Critical Engagement

The Community Health Educator Model as a participatory strategy for promoting minority ethnic health

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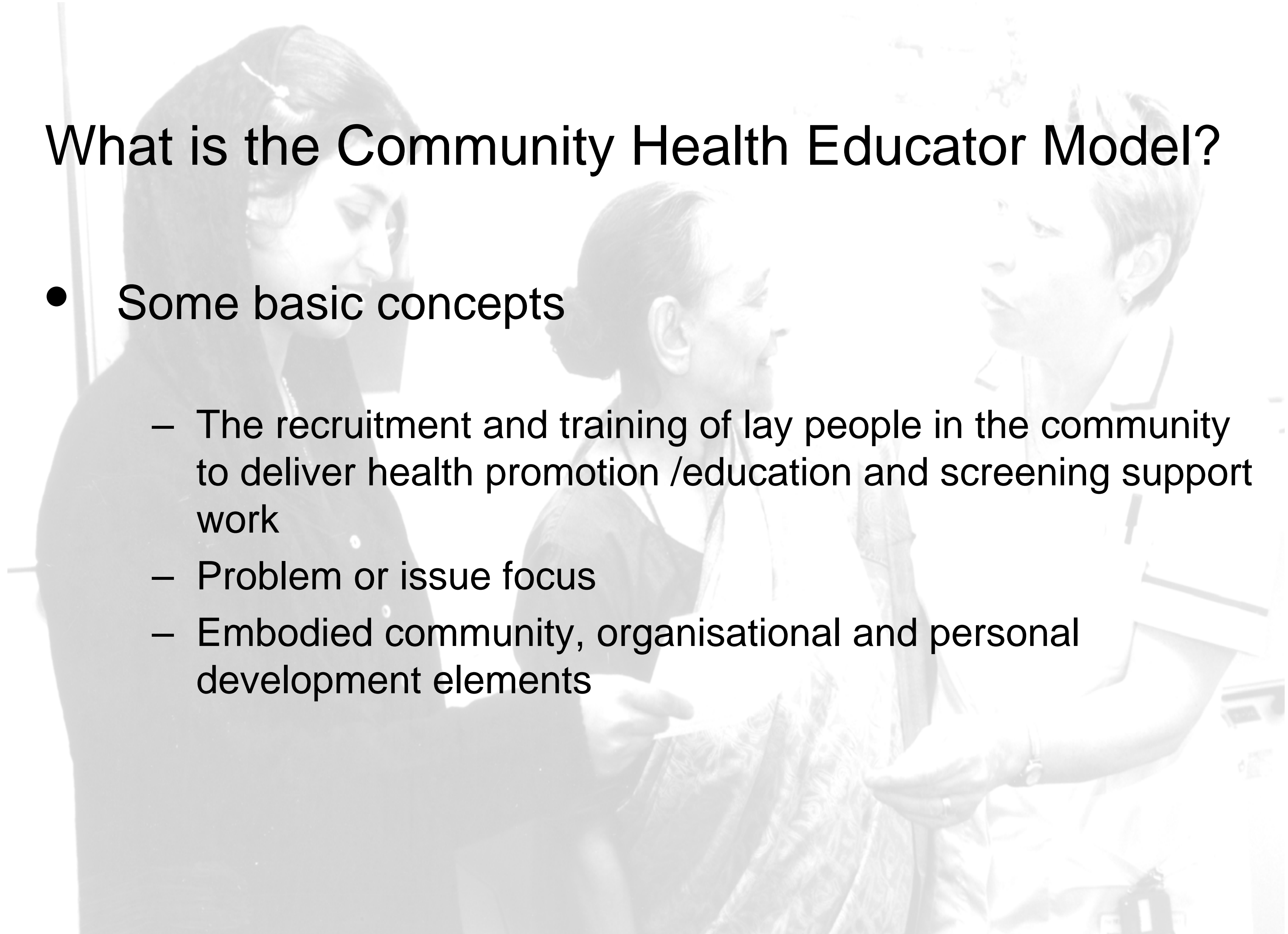
Background

- Concerns over access to health services e.g. cancer screening programmes
- Beyond language and cultural barriers addressed by previous model: Linkworkers/Liaison officers (hospital based), focus on interpreting, translation and cultural practice.
- CHE model: community based, focus on empowerment and participation.

The knowledge base of the CHE model

- Communicating Breast Screening Messages to Minority Women: Constructing a Community Health Education Model (1990-1993)
- Woman-to-Woman: Promoting Cervical Screening among Minority Ethnic Women in Primary Care (1994-1997)
- Straight Talking: Communicating Breast Screening Information in Primary Care (1999-2001)
- C4H (Communication for Health): the efficacy of participation videos in promoting access to breast screening information among South Asian and Chinese communities (2004 – September, 2005)

What is the Community Health Educator Model?



- Some basic concepts
  - The recruitment and training of lay people in the community to deliver health promotion /education and screening support work
  - Problem or issue focus
  - Embodied community, organisational and personal development elements

Framework & key process for participation and Partnership

Stage 1		Stage 2		Stage 3
Problem Identification Stage		Constructing the intervention programme		Implementation, Monitoring, and Evaluation
Focus groups/	→	Training CHEs to deliver health intervention.	→	Strong support required from all stakeholders e.g.
Individual interviews		Training Professionals to work with CHEs		G.P. Practices, Acute sectors &
Rapid appraisal				Communities
Workshops				

REVIEW (from Stage 3 back to Stage 1)

Multi-methods

- Stage 1 — Focus groups
- Stage 2 — Action learning group and training programmes
- Stage 3 — quasi- experimental
  Interviews & Focus groups

Stage 1

CHEs (Cantonese, English, Mirpuri and Syhleti) trained to conduct focus groups

Professionals: eg.practice nurses

focus groups

Research Outcomes

- Information and communication needs
- .Other personal and cultural factors affecting access in relation to the particular issue in hand (e.g. cancer screening, immunisation, diabetes)
- The effectiveness of current information and dissemination strategies

Action:

- Constructing the intervention programme
- Training CHEs on the issue in question
- Training Professionals to work with CHEs
- Planning for implementation

Consequences:

- ❖ An intervention strategy and plan based on needs
- ❖ Capacity building of CHEs
- ❖ Empowering CHEs
- ❖ Confronting system barriers

- Introduction to CHE programme and health promotion
- Reproductive health
- You and the NHS*
- Cancer Education
- Skills in community health education and promotion
- Self empowerment and community health development
- The NHS Breast Screening Programme
- Evaluation
- Using health education resources ….. (Visits)

- Stakeholders buy-in e.g. hospital doctors, general practitioners
- Management needs to understand the principle of the model
- Focussed on both tangible outcomes of the intervention programme and developmental processes of the CHE scheme
- Qualitative and quantitative methods to collect data for evaluation
- Reflective practice method to nurture and support CHEs

Involvement in production of health education materials

- Local knowledge is explicitly valued
- CHEs’ symbolic and cultural resources (dual system) are not taken for granted but viewed as strategies and instruments in democratising health knowledge
  - Production of photostories
  - Contributing to CHE training materials

Telling their own stories

Languages available

Urdu

Chinese

Bengali

English

A vehicle for empowerment

- Enhanced existing social knowledge and skills in communities
- Improved access to knowledge (e.g. about the NHS and cancer screening) and new skills (health promotion and education e.g. one to one; group; organisational; campaigning)
- Problem solving and support for personal development through critical reflective sessions.
- Improved confidence generalisable to many aspects of life

- The inter-connectedness of theoretical concepts i.e. symbolic power, agency, lay knowledge, community resources, social networks and social capital.
- Valuing different ethnic identities
- The notion of agency becomes tangible with the practice of the CHE model.
- Engagement with different communities can enhance social cohesion.

Limitations on the development of the model

- Changes in the system are difficult.
- Demand for evidence based practice, but evidence from practice is not valued.
- The focus on conventional outcomes in evaluation (quick fix for uptake rates or waiting lists).
- Ignore developmental processes
- Rethinking of evaluation research methodology and practice in health intervention
  - Simplistic - complex and pluralistic evaluation.
  - Process of learning-for-all versus concerns over outcomes

Conclusions

- The CHE model not only has the potential to improve access to services and intercultural care, but also to act as a practical programme for social inclusion.
- The model is an action learning programme for all concerned.
- Developing the CHE model requires a fundamental change of the ways in which we think about people, organisation and practice, and the knowledge we purport to have about them.