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Identifying the Core Elements of Effective Community Health Worker Programs: A Research Agenda

Sarah R. Arvey, PhD, and Maria E. Fernandez, PhD

Community health workers (CHWs) are increasingly being incorporated into health programs because they are assumed to effectively deliver health messages in a culturally relevant manner to disenfranchised communities.

Nevertheless, the role of CHWs—who they are, what they do, and how they do it—is tremendously varied. This variability presents a number of challenges for conducting research to determine the effectiveness of CHW programs, and translating research into practice.

We discuss some of these challenges and provide examples from our experience working with CHWs. We call for future research to identify the "core elements" of effective CHW programs that improve the health and well-being of disenfranchised communities. (*Am J Public Health.* 2012;102:1633–1637. doi:10.2105/AJPH.2012.300649)

THERE SEEMS TO BE A CONsensus: Community health workers (CHWs) are a good idea. They are a cost-effective way to promote health and provide some health care services to disenfranchised communities. Furthermore, because most CHWs are members of the communities within which they work, they are assumed to deliver health messages in a culturally relevant manner.[1–4] Systematic literature reviews of CHW programs worldwide have provided evidence of their effectiveness for certain behaviors and disease categories, but evidence is still insufficient to justify general recommendations for policy and practice.[4–8]

Although community educators and healers have existed worldwide for centuries, CHWs, defined as laypersons who serve as liaisons between members of their communities and health care providers and services, have played a formal role in health care since the 1940s.[6,9] Over time, health program planners' efforts to collaborate with CHWs have waxed and waned because of factors such as economic need or health care labor shortages.[9,10] Yet, in the United States since the 1980s, health program planners have increasingly collaborated with CHWs to deliver various types of health promotion programs.[9,11] With this increase, it has become undoubtedly clear that the role of CHWs today—who they are, what they do, and how they do it—is tremendously varied.[10] This variability presents a number of challenges for conducting research to determine the effectiveness of CHW programs and to translate that research and evidence into practice.

To ensure that planners integrate CHWs into programs effectively, researchers must seek clarity about the following issues: What problems arise because of the variability surrounding who CHWs are and what they do? How can we evaluate CHW programs to better document their effectiveness? And, ultimately, how can we elucidate the core elements of CHW programs so that effective programs can be adopted and implemented in other settings? We explore these issues and provide some examples from our firsthand experience as academic researchers who collaborate primarily with *promotores* (CHWs for Latino populations).

Community health workers are described by using several different terms, including lay health advisors, patient navigators, *promotores*, outreach workers, peer leaders, peer educators, and community health advocates. The diversity of names reflects the different types of roles, or even opposing roles, CHWs are expected to play. For example, the word "lay" in "lay health advisors" suggests that CHWs are not "professionals," nor have they acquired "expert" knowledge that would set them apart from an ordinary person. The term "patient navigators" implies that the CHWs are embedded within a health care system to the extent that they can help link patients to appropriate care. "Peer leaders" suggests that there is a commonality

between the CHWs and their clients, and that they have some leadership characteristics that motivate community members to model or adhere to their recommendations. The term "health advocate" implies that CHWs play an activist role within their community and that their work is related to the larger struggle for social justice for disenfranchised communities. The differences in roles implied by these terms are more than simple semantics; they imply skills and training that would likely vary considerably.

THE ASSUMPTION OF SHARED CULTURE

The idea that CHWs are most effective when they share the culture of the populations they serve has important implications for the ways program planners expect CHWs to function and how they are trained.[4,6,12–14] Many planners assume that if CHWs share (or, at the very least, understand) the culture of the community member with whom they are interacting, then they will be better able to tailor health messages, understand the underlying or unspoken reasons that person might adopt or reject recommended behaviors, and act as plausible role models. Nevertheless, important questions remain: What exactly is shared culture? How does it influence CHW program effectiveness? How can planners consistently and appropriately integrate it into program design and training?

"Culture" is more complex than simply sharing language and ethnicity, and researchers have expressed the need for programs founded upon a rich and nuanced understanding of culture.[15] Culture, "the patterned processes of people making sense of their world,"[16(p15S)] is embedded in social context, the sociocultural forces that shape people's day-to-day experiences, and is determined by multiple levels of influence (structural, historical, environmental, local, and individual.[17]

It is unclear which elements of culture and social context should be shared for CHWs to be effective. It may be that being able to speak the same language or dialect is enough to ensure program effectiveness. On the other hand, there may be unconscious and unspoken understandings between peoples of the same culture that go beyond language that are at play. For example, it may be that *promotores* at sites with little diversity among Latino populations are more likely to share the culture of their fellow community members, but in large, diverse cities such as Los Angeles, Houston, Chicago, or New York that include subpopulations of Latinos of different cultural backgrounds and influenced by different forces of social context, these assumptions must be questioned.[18] These subpopulations may originate from many different countries and may have different immigration patterns, levels of acculturation, socioeconomic status, etc.[18] To design effective health programs, researchers must fully explore how the complex forces of social context and culture play into CHW effectiveness. Furthermore, it should be determined how shared culture differs in importance for programs that address different health issues and different communities.

SETTINGS AND ROLES FOR PROGRAM DELIVERY

Community health workers work in many different settings, deliver programs to a varying number of people at one or more times, and use a diverse set of tools, all of which influence what they do.[1,19–24] They work in public hospitals, community clinics, cancer centers, religiously affiliated community centers, etc. They can work inside formal and established centers of health care, but they are also known for neighborhood outreach (i.e., interacting with community members in homes, workplaces, or churches). Despite this diversity of settings, program planners often assume that CHWs function similarly in all sites. This may not be the case, and it is important to take into account the fact that different settings are populated by different people whose health education needs, time available, predisposition to receive health information, and adherence to health messages may differ dramatically. An individual who has access to primary care providers may have very different health-seeking practices than one who does not. There is little evidence on the comparative effectiveness of CHW programs that deliver health education to people in their own homes compared with in clinical settings. In a similar way, it is unclear if program effectiveness differs when CHWs work with groups of people (such as families or neighbors) compared with individuals.[6] Some research shows that the answers to these questions might depend upon cultural preferences for health communication.[25–29]

A complicating factor in research with CHWs is that there is little consensus about who or what CHWs really are. Are they community activists engaging in mutually constitutive dialogues with their community members or are they a mere delivery mechanism for health programs?[9,30] Not all program planners are clear about which role they expect CHWs to take and existing recommendations for practice do not necessarily provide guidance. For example, the Task Force on Community Preventive Services provides recommendations for increasing certain cancer prevention interventions based on a systematic review of the literature. In a review designed to provide guidance about the effectiveness of one-on-one interventions, the Task Force classified CHW programs with other one-on-one programs delivered by clinic-based health care providers.[30] This classification (necessary because of the small number of high-quality published studies on the effectiveness of CHWs for cancer control) is problematic in that it obfuscates the advocate role of CHWs and excludes CHW programs that are delivered to groups of community members. The consequences of different expectations for CHWs and a lack of understanding of the core elements that make these programs effective may drastically influence program impact. It may be that CHWs who act as community activists are more effective in improving health outcomes of certain populations, but less so in others. In a similar way, it may be that didactic strategies are more effective for some populations than for others.[30] Creating a separate analytical category for CHW programs in systematic reviews could provide more information about the impact of CHWs and under which circumstances and for what behaviors they are most effective. Furthermore, conducting research on cultural preferences for CHW roles and communication styles could illuminate the broad spectrum of roles that CHWs can and should

take when working with different populations.

Differences in program delivery affect the quality of the relationship, and the interaction that CHWs have with community members can vary widely across programs. The quality of that relationship can be influenced by things such as the number of interactions and the tools that are used to facilitate the interaction. Some programs provide multiple opportunities for CHWs to interact with community members, whereas other interventions involve just 1 meeting.[22] In some cases, the community members with whom CHWs interact are part of their immediate social network; in others, they are complete strangers. In addition, multimedia tools, increasingly being used by CHWs, may be a way to enhance communication between CHWs and community members, but use of such tools varies widely. The CHWs are often charged with using a wide variety of tools ranging from nothing other than their own voice to pamphlets, videos, or advanced multimedia and computer-based interactive technologies to enhance their communication with individuals. Our research comparing low- and high-tech multimedia tools used by *promotores* suggests that tools can either enhance or hinder *promotores'* efforts.[31] It is important to identify what elements of CHW programs enhance the quality of the relationship between CHWs and community members, noting that this may be different for different health behaviors and for different populations.

For evaluation purposes, it is also important to understand how community members themselves recognize and understand CHWs' role in their own health-seeking practices. Our experience suggests that ordinary people may not know what a CHW is and what CHWs are supposed to do. For example, we found that only 61.9% of 341 study participants who received a *promotor*-delivered intervention in their home answered positively that they had been visited by a *promotor* in the past 6 months. This suggests that some of our study participants may have thought that the concerned person who visited them to talk about colorectal cancer was just that—a concerned person—or that they do not remember being visited by a "CHW" at all. Or, perhaps study participants were unable to differentiate between data collectors and *promotores* because both asked questions about colorectal cancer screening. Essentially, the concrete categories researchers use to determine program effectiveness might not resonate with the people they want to help, and from whom they rely on for information. Researchers must find a way to measure this accurately to ensure findings can inform practice.

INSTITUTIONALIZING COMMUNITY HEALTH WORKERS

Public health practitioners have called for the integration of CHWs in health care systems via the creation of formal infrastructures to make CHW programs remain viable in the long term.[11,14,32,33] Indeed, in many states, CHWs have formed formal associations; departments of health have initiated components of institutionalization such as instituting credentialing programs with required education, training, and certification (see http://www.chw-nec.org); and state and federal agencies are beginning to enact policy regarding CHWs.[32,34] There are valid reasons for this move. Institutionalizing CHWs could help legitimize their role in the health care system and ensure some consistency in terms of the quality of care they are able to provide. In addition, it could provide them with opportunities for education and career advancement. Lessons learned from other health care fields (e.g., nursing) that went through similar processes may be useful to consider.[35]

Nevertheless, there are also reasons to be cautious about this movement. For example, the impact of 1 component of institutionalization, CHW certification, is still unknown, and we suspect that in some cases the opportunity or a requirement for certification could adversely affect CHWs. For example, organizational preferences for hiring certified CHWs are unknown, and whether certified CHWs are paid more than those who are not certified is undocumented. Our research in South Texas revealed that some *promotores* had been certified by the Texas Department of Health and Human Services, some had not, and that some who had been certified chose *not* to renew their certification despite the fact that they still worked as *promotores*. The *promotores* claimed that organizations preferred to hire certified *promotores*, but that certified *promotores* were not paid more than those without certification, and that the community members with whom they worked did not care whether they were certified or not. One of the *promotoras* reported that, for her, the value in certification was in the educational opportunities it provided. The consequences of creating such hierarchies among CHWs, and the hierarchy's effects on their efforts should be known before we invest in widespread programmatic changes.

Furthermore, it may not be easy for CHWs to comply with components integral to certification. Although community colleges should be commended for creating innovative mechanisms for delivering CHW certification curriculums, the practical matters and costs related to obtaining certification should not be underestimated. It not only costs money to become certified but nonmonetary costs such as time away from paid work (as CHWs or other positions—many of the *promotores* we have collaborated with have worked 2 or more paying jobs at a time) or costs of childcare also may be incurred when CHWs seek certification. In addition, health program planners and state certification agencies should consider whether it is fair to expect and require CHWs to be able to navigate community college courses for certification, particularly those who are members of underserved and disadvantaged communities for whom access to and integration into formal higher educational systems may be difficult and uncommon. Above all, if formal training is to be required, it must be affordable and accessible.

Indeed, institutionalization might alter the very elements of CHWs that make them effective. Witmer et al. illuminated some of the "potential risks" in building a formal infrastructure, stating,

> Although such support can offer financial and other securities, it can also threaten what makes CHWs unique and effective. The strength of the programs appears to be their flexibility to provide innovative solutions and adapt to changing community health needs and circumstances.[36(p1057)]

Beyond flexibility, it may be the very fact that CHWs are not

"experts" (i.e., that they most likely do *not* differ in terms of education, power, or social capital from their clients) that makes them most effective.[13] How might making experts out of CHWs who are supposed to be "like" the community members with whom they work change the dynamic of CHW program delivery and interpersonal communication with clients? Public health practitioners should understand how the institutionalization of CHWs could alter the core elements that help them develop quality relationships with community members and, in turn, increase program effectiveness.

Finally, although institutionalizing CHWs may provide new opportunities for women because most CHWs are female,[1] often those opportunities exist at the lowest level of health care professionals in terms of education and, most likely, in terms of pay.[37] Essentially, program planners are asking women to do some of the work for low or no remuneration that those more highly trained professionals do not have time for, have no incentive to do, or are not interested in doing. If CHWs are effective and essential, they must be fairly compensated.[38,39]

SUMMARY AND IMPLICATIONS

Among the points we raise here, we believe that one of the most critical for increasing the effectiveness of CHW programs as well as their adoption and implementation in community settings around the country is the need to understand the core elements of these programs. What are the active ingredients in CHW programs that make them effective (e.g., interpersonal connectedness and rapport, their function as role model or community advocate, the commitment a person feels to comply with *promotoras'* recommendations because of cultural norms)? These largely unanswered questions require thoughtful evaluation approaches to address. Ethnographic methods that highlight culture and social context and seek to situate findings in the fabric of daily life and social context are optimal for this pursuit.[40,41] We strongly believe that CHWs can help improve the health and overall well-being of disenfranchised, medically underserved communities. Nevertheless, we recognize that research that provides evidence to this end must be conducted to elucidate the components or core elements that ensure their effectiveness and ultimately ensure their place in our health care system. ■

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