OREGON PUBLIC HEALTH ASSOCIATION
LAY HEALTH PROMOTER POSITION PAPER

Currently , millions of U.S. residents lack appropriate and accessible health services. For people of color and immigrants, the situation is especially severe. Even when health services are available, language barriers, lack of transportation and provider insensitivity can make services inaccessible. This paper proposes a solution. For centuries, the Lay Health Promoter (LHP) model has increased health service availability and accessibility in the developing world. This model shows great promise for helping to make health care more available and accessible to populations throughout the U.S.

Lay Health Promoters: A Community-Based Solution

Lay Health Promoters are community members who are trained to meet essential health care needs of the communities in which they live.

Common characteristics of Lay Health Promoters include:

* Come from the community in which they work;
* Are defined by their active stance within the community and the health care setting;
* Are well trained and expected to perform health promotion, education and service delivery within a limited scope. They are not "doctors and nurses without a license" but may deliver primary care and preventive services within a limited scope of practice which they have been specially trained to do;
* Promote health among groups which have traditionally been denied adequate health care, and work for more equitable distribution of health services;
* Respond creatively to local and national realities;
* Use "popular education" in their work.

Health Promoters are not Outreach Workers. Outreach Workers are based in the clinic and often perform tasks which are extensions of the clinical health care setting, scheduling appointments, transporting patients, delivering medicine, making referrals, and handing out brochures. While Lay Health Promoters may perform some of these tasks, they are based in the community and advocate for the community within the health care system. Health Promoters are not untrained volunteers. They are well trained and are usually (but not always) paid for their work. The amount and type of training which LHPs receive varies widely from program to program, and depends on the role which the LHP is to play and the resources of the program, among other factors.

Lay Health Promoters: Meeting Community Health Objectives

Lay Health Promoters show promise in helping to achieve the Healthy People 2000 National Health Promotion and Disease Prevention Objectives and the Oregon Benchmarks. They address specific health promotion factors such as changing individual health beliefs and behaviors and improving access to basic health services. Findings from LHP program evaluations show that client health is enhanced by the receipt of LHP services. Furthermore, LHP programs protect and improve community health status by educating and empowering communities to seek the best solutions. LHPs do so by developing individual decision-making skills and community leadership.

The Lay Health Promoter movement is gaining acceptance and advocates around the country. LHPs and their supporters are working through existing organizations such as the American Public Health Association's New Professions Special Interest Group to ensure that LHP programs become an accepted and established part of the health care system.

Policy Statement

The Oregon Public Health Association supports 1) the recognition of LHPs as vital members of the health care system, 2) inclusion of LHPs within a reformed health care system, 3) creation of stable funding mechanisms for LHP programs, and 4) assurance that training and skills are commensurate with the level of LHP responsibilities, and 5)recognition of LHP contributions toward achieving the Oregon and National Health Objectives. 5/95

BACKGROUND INFORMATION ON LAY HEALTH PROMOTERS

1. DESCRIPTION/DEFINITION

Lay Health Promoters have a long history of providing public health services in many different cultures and countries. Lay Health Promoters have gone by many names including: Village Health Workers, Primary Health Care Workers, Indigenous Health Care Workers, Community Health Workers, Community Health Assistants, Community Health Representatives, Medical Auxiliaries, Rural Health Assistants, Community Health Aides, Brigadistas, Promoters y Promotoras de Salud, Indigenous Health Aides, Lay Health Advisors, Auxiliary Health Workers, Front Line Health Workers, Barefoot Doctors, Feldsher, Community Health Promoters, Kaders, Prokesa. These terms are by no means interchangeable, since each has its own practical, historical and political significance.

These are characteristics some Lay Health Promoter Programs have in common:

* Come from the community in which they work,
* Are defined by their active stance within the community and health care setting,
* Are well trained and expected to perform health promotion, education and service delivery within a limited scope. They are not "doctors and nurses without a license" but may deliver primary care and preventive services within a limited scope of practice which they have been specially trained to do;
* Promote health among groups which have traditionally been denied adequate health care, and work for a more equitable distribution of health services;
* Respond creatively to local and national realities;
* Use "popular education" in their work.

It is important to also mention what health promoters are not. Because at times health promoter programs are adapted to fit into positions and programs we are already familiar with within our health care system, they often lose their power and effectiveness in the process.

Health Promoters are not Outreach Workers. Outreach Workers often perform tasks which are extensions of the clinical health care setting, scheduling appointments, transporting patients, delivering medicine, making referrals, and handing out brochures. While Lay Health Promoters may perform some of these tasks, they do much more.

Health Promoters are not untrained volunteers. Depending on what is expected of them, they are well trained and are usually (but not always) paid for their work.

2. HISTORY

In almost all human communities through history, people have looked to their family members, friends, and neighbors for health care and health information. Before the development of the medical profession, community members (many of whom had received their training from older relatives) were the only health practitioners.

As early as the seventeenth century, a shortage of doctors in Russia led to the formalization of these natural helping and healing relationships. Lay people known as "feldshers" were trained to provide medical care to members of the military. After the Chinese Revolution of 1949, Mao Tse Tung promoted the training of "barefoot doctors". These health care workers were so called because most were peasants, many of whom couldn't afford shoes. Their mission was to take primary health care to remote rural areas where there were no doctors.

Beginning in the 1950's, in conjunction with the development of labor unions and "liberation theology", Community Health Promoter programs flourished throughout Latin America. Because the LHPs were determined to remedy an unequal distribution of health resources and bring health care to the poor, they were seen as a threat by many Latin American governments and armies. Hundreds of LHPs were captured, tortured, and killed.

While the lay health promoter model is often associated with primary health care campaigns in the developing world, lay workers were also key staff "in domestic programs in the 1960's providing health education, child care, parenting education , and patient advocacy." (Giblin, 1989) These programs were frequently located in communities of color in large U.S. cities such as New York and Los Angeles. It was also during this period that the Indian Health Service founded its Community Health Representative (CHR) program. The CHR program remains one of the largest and best-established lay worker programs in the country.

After falling out of favor in the 1970's and early '80's, community health worker programs experienced a resurgence in migrant and seasonal farmworking communities in the late 1980's. Programs founded during this period (which still exist today) include the Camp Health Aide Program sponsored by the Midwest Migrant Health Information Office; the Comienzo Sano (Healthy Start) Program based at the University of Arizona; and the El Nino Sano/La Familia Sana (The Healthy Child/Healthy Family Program based in Hood River, Oregon.

3. CAPACITATION/TRAINING

Training for community health workers is most often provided in-house once the LHP has been hired. The amount and type of training which LHPs receive varies widely from program to program, and depends on the role which the LHP is to play and the resources of the program, among other factors. On one side of the spectrum are programs in which training time is short, perhaps several hours or a couple of days. LHP's trained in this way often work as volunteers or receive a small stipend for their work. In the case of migrant and seasonal farmworking health

aides, they continue to travel up and down the migrant stream. They share information informally with friends and family members.

On the other side of the spectrum are programs in which initial training is intensive, perhaps lasting several months. Usually, the LHPs who participate in such training are full- or part-time employees of a clinic or community-based agency. After their training they are able to carry out complicated and self-directed work, including lay counseling and health education with groups.

Because a goal for many LHP programs is the empowerment of the workers and their communities, a number of programs have found that Latin American style "Popular Education" is particularly appropriate for their work. Popular Education is based largely on the ideas of Brazilian Paulo Freire. According to Popular Education theory, all people have a large store of knowledge as a result of their life experience. The task of the educator is to tap into that store of knowledge, and help people organize their knowledge and use it to benefit their communities. The methodology of Popular Education is interactive, participatory, and fun, and is thus much more accessible for community members lacking formal education. In addition, Popular Education is directed toward action, and thus especially appropriate for public health education.

Instead of the word "training", programs using Popular Education prefer the word capacitation (from the Spanish capacitar, "to build capacity".) LHPs participate in capacitation, rather than "receiving training." Programs using Popular Education also frequently support the practice of having experienced LHPs play a large role in the capacitation of new LHPs.

4. APPLICATIONS WITH VARIOUS CULTURES AND COMMUNITIES

The concept of lay health promoters is applicable to many cultures and communities, all age groups, and a wide variety of health topics. These programs have been used in a wide variety of settings worldwide, targeting populations and needs specific to the community. In the United States, the range of successful programs has included church-based hypertension and stroke prevention in African-American communities, improved access to health care for elder Hispanic farm workers, school-based peer counseling, and many others. These programs have succeeded because they are culturally appropriate and are integrated into key community activities.

An example of a successful program is the Speak to your Sisters Program in Rural North Carolina. The objective of this program is to reduce the morbidity and mortality from breast cancer among African-American women over 50 in rural North Carolina. Since the church is a social gathering place for African-American women in rural North Carolina, recruitment took place after church services. Women in the church recruited other women by wearing a button saying "Speak to Your Sisters" and "Have You Had Your Mammogram?". The women arranged health fairs to educate other women around the issues of breast cancer and schedule appointments for mammograms. They also coordinated free mammograms for women who could not afford them, held support groups for survivors of breast cancer, and provided a forum for older women to "speak to their sisters" and provide social support around other health issues.

Another program is the Indian Health Service Community Health Representatives Program (Oregon and nationwide). Native Americans are selected, employed and supervised by their tribes and trained by IHS to provide specific health care services at the community level. Nationwide, Community Health Representatives made over 4,218,617 client contacts in 1991. Sixty-four percent were done in the community or in the client's home. Sixty-six percent were to address issues of general health care, 10% were for maternal and child health issues. Many contacts were also related to environmental, gerontological, dental and mental health issues. The CHRs most commonly provide problem assessment, health education and consultation, and surveillance and they address physical, economic, and cultural barriers to health care.

Successful Lay Health Promoter programs, according to the Pew Health Professions Commission, include these elements:

* A community needs assessment guides the LHP program development
* The sponsoring organization has an established rapport with its community, and has hired staff who are multilingual and multicultural as needed to gain the trust of the community.
* The program has shared ownership empowering LHPs to design strategies, conduct training, and evaluate and refine program goals and objectives.
* The program has the flexibility to adapt to changing community needs and it has established partnerships with community-based health and social services agencies.

A BRIEF BIBLIOGRAPHY OF LAY HEALTH PROMOTER LITERATURE

Bender, D.E. and K. Pitkin. "Bridging the gap: The village health worker as the cornerstone of the primary health care model." Social Science and Medicine. No. 6., pp. 515-528: 1987.

Berman, P.A. "Village health workers in Java, Indonesia: Coverage and equity." Social Science and Medicine. Vol. 19, No. 4, pp. 411-422: 1984.

Caufmann, J. G., et al. "Community health aides: How effective are they?" American Journal of Public Health. Vol. 60, No. 10, pp. 1904-1909: 1970.

Chase, H. P. et al. "Effectiveness of nutrition aides in a migrant population." The American Journal of Clinical Nutrition. Vol. 26, pp. 849-857: 1973.

Fendall, N.R.E. "The barefoot doctors: Health workers in the front line." The Round Table: The Commonwealth Journal of International Affairs. No. 264, pp. 361- 369: 1976.

Giblin, P.T. "Effective utilization and evaluation of indigenous health care workers." Public Health Reports. Vol. 104, No. 4, pp. 361-368: 1989.

Heggenhougen, H.K. "Will primary health care efforts be allowed to succeed?" Social Science and Medicine. Vol. 19, No. 3, pp. 217-224: 1984.

Koplan, J.P., et al. "The barefoot doctor: Shanghai county revisited." American Journal of Public Health. Vol. 75, No. 7, pp. 768-770: 1985.

Matamora, M.K.S. "Mass-produced village health workers and the promise of primary health care." Social Science and Medicine. Vol. 28, No. 10, pp. 1081-1094: 1989.

Richter, R.W. "The community health worker." American Journal of Public Health. Vol. 64, No. 11, pp. 1056-1061: 1974.

Ronaghy, H.A. "The front line health worker: Selection, training and performance." American Journal of Public Health. Vol. 66, No. 3, pp. 273-277: 1976.

Rosenthal, M., and J.R. Greiner. "The barefoot doctors of China: From political creation to professionalization. Human Organization. Vol. 41, No. 4, pp. 330-341: 1982.

Scholl, E.A. "An assessment of community health workers in Nicaragua." Social Science and Medicine. Vol. 20, No. 3, pp. 207-214: 1985.

Sidel, V. and R. Sidel. "Primary health care in relation to socio-political structure." Social Science and Medicine. Vol. 11, pp. 415-419: 1977.

Stark, R. "Lay workers in primary health care: Victims in the process of social transformation." Social Science and Medicine. Vol. 20, No. 3, pp. 269-275: 1985.

Warrick, L.H., et al. "Evaluation of a peer health worker prenatal outreach and education program for hispanic farmworking families." Journal of Community Health. Vol. 17, No. 1, pp. 13-25: 1975.

Wingert, W.A., et al. "Effectiveness and efficiency of indigenous health aides in a pediatric outpatient department. American Journal of Public Health. Vol. 65, No.8, pp. 849-857: 1975.

Witmer, A., et al. "Community Health Workers: Integral Members of the Health Care Work Force." American Journal of Public Health. Vol. 5, No. 8, pp. 1055-1058: 1995.