

GLOBAL HEALTH INITIATIVE SEMINAR

**COMMUNITY HEALTH WORKERS:
PROMOTING HEALTH FROM THE BOTTOM UP**

PAUL W. COLSON, PHD

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My Experience with CHWs/Peers

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

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



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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)

See also Findley, et al. AJPB 2012. 102(10):1981-1987

* 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.”



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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.”*



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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



Common Experiences

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 Entenmann’s cake, you know that food is really like a drug, for me it is. And I’m still in recovery for that addiction.”



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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



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