Paper presented at "Hospitals in a culturally diverse Europe" Conference,
9-11 December, 2004 Amsterdam.

Critical Engagement: The Community Health Educator Model as a participatory strategy for improving minority ethnic health.

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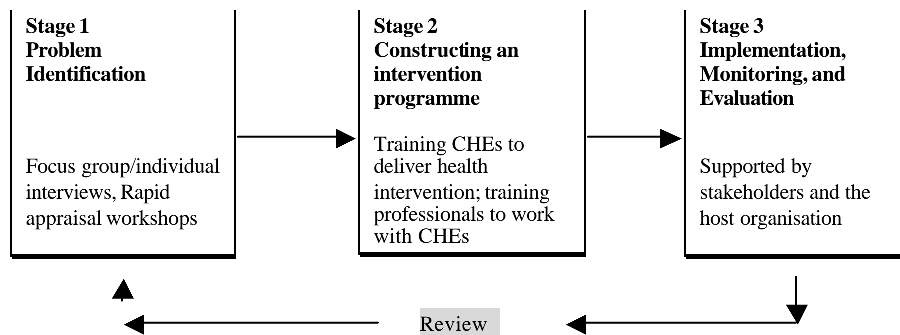
Introduction In the U.K. epidemiologists have long highlighted the health differentials between ethnic groups. Although the picture of inequalities of health among the minority ethnic population is incomplete, recent health policies have acknowledged the need to tackle such inequalities and to ensure fair assess to health services for all. This paper introduces the Community Health Educator model, which is an empowering health promotion model developed through three participatory research projects. It suggests that the model has the potential for community capacity building, going beyond the breaking down of the language and cultural barriers. However, the development of the model to its full potential as a vehicle for empowerment can also be restricted by many factors that are inherent in the present health system. Some of these are highlighted.

The Community Health Educator Model Community Health Educators are members of the minority ethnic communities who are recruited and trained to participate in the delivery of health promotion activities in their own neighbourhood. The model often requires a multi-agencies approach with the support from Local Public Health and Health Development/Promotion Agencies. Since its inception, the model has been adopted by many health organisations across the U.K.

The philosophical foundation of the model is provided by the humanist philosophy of Michel de Montaigne, Marxian epistemology, and the pragmatist philosophy of John Dewey and Richard Rorty. The knowledge base is accumulated through practice and reflection on practice drawing from critical sociological theories such as Habermas' communicative competence and Bourdieu's theory of practice. The practical resource of the model is furnished by the conscientization principle developed by the radical Brazilian educationist Paulo Freire. It is, therefore, a model of health education that emphasises the need to fully engage people in making their own choices about health as well as recognising the need to tackle the wider social, political and economic determinants of health. Empowerment in this context focuses on the building capacity of people in decision-making and community organising skills through non-traditional pedagogy. Dewey's emphasis on experiential learning can also be discerned in the practice of the model.

Depending on the context in which the model is adopted, CHEs would normally be recruited from the neighbourhood of the target communities to tackle a specific health issue. Since the model recognises the part played by the system in individuals' access, it strongly advocates the involvement of health professionals in the process. This facilitates the building of partnership working between professionals and CHEs. Members of the targeted communities are also systematically involved by CHEs in all aspects of planning, implementation and evaluation of health promotion programmes through three stages of an iterative action research process: Stage 1. Identification of needs; Stage 2. Development of health intervention; Stage 3. Implementation and evaluation (See fig. 1)



[Figure 1. The Community Health Educator Model in a 3 staged action research framework]

Stage 1- Problem identification: This is an important Stage in which details of the local conditions are considered. Needs information is gathered through focus groups with target communities and related health professionals. The information gleaned from this Stage is the basis upon which a health intervention programme is constructed.

Stage 2- Solution generation: This Stage requires participants to contribute to the construction and implementation of a health intervention programme. It is one in which CHEs identify their own knowledge and training needs. It also provides an opportunity for other relevant health professionals to be involved with the CHEs' training programme. The training programme is not only focussed on health knowledge and skills for delivering health messages, but most fundamentally is an opportunity for personal development through conscientisation and participation. For example, the training programme will include critical analysis of power and the exploration of the impacts of dominant social systems on health. Through experiential learning and support, CHEs will come to recognise their own capacity for change.

*Stage 3- Implementation and Evaluation: S*tage 3 provides the health intervention programme with a period for implementation. It is recommended that this period should be clearly defined with a date for review to complete the cycle before the programme continues. At this stage, the day-to-day management activities of the CHE model will be intensified. Effective leadership and change management skills are required to support the CHEs during this period. Good facilitation skills to involve stakeholders and communities are ever more important at this stage. The evaluation of the health programme is best done in a participatory manner, so that all participants can play a part in collecting evidence of success and identifying areas for improvement, as well as the unmet needs of the communities.

A vehicle for empowerment: Building the capacity of lay people as Community Health Educators, who then can resource and support other community members in developing their own capacities for tackling health issues, is an essential part of the community development approach. The CHEs who participated in our projects often reported successes in raising awareness of particular health issues and bringing about behavioural changes among members of their communities. Personal development is essential for CHEs to become successful brokers between their communities and health agencies.

Some of the CHEs who have developed their community leadership skills have reported not only that their confidence in their role has increased but that the development process has also benefited them personally in their day-to-day lives. The presence of the Community Health Educators recruited from the communities will have an effect on the attitude, knowledge and behaviour of health professionals. The host organisation will not only be able to develop more appropriate, linguistically and culturally sensitive services, thus improving the quality and acceptability of their services, but will also be able to improve their general accessibility to a diverse population. It is important to note that the use of the CHE model is by no means confined to minority communities. It is relevant to many, particularly disadvantaged, communities and should be considered whatever the ethnic group.

Theoretical and practical contributions While the use of social theories can illuminate some of the contradictions, ironies, and unexpected events and outcomes encountered in practice, events in the real-world as CHEs have experienced can also challenge the explanations offered by social theories. It has become clear that the understanding of social change require an understanding of the interconnectedness of theoretical concepts of agency, lay knowledge, social networks and social capital. The variations found among and between CHEs and their corresponding communities also challenge the concept of ethnicity as immutable social categories. Theorising ethnicity vis-à-vis CHE's social practice has brought insights into the dynamic of cultural power and agency.

Factors limits the development of the CHE model It is necessary to recognise that the CHE model has been developed within the conventional medical model of health in which CHEs are expected to be carriers of health information. The evaluation of CHEs' effectiveness tends to focus on behavioural changes (numbers of people who stop smoking) and quantitative outcomes (impacts on uptake rates). The funding for CHE projects is often short-term, with threat of withdrawal whenever demands for 'hard' evidence are not met. Pressure for such evidence can often distort programme activities, thus perverting the course of development of the CHEs and their communities. There is a urgent need for policy makers and funders to recognise this and to consider alternative evaluation strategies that are appropriate for the model.

Conclusion If we hold firm to the twin principles- empowerment and participation- that underpin the CHE model, it not only has the potential to improve access and care but also to act as a practical programme for social inclusion. Practiced well, the CHE model makes tangible the abstract notion of agency. However, it has to be borne in mind that effective implementation the CHE model requires a fundamental shift in the ways in which we think about people, organisation and practice and the knowledge we purport to have about them.