Interventions not standardized
  – Scientific literature focused on outcomes, not process
  – CHW programs not subjected to rigorous study
  – Anecdotal evidence is not valued

• As a result, no objective proof that CHW programs have value

• Thus, are quickly cut when funding is tight or funders move on to new initiatives