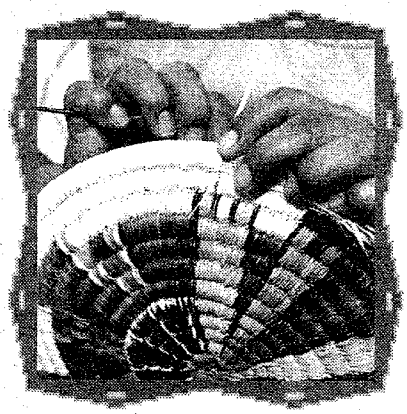
THE FINAL REPORT OF
THE NATIONAL COMMUNITY HEALTH ADVISOR STUDY



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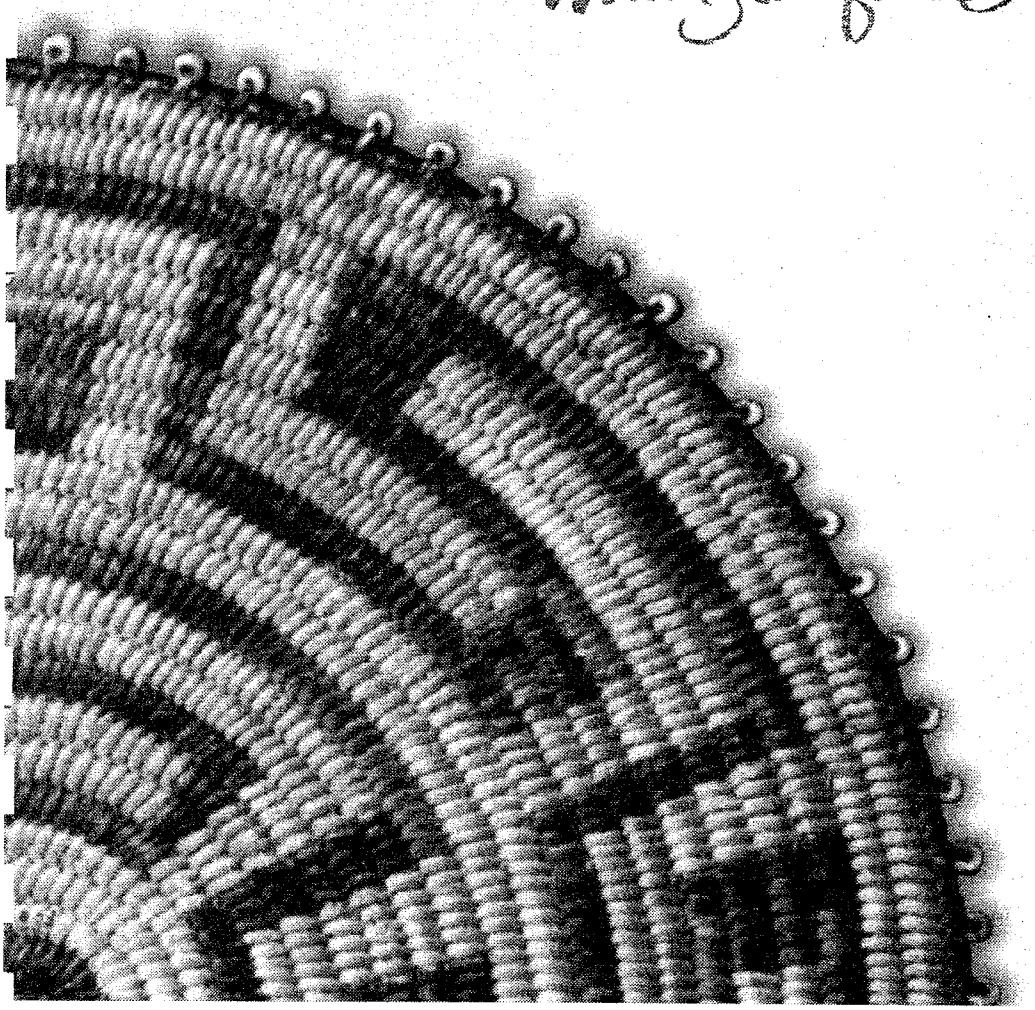

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CHAPTER THREE:
Core Roles and Competencies of Community Health Advisors

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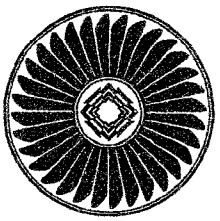

Introduction

The prominence of Community Health Advisors (CHAs) within the U.S. health care system is growing at a phenomenal rate. Managed care organizations (MCOs), the newly-dominant players in the health care system, are becoming increasingly interested in the potential of CHAs to achieve a variety of objectives, from improving the health status of their members, to changing utilization patterns, to recruiting new members for the health plans. Yet this rapid expansion is occurring in the absence of a broad understanding of CHAs: their history, their roles, and their potential contribution to communities and the health care system. According to the Community Health Worker Training Program at San Francisco State University, "[there] is not an agreed-upon set of skills for these health workers nor is there a clear definition of their role." (Love, Gardner & Legion, 1996) The authors of an article about CHAs that appeared in the *American Journal of Public Health* concur, adding that "consensus on a working definition is needed" (Witmer et al., 1995).

The time is right for the development of such a definition for a number of reasons. Although CHA programs in the U.S. have fallen in and out of favor since the first formal programs were implemented in the late 1950s and early 1960s, they are currently in the midst of resurgence. Literally hundreds of programs have been founded since the late 1980s and could be enhanced by the creation of a common definition and set of role and competencies.

As the number of CHA programs has grown, the need to develop both long-term funding strategies and a vision of how CHA programs fit into the broader health care system has become increasingly apparent. This need has produced several policy initiatives focusing on CHAs. These included a 1993 report by the Pew Health Professions Commission, the 1994 National Community Health Advisor Act, and a 1997 "Leadership Brief" produced by the Harrison Institute at Georgetown University in collaboration with the Boston-area Civic Health Institute at the Codman Square Health Center. Since policy development depends, to a large degree, on common definitions and understandings, these initiatives have made more apparent the need for a definition of CHAs and their work.

A definition is necessary not just for policy work, but also for the daily work of CHAs. "Nobody knows who we are or what we do," was a sentiment voiced by many CHAs who participated in the individual and group interviews that we conducted around the country. The lack of an understanding of their roles and abilities negatively affects CHAs in many ways. Most importantly, it can impair their ability to obtain services for their clients. "I was taking a resident . . . to an appointment at [the] hospital," related Gracie Camarina, a CHA in Michigan, "and I came up to the receptionist's desk and said, 'Hi, my name is Gracie and I am a CHA . . .' and they go, 'What's that?'" Lack of awareness about CHAs on the part of other health care workers makes CHAs less effective in increasing access to care.

Both analytic and anecdotal evidence suggest that CHAs are an extremely skilled and valuable group of workers who make a unique contribution to their communities and to the health care system (Witmer et al., 1995). Yet a pervasive lack of understanding of their roles and skills causes them to be undervalued and disrespected by other health and social service workers. CHAs in many of our individual and group interviews spoke movingly of the disrespect they experience from other workers. "Broad dissemination of the capabilities of CHWs [is] needed to expand their recognition . . . as integral members of the health care workforce," Witmer and colleagues concluded in the *AJPH* article (Witmer et al., 1995).

CHAs report also that, as a result of their ill-defined role, they are frequently pulled away from their regular work to answer phones, translate, or otherwise do work that does not take advantage of their full range of skills. "[They haven't] defined very clearly what outreach workers are," said one CHA attending a Massachusetts conference. They're *not* what everybody else doesn't have time to do." (Emphasis added.)

The many titles CHAs use and the variety of settings in which they work also make it difficult for CHAs to organize around their common interests. An Outreach Educator from Boston and a *promotor de salud* from Oregon may have much in common and much to learn from one another, but the lack of a unifying identity obscures this fact. As CHAs have begun to come together across lines of geography, race/ethnicity and health issue area, one of their first actions has been to seek to find a title on which all can agree.

Unquestionably, the lack of a "standard definition and conceptualization of who CHWs are and what they do" (Witmer et al., 1995) is one of the principal barriers to an expanded role for these workers within the health care system. This barrier must be overcome, for a simple and pressing reason.

Many of the most intractable health problems plaguing communities today — infant mortality among African Americans, asthma among poor children, diabetes in Native American and Latino communities, violence among inner-city youth — are the result of environmental, social, and economic conditions. "Traditional personal medical services," say doctors writing in the October 1996 issue of *JAMA,* "have had little success in addressing these determinants of health" (Showstack et al., 1996). Shared financial risk for the health of their members is one reason that MCOs and other providers are increasingly concerned about influencing the basic determinants of health. Another is their desire to be good corporate citizens. "We believe we have a responsibility to be leaders in improving the health of the communities we serve," says Karen Ignagni, President and CEO of the American Association of Health Plans (AAHP). "That means not only in providing high quality health care but in making each community a better and healthier place to live" (Belfiglio, 1997).

Increasingly motivated to address the basic determinants of health, MCOs are rightly looking to CHAs, who can, according to a 1987 document produced by the World Health Organization (WHO), "reduce the geographic, social, and cultural distance between the service and its target population, . . . concentrate upon the sorts of changes that may influence the true nature of the health problem, and achieve aims within acceptable costs" (WHO, 1987). Developing a working consensus about the roles and skills of CHAs will facilitate their integration into the health care system, and thus enhance the system's ability to address the basic determinants of health.

"An Outreach Educator from Boston and a* promotor de salud *from Oregon may have much in common and much to learn from one another, but the lack of a unifying identity obscures this fact."

Research Questions and Goals of the Chapter

Responding to the pressing need in the CHA field for a set of role and competency definitions, the *research questions* of this chapter are as follows:

Research Questions:

- What are the *core roles* that CHAs play within communities and the health care system?

- What are the *core competencies* that CHAs need in order to be optimally effective in these roles?

Definitions of the key terms used in this chapter will be useful at this point. *Roles* we define as "the functions that CHAs serve in communities and the health care system." For example, one of the roles that CHAs play in their communities is that of providing health education. The concept of roles includes within it the *responsibilities* of CHAs and the *activities* CHAs carry out.

A *competency* is usually defined as "something that a person is capable of doing." However, due to the nature of this field, we will need to expand the definition of competencies to "something that a person is capable of doing *or being*." Included in our definition of competencies are both *qualities* and *skills*. In this context, qualities will be taken to mean "personal characteristics or traits that can be enhanced but not taught." Patience, compassion, and persistence are examples of *qualities*. The word *skills*, on the other hand, will be used to describe "things people know how to do because they have learned." While some people may have more talent at playing the piano than others, and while a few *savants* may "just know" how to do it, in order to play the piano, the vast majority of us have to take lessons and learn. Playing the piano, therefore, is a skill.

It is our hope that answering the research questions outlined above will contribute to the achievement of several interrelated goals, among which are the following:

Policy Goals:

- To increase understanding about and appreciation of the skills and abilities of CHAs among other health care providers, including clinicians, MCOs, and others;
- To facilitate the better integration of CHAs into the health care system;
- To help assure that CHAs assume their deserved place as "essential members of the health care workforce" (Witmer et al., 1995);
- To move forward a dialogue about CHAs, their roles and skills that will "continue long after this project has ended" (Taylor et al., 1996).

In order to be optimally useful, a set of role and competency definitions needs to possess a number of characteristics. We have established the following standards for our definitions of the core roles and competencies of Community Health Advisors:

Standards of the Role and Competency Definitions:

- They should be based on the *day-to-day experience* of Community Health Advisors.
- They should be informed by the experience of others with substantial knowledge about CHAs and/or the health care system, including supervisors, program administrators, clinicians, and academics.
- They should be equally comprehensible and useful to all the stakeholders mentioned above.
- They should be specific enough to be useful, yet broad enough to cover the range of activities conducted and health issue areas addressed by CHAs.

(For an explanation of these standards, see Appendix H1.)

Historical Roles and Competencies of CHAs

The CHA model has deep historical roots that explain to a large degree its current forms and uses. While ignorance of history may not doom us to repeat it, the failure to consider the origins of a model probably will impair our ability to use it wisely. In addition, CHAs themselves have expressed an interest in knowing their own history. Thus, we begin the process of defining the core roles and competencies of CHAs by reviewing articles written both nationally and internationally about CHA programs by researchers .

Roles and Competencies of CHAs in the Developing World

Although U.S. residents certainly have our own traditions of informal health advising and helping, the principal model for U.S. CHA programs comes from the developing world, where it has been used for various purposes for more than 300 years. As early as the 17th century in Russia, lay people called "feldshers"

underwent a one-year course of training enabling them to care for civilian and military populations (Fendall, 1976). Perhaps the best-known CHAs are the "barefoot doctors" of China, peasant farmers trained to care for rural populations at least partly so that urban doctors could return to their homes in the cities. (Fendall, 1976) In the 1960s and 70s, in the context of growing political activism and liberation theology, *promotores de salud* (health promoters) were trained by popular organizations and church groups throughout Latin America. The term "promoter" was chosen deliberately to suggest the workers' pro-active stance *vis-a-vis* the health problems in their communities. An overview of the titles used in a selection of international programs can be found in Table 1.

Table 1
Titles Used by and for International Community Health Workers*

Title	Country of Use
Auxiliary Health Workers	Iran
Barefoot Doctors	China
Brigadistas	Nicaragua, El Salvador
Community Health Aides	Costa Rica
Community Health Promoters	Tanzania
Feldshers	Russia
Front Line Health Workers	Iran
Kaders (cadres)	Indonesia
Prokesa (promoters)	Indonesia
Promotores de Salud	Mexico, Guatemala, El Salvador
Primary Health Care Workers	Used widely
Rural Health Assistants	Costa Rica
Village Health Workers	Used widely

Source: "A Lexicon of Community Health Worker Terms." Hood River, OR: La Familia Sana Program, 1992.
*Please note that this list is far from exhaustive.

In 1978, at its conference in Alma Ata, USSR, the World Health Organization (WHO) adopted the concept of primary health care (PHC) as its fundamental strategy for achieving its goal of "health for all by the year 2000." A key component of this strategy was "community participation in health," which meant involving community members in identifying health problems and participating in their solution (Matomora, 1989). The principal actors charged by the WHO with bringing about community participation were the so-called "village health workers." As community members who would understand and treat health problems in a holistic way, VHWs fit in well with the definition of health as "a state of complete mental, physical, and social well-being" adopted by the WHO in 1948.

Table 2
Responsibilities of International Community Health Workers

Responsibility	Country(ies)
Community Organizing	Costa Rica, El Salvador
Family Planning	Costa Rica, Indonesia
Health Education	Costa Rica, Indonesia, Nicaragua
Home Visits	Colombia, El Salvador, Iran, Nicaragua
Immunizations	China, Costa Rica, Nicaragua
Maternal/Child Health Promotion	Colombia, Nicaragua
Referral	Costa Rica, Indonesia
Treatment of Common Illnesses	China, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua

Source: "An Historical Overview of Lay Health Worker Programs." Hood River, OR: *La Familia Sana* Program, 1992.

After almost ten years of field experience with CHA programs, members of the WHO reassembled in 1987 and adopted a definition of CHAs. According to this definition, CHAs should be "members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have a shorter training than professional workers" (WHO).

Consonant with the realities of life in the developing world, the WHO working document identified the following roles for CHAs: **education** about prevention and control of health problems; **promotion** (of the food supply and nutrition, of a safe and adequate water supply, of immunizations, and of maternal/child health);

prevention and control of common local diseases; **treatment** of common diseases and injuries, and **provision** of essential drugs. Qualities mentioned by the WHO as desirable in CHAs were social standing in the community, "a long-term commitment to the lifestyle of the community served," and the ability to influence key constituencies, such as mothers. (WHO) (For a further discussion of ways in which the WHO document foreshadows dilemmas that complicate efforts to define CHA roles, see Appendix H2. For a discussion of the political roles CHAs have played in the developing world, see Appendix H3.)

Table 3
Characteristics of International Community Health Workers

Characteristic	Country(ies)
Chosen by Community	Mexico, Guatemala, Indonesia
Community Member	Colombia, Guatemala, Iran
Desire to Serve Community	El Salvador, Nicaragua
Experience in Health Work	China
Formal Schooling	Colombia, Iran, Tanzania
Interest in Health Work	China
Limited Formal Schooling	Mexico
Political Awareness	China, Nicaragua

Source: "An Historical Overview of Lay Health Worker Programs." Hood River, OR: La Familia Sana Program, 1992.

Tables 2 and 3 provide lists, by no means exhaustive, of some of the roles played by CHAs in a convenience sample[1] of international programs and characteristics of CHAs sought by those same programs.

Many of the most successful rural CHA programs in the U.S. have been strongly influenced by a group of international practitioners and researchers who focus on the empowerment role of CHAs. Members of this group, in turn, owe much to the Popular Education philosophy and practice developed by Brazilian educator Paulo Freire. The ideas of this group have been disseminated to various countries via the books *Where There is No Doctor* and *Helping Health Workers Learn* (Werner and Bower, 1982).

The main role of CHAs, according to this group, is to "increase people's awareness of their own situation, to help them recognize problems, and to develop a reasonable and jointly agreed upon plan of procedure" (Heggenhougen, 1984). The most important characteristics of CHAs, they feel, are that they be from the communities where they live, and that they be selected by the community. Unlike others who assert that community members will develop trust more quickly than outsiders, Werner & Bower state that experience has shown that it often takes *longer* for community members to trust the skills of a local person. But whereas training outsiders reinforces the myth that local people are incapable, training local people reaffirms what the community can do for itself.

Rather than constructing a strict list of qualities for communities to use in selecting CHAs, Werner & Bower recommend that program planners help communities "decide wisely for [themselves]" what criteria to use (Werner & Bower, 1982). But they do suggest a number of qualities and skills that communities may want to consider as they select CHAs. Because of their marked similarity to the qualities and skills identified in our study, we list them here:

- kindness
- honesty
- eagerness to learn
- humility
- responsibility
- good self-care
- identification with those in greatest need
- interest and some experience in health
- leadership and organizing skills
- respect for people's beliefs
- literacy

With many years of experience, CHAs in the developing world and those who have written about them lay the groundwork for a description of the roles and competencies of CHAs in the U.S.

Roles and Competencies of CHAs in the U.S.

Like many programs in the developing world, the first formal CHA programs in the U.S. grew out of a desire to create accessible and appropriate health care resources for communities that were underserved or unserved by the traditional medical system. A variety of federal agencies sponsored these programs. The Federal Migrant Act of 1962 "stimulated the growth of CHW programs by requiring outreach services in migrant labor camps." In 1968, the Indian Health Service (IHS) initiated its Community Health Representative (CHR) program, still the largest and oldest CHA program in the country. A number of programs were founded in poor urban areas under the aegis of the Office of Economic Opportunity (OEO) (Meister, 1992).

Table 4
Titles, Roles and Competencies of CHWs in a Sample of Early U.S. Programs

Name and Date*	Title Used	Roles and Responsibilities	Qualities and Skills**
1) Denver, Co. Maternity and Infant Project 1967)	Neighbor hood represen tatives	* community organizing * linkage * mediation * advocacy	* identification with target group * communication skills * accepted as neighborhood member * possess work ethic * value health care * be socially mobile * female, over 35 yrs. old
2) DC Dept. of Health MCH Project (1968)	Health education aides	* home visits * provision of ed materials * motivation to seek care	* high school diploma * 2 yrs. appropriate experience * knowledge of the concept of public health * knowledge of MCH issues and health care system
3) LA County General Hospital Project (1969)	Indigenous health aides	* health education about iron deficiency anemia	* high school graduate * knowledge about nutrition (importance of ironrich diet)
4) Tulsa, OK Immunization Project (1970)	Indigenous personnel	* home visits * health education * motivation * education of health care system	* frequent recommendation by expert informants * ability to conduct survey work * understanding of: the rationale of the project; the health dept. and clinic systems; and communicable diseases and immunizations
5) Kaiser Permanente Neighborhood Health Center Project (1979)	Outreach worker, Neighbor hood health co ordinator	* recruitment * health education * utilization management * referral to community resources	* meet OEO income criteria * indigenous to community * communication skills * understanding of the importance of preventive services * understanding of health care and health education concepts

* Dates refer to publication date of cited article.
**Competencies include both recruitment criteria and skills taught in the program.

Table 4 presents an overview of the terms used, roles played, and competencies possessed or developed by CHAs in a convenience sample of urban U.S. programs from the 1960s through the 1970s. Characteristics unifying these programs include the fact that all were designed as research studies (although the Kaiser-Permanente Neighborhood Health Center program had existed previous to the research), and workers in all programs were paid. Three competencies — an intimate understanding of the community, communication skills, and a knowledge of health issues and the health care system — are those most evident in this sample of programs. All three also figure prominently in our own findings. (For a discussion of how these projects exemplify the way in which the underlying goals and philosophy of a project determine what competencies will be sought and developed and what roles CHAs will play, see Appendix H4.)

With the end of the War on Poverty and a shift away from a focus on community development, many of the early urban programs expired for lack of funds. By the mid-1980s, however, continuing poor health status in many rural areas of the U.S. motivated communities and program developers to create a second wave of CHA programs.

In many ways, the roles played and skills possessed by the rural CHAs were quite similar to those of their earlier urban counterparts. For example, roles and responsibilities of the "lay health workers" (also called *promotoras)* in Arizona's *Comienzo Sano* (Healthy Beginning) project included: formal health education, support, advocacy, case-finding, and referral. The program recruited as *promotoras* women who were members of the target communities and who were bilingual and bi-literate in Spanish and English. The *promotoras'* training program focused on outreach strategies, educational methodology, negotiating the health care system, medical eligibility rules for the state's version of Medicaid, and advocacy skills. At the request of the *promotoras*, counseling techniques and early childhood development were later added to the curriculum (Meister, 1992).

As academic literature began to develop around the rural CHAs, the philosophical rift between the rural and urban programs began to grow. The concept of the "lay health advisor" (LHA), separate and different from the outreach worker, began to be advanced. In 1985, Barbara Israel defined lay health advisors as "lay people to whom others naturally turn for advice, emotional support, and tangible aid. They provide informal, spontaneous assistance, which is so much a part of every day life that its value is often not recognized" (Eng & Young, 1992). Other roles developed for LHAs by the researchers include linking people to services, helping them to negotiate the health care system, counseling, and education and organizing. Some of the qualities attributed to LHAs are respect and trust in the community, interest in "learning more about their life circumstances," the tendency to ask questions, and a willingness to help others by sharing what they know (Eng & Young, 1992).

The LHA advocates feel that it is important to make a distinction between LHAs and "those personnel who may be indigenous to the community but who work as paraprofessionals or extensions of the health care system. The latter many times are seen as stopgap measures used to respond to a shortage of trained personnel." (Harlan, Eng & Watkins, 1992). In this schema, LHAs *advocate* whereas outreach workers (OWs) *persuade*; LHAs are *internal* and OWs are *external*; LHAs are *identified* while OWs are *created.*

While these researchers contrast LHAs with "paraprofessionals" and "outreach workers" (rather than with urban CHAs), it seems clear that they would consider most urban CHAs to be paraprofessionals rather than LHAs. At the same time, many rural CHA programs have either begun at or moved towards a position much closer to that of the urban programs, in terms of the formality and complexity of the work CHAs do. Is there a middle ground where the roles and competencies of the LHAs and the OWs can come together?

To some degree, that question will be answered in the findings section of this report. But provisionally, the LHA advocates offer a possible solution when they say that both LHAs and paraprofessionals exist along a continuum from "the most informal and most naturally occurring to the very formal" (Harlan, Eng & Watkins, 1992). Clearly, as this review of the literature shows, CHAs in urban and rural programs share many of the same roles, qualities, and skills. The common experience of seeking to promote health in underserved communities tends to push urban and rural CHAs towards many of the same strategies.

Methods

Introduction

The primary objective of this chapter was to determine the *core roles* that Community Health Advisors play within their communities and the health care system, and to define the *core competencies* they need to be optimally effective. From among the variety of methods we could have used to reach these objectives, we chose to *go to the source* and speak with CHAs themselves and those who work most closely with them. This decision was made for several reasons.

First, we felt that those best qualified to define a profession are its practitioners, those who are intimately familiar with the needs they are called on to address and the personal resources they possess that enable them to address these needs. A strategy of analyzing job descriptions did not seem workable, however, since CHAs almost universally report that the situations in which they work regularly require them to do tasks that are not

in their job descriptions. Other possible approaches, such as questioning health plan administrators, are necessary and valuable next steps. (Perspectives of other health care professionals and administrators are covered to some extent in other sections of this report.) But the experience of veteran qualitative researchers convinced us that any investigation of the skills and roles of a group of workers should begin with the workers themselves (Merriam, 1988).

Once the unit of observation[2] for the research had been identified, we had to decide how best to collect the wisdom of members of this group. Reliance on qualitative methods[3] in this chapter was dictated by one primary factor: the exploratory nature of the study. This chapter represents the sort of exploratory research for which qualitative methods are most appropriate[4] (Strauss & Corbin, 1990).

Sampling Strategy

The findings in this chapter are based primarily on individual and group interviews and discussion groups with CHAs, CHA program coordinators and administrators, conducted in the context of site visits and CHA conferences. Group interviews and focus groups are referred to as discussion groups in this chapter. In order to determine which programs we would visit, we devised a working definition of a CHA program (see Appendix C). This definition provided the inclusion and exclusion criteria for our sample. We then constructed a purposive sample based on our professional experience in the field and recommendations from expert informants. (A more complete description of the sampling strategy is provided in *Chapter Two: Study Methodology* of this report.)

The Sample

The findings presented here are drawn from a subset of the larger sample of CHA programs. The subset sample consists of ten programs, six of them rural and four of them urban. In terms of race/ethnicity, three of the programs serve primarily African Americans; three serve primarily Latinos; one program serves primarily Native Americans, and three programs serve a variety of racial/ethnic communities. In addition, data for this chapter are also drawn from four focus groups, three with CHAs and one with supervisors, from a variety of programs. Finally, we made one site visit to a CHA training program. A total of 88 CHAs and 14 program coordinators and program directors participated in group and individual interviews and focus groups. (List of the programs visited and focus groups conducted are provided in Appendix E & F.)

Data Collection

In our interviews and discussion groups, we asked two discrete questions related to CHA core roles: 1) What activities do CHAs in your program most commonly carry out? and 2) What unique contributions do CHAs make to communities and the health care system? Based on past experience in the field, we believed that these more concrete questions would elicit more responses than questions using the more abstract term, "roles." Because of widespread unfamiliarity with the concept of "competencies," we asked respondents what skills, abilities, and qualities people need to work effectively as CHAs. When reporting results from the interviews and discussion groups, we will use the term "participants."

The findings in this chapter are supplemented by information from the Study's survey of CHAs and supervisors. Three questions were used to collect data about roles and competencies. The questions were virtually the same as those used in the interviews, with the exception that the survey did not include a question about contributions to the health care system. The question about activities was open-ended and respondents were able to list as many as ten activities. On the subject of qualities, respondents were asked to rate a list of seven qualities as "very important," "somewhat important," or "not important." They were also able to list two other qualities and rate these. The question about skills and abilities was also open-ended with ten responses possible. When reporting on the survey, we will use the term "respondents."

A final step that bridged data collection and analysis involved the creation of a Working Group of the Advisory Council composed of three CHAs, one CHA supervisor, and one supervisor who had previously been a CHA. An outline of this chapter was prepared and reviewed by members of the Working Group, who offered suggestions for additional roles and skills. The product of this group was then presented at a meeting of the Study Advisory Council, where additional refinement took place.

Data Analysis

The analysis process used for the qualitative data for this chapter is loosely based on the *grounded theory* approach developed by Barney Glaser and Anselm Strauss (Strauss & Corbin, 1990). In this approach, the data are first examined closely with the intent of identifying major concepts, organizing the concepts into categories, and naming the categories. The next step consists of "putting the data back together by making connections between categories." (Strauss & Corbin, 1990) The final step in the process involves the search for a central concept or *core category* around which all the other sub-categories can be organized. In many ways, this strategy of data analysis was particularly well-suited to the objectives of this chapter, since our task was to develop general categories that describe the roles CHAs play and the skills and qualities they need to play these roles.

The process of data analysis for the survey is described in detail elsewhere in this report. In order to understand some of the limitations of the data related to this chapter, however, it will be useful to describe two analytical points in detail. Responses to the open-ended survey question about activities were coded using a pre-made code list; other codes were created as necessary. For the question about skills and abilities, an extensive coding list was also developed in advance. However, many of the responses to this question resembled qualities more than skills and therefore did not fit well into the pre-made categories. Because the initial coding and statistical analysis were not conducted by the primary researchers, we were not able to create new codes and use them in statistical analyses. Rather, it was necessary to re-code and calculate frequencies[5] by hand. The codes and frequencies reported here are the result of this re-coding process.

Limitations of the Data

The refined coding list we created for the question about skills and abilities was extremely fine-grained, including a total of more than 60 possible responses. However, due to the same respondent saying essentially the same thing more than once in several cases, there was undoubtedly some double-coding of respondents. (For this reason, we do not report percentages of respondents providing a given response. See Tables 7a and 7b.) We have chosen to use the qualitative data as the primary data source for this chapter. Survey data are used to supplement and validate the conclusions drawn based on the interviews and discussion groups.

Results

Introduction

The task of attempting to define and delineate the roles and competencies of Community Health Advisors must be approached with care, for at least two reasons. The first is the risk, mentioned above, that strict adherence to a list of roles and competencies will rob the CHA model of its responsiveness to the unique needs of individual communities. And yet a lack of role definition can also lead to sub-optimal use of the model and of the unique skills of CHAs. We have attempted to balance these two conflicting pressures by creating a set of roles and competencies specific enough to be useful for policy and program development, yet broad enough to be applied nationally in the huge variety of settings and communities in which CHAs work. In order to do this we have necessarily left out many roles that are important in some programs and abilities that are crucial in others. Our purpose has not been to draw a comprehensive picture of all CHA programs, but rather to highlight those commonalities that unify and define the field. Specific task and job analysis is certainly valuable, but is more appropriately carried out at the level of geographic regions and sectors of the health care system. Indeed, several groups around the country are already involved in this type of regional and sectorial analysis (Love, Gardner & Legion, 1996).

Another crucial characteristic of CHA work is that it is genuinely holistic. The most effective CHAs work with whole people, not just organ systems or disease entities. The nature of their work makes it impossible to impose false distinctions between physical, mental, and psychosocial health. The definition of health in CHA programs is broad, encompassing adequate housing and stable employment and appropriate nutrition and respect and dignity. To try to break their roles up into neat categories, therefore, is somewhat contradictory.

Health education shades into social support, which is connected to facilitation of services, which is related to advocacy. The same is true of the types of competencies CHAs need to do their complex and interrelated work. Therefore, the categories we have created are not mutually exclusive; we try to make explicit the ways in which they are interrelated. Also, because the same competencies allow CHAs to play a variety of roles, individual competencies are not linked to specific roles.

Core Roles of Community Health Workers in the U.S.

Role 1: Bridging Cultural Mediation Between Communities and the Health and Social Service Systems

Our research confirms the assumption that in the U.S., CHAs play an important role as bridges and mediators between the communities in which they work and the health care system. This role corresponds to four functions.

A) Educating community members about how to use the health care and social service systems. CHAs around the U.S., in both urban and rural settings, help community members get the services they need and help systems run more smoothly and effectively by teaching people where and when to go for services. In the language of managed care, CHAs assist in *utilization management.* One of the most common ways in which CHAs promote appropriate utilization of the health care system is by teaching people when they need to go see a doctor and when they can safely treat an illness in themselves or their children at home. A CHA in Michigan summarized this function well. "Like, if [people] have headaches or they feel nauseated, they might say, 'Do you have anything I can take?' Well, I'm not a doctor, I can't give you anything but I can tell you what it might be, and if it sounds serious you should see a doctor . . . That is mostly what we do. Find out, [and if] we think it is something serious that needs to be attended to, we say, 'Make an appointment,' or 'go to your doctor,' or 'go to the emergency room.'" In this way, CHAs decrease reliance on emergency care and increase use of preventive care. CHAs also regularly pass on information about the hours and work practices of health care delivery systems such as clinics and hospitals.

B) Educating the health and social service systems about community needs and perspectives. As people with an intimate understanding of communities, CHAs are uniquely able to educate and raise consciousness in the health and social service systems, thus helping to create systems that are more culturally competent, responsive, and effective. A Michigan Camp Health Aide puts it this way: "Let's say there's this person that needs something special and . . . the health community won't know what it is because this person can't communicate with them . . . And if there is a CHA who says, 'You know what? There is this person at this camp and this is what they need.' And then, it will make the health community better because they will provide that service once it knows [that the need] exists."

The information CHAs pass on to the system can be used in a variety of ways. First, it can be used to bring about actual *changes in the services that the system*

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offers. A CHA offered the example of a plan to provide dental services in a rural Michigan community that came about after repeated requests from CHAs. CHA intervention can also bring about *changes in the way in which services are offered.* Clinic hours have been changed, triage practices adapted, and toys added to clinic waiting rooms as the result of CHA education of the system. Most important, CHAs play a role in helping their colleagues in the health and social service systems to *change attitudes and behaviors* that act as formidable barriers to care. Under the terms of a contract with the Oregon Health Sciences University (OHSU), Community Health Promoters (CHPs) from *La Familia Sana, Inc.*, regularly facilitate cultural competence workshops for medical and nursing students. In these workshops, the CHPs teach participants about Mexican beliefs about illnesses such as *empacho* and *mal de ojo*, and deal with broader topics such as how to build trust with patients and how to work with interpreters. Community Organizers with the People of Color Against AIDS Network (POCAAN) in Seattle provide employee trainings in clinics and hospitals that deal primarily with recognizing and combating homophobia.

Gracie Camarena told us how the workshops she and her co-workers present for clinic workers in Texas address the more subtle aspects of cultural competence. "[The purpose was] for them to understand . . . the type of people who go to their facilities and seek their help and for them not to discriminate. You know, they say, 'We do not discriminate,' but they do. They do at first sight, when they see you . . . wearing a hat or a bandana . . . That's not important, how you are dressed or if you haven't had a shower or something. These people don't have running water." Their knowledge of community perspectives and needs and their ability to pass on this knowledge allow CHAs to play a vital role in making the health and social service systems more responsive and competent.

C) Information Gathering. At the individual level, the high level of trust that many CHAs are able to establish with their clients enables them to collect information that is often inaccessible to other health and social service providers. This may include more complete medical histories or information about the underlying causes of health problems. When passed on, with clients' permission, to the appropriate person, this information can lead to more accurate diagnoses and treatment, thereby improving health outcomes. Part of their ability to collect information is related to the pro-active strategies, such as outreach and home visiting, that CHAs use in their work. "The doctors" commented one CHA in New Mexico, "don't go to the homes and listen to [clients]."[6] The ability of CHAs to collect valuable information was underscored by another New Mexico CHA. "If the midwife can't get some kind of information, something that worries her about a patient, she tells us and we are the intermediaries and yes we obtain it."[7] The information CHAs are able to obtain and share facilitates the work of other health and social service providers and enhances the effectiveness of services offered to clients.

D) Interpretation and Translation. CHAs facilitate patient-provider communication by providing interpretation and translation. CHAs frequently work with immigrants who speak little or no English and providers who do not speak the native languages of their clients. In this case, bilingual CHAs provide literal translation from one language to another. A Michigan CHA expressed the benefits to both system and client of this function: "I remember being in emergency situations. I would accompany . . . anyone in the camp to the hospital. And then they would come up and . . . ask questions of the patient. The patient didn't know how to answer so they would put it off, and put it off, 'till they could get somebody to translate. Accompanying them to the health [center] or to the doctor's [office] can make things a lot faster and a lot more accurate."

By providing literal translation, CHAs further contribute to the cultural competence of the health and social service systems. But care needs to be exercised with this function. Like other bilingual providers, bilingual CHAs are often called away from other important work to provide translation. CHAs are not appropriate substitutes for additional bilingual providers or trained translators, and when they are used as such, they become less effective in their primary roles.

CHAs provide other types of translation. They translate letters and correspondence from health and social service agencies. They read written correspondence and write letters for illiterate clients. Perhaps most

importantly, CHAs "translate" medical and other terminology into lay language, teaching clients how to follow medication or other treatment regimes in ways that clients can understand. According to June Robinson, Program Director with the Midwest Migrant Health Information Office, "I think that providers often assume that the person they see knows or understands what they said but . . . we all know that often that isn't the case and the [CHA] is there to help that person . . . or to call back to the clinic for instructions . . ."

Role 2: Providing Culturally Appropriate Health Education and Information

Community Health Workers' understanding of community norms and idioms, coupled with their training in health issues, allow them to play a role as providers of health education and information.

The hallmark of CHA health education is its *accessibility*. CHAs make health education physically accessible by taking it directly to the community. This may involve handing out pamphlets on street corners, conducting door-to-door outreach, facilitating on-going health education classes, making presentations in migrant labor camps, organizing health fairs, or presenting community conferences. Certainly the best known settings for CHA educational work are clients' homes. Indeed, home visiting is the primary tactic used in many CHA programs.

Further, CHAs provide education that is culturally accessible. Cultural accessibility can mean providing education in an appropriate language, or from an appropriate source, or both. At the Laguna Pueblo in New Mexico, Community Health Representatives facilitate "growing old sessions." "We get Indians to speak," they told us, "so it's understandable for elders."

Cultural accessibility also depends on appropriate methodology. Many CHAs around the country, especially those working in Latino communities, use methods derived from Popular Education. Popular Education, originally developed for adult literacy work by Brazilian Paulo Freire, is based on the assumption that all people have learned a great deal from their life experience. Therefore, the role of the educator is to draw out what people already know, supplement it as necessary, and help people use what they know to improve their communities. A *promotor de salud* from Oregon described the Popular Education environment this way: "An environment of Popular Education is where we all know a lot, where we are all valued because we have good ideas, an environment where we are going to be enriched ourselves and then we are going to enrich the community. It is a special way of working with the community."[8] By using empowering and interactive methods such as Popular Education and sharing education in community settings, CHAs make health education accessible and effective.

CHAs' role in health education can be further explained in terms of three functions.

A) Teaching concepts of health promotion and disease prevention. The most important general topics of the health education and information that CHAs provide are health promotion and disease prevention. In a classic public health mode, CHAs direct their attention towards keeping people healthy and intervening so that existing problems do not worsen. For example, CHAs promote health by teaching people about the value of exercise and a healthy diet. They prevent disease by encouraging people to reduce risk factors such as smoking and alcohol consumption. And they increase the likelihood of early detection by stressing the importance of screening tests and regular medical check-ups.

Specific topics of CHA health education run the gamut from dental health to domestic violence. Among the most common topics mentioned in our interviews and discussion groups were perinatal health (including prenatal care and nutrition, childbirth, infant care, and breast feeding); STDs and AIDS; pesticide and field safety; and breast and cervical cancer. All the education CHAs share is not strictly health-related. In some programs, it includes life skills training, budgeting, and many other topics. Even in categorical programs with a specific health issue focus, clients frequently ask CHAs about a wide range of issues.

CHAs are well aware of the value of stressing prevention. "[We] save money by speaking prevention," said another New Mexico CHA. In the same vein, a Michigan CHA talked about the advantages of assuring that a

small infection doesn't get bigger, or a mild illness doesn't become more serious. "[Because] what you could prevent at home, if you do not give it attention, can cause greater expenses to the medical system."[9]

B) Helping to manage chronic illness. Another focus for health education by CHAs is management of chronic illnesses such as diabetes and hypertension. An Oregon program offers a "Cooking Class Support Group" where Latina women with diabetes or at risk of developing it participate in an interactive class, do exercises geared to their ability level, and prepare an appropriate nutritious meal. All these activities are directed at achieving good diabetic control.

CHAs also work one-on-one to help individuals manage their chronic illnesses. A Michigan CHA told the story of a farmworker who, at her insistence, finally went to the clinic and was diagnosed with diabetes. He then came to her asking why he shook so much. "And then I say to him, 'you are taking the pills for diabetes and you do a lot of work picking and that's why your body shakes, because your sugar goes down and you have to eat something. Take with you all the time a candy, a peanut butter and jelly sandwich, orange juice or apple juice' . . . And that's what I tell him, right? 'And always take something along to eat when you feel that way at work.' And yes, yes he does it."[10]

C) Training other CHAs. In the developing world, the practice of having experienced CHAs train and supervise new CHAs is well-accepted. Indeed, some authorities such as Werner and Bower believe that CHAs make the *best* teachers for other CHAs (Werner & Bower, 1982). But only recently has this practice been adopted in the U.S. Currently, experienced CHAs in Oregon provide *capacitation* (empowering training) covering health education methodology and health topic areas for other health care workers from throughout the state. CHAs also capacitate one another informally by acting as mentors.

Several CHA program administrators with whom we talked reflected on the results of the health education that is provided by CHAs. June Robinson of the Midwest Migrant Health Information Office (MMHIO) stated that "clinicians have said that they feel like farmworkers coming in are much more educated about health issues and therefore can ask more [informed] questions . . . and take better care of themselves as a result." A CHA supervisor who previously worked for a managed care organization believes that CHA education contributes to the goal of creating more self-reliant health care consumers who can do "an awful lot of health care . . . for themselves as long as they have access to certain kinds of information." CHAs' role in providing health education and information has obvious benefits for both communities and the health care system.

Role 3: Assuring that People Get the Services They Need

According to the participants in our interviews and discussion groups, another key responsibility of CHAs is connecting people to services. In the words of one CHA who works in a rural area, "When people ask me, 'What do you do?' I tell them, 'People that need services, I put them in contact with services.'" But participants also made it clear that CHAs do not stop at simply putting people in contact with services; often, they go much further to *make sure that the services are actually obtained.* For example, a Seattle-area outreach worker described his role as "going all the way through in order to get this person to the right place to get the services they need."

The question of whether the term "case management" is an appropriate title for this role is a controversial one, since case management can imply a defined set of skills and purview of action. Certainly, some CHAs act more like case managers than others. The "Research Advocates" (RAs) in Seattle's Birth to Three Program, for example, have a limited caseload of clients whom they follow over a three-year period. Their interaction with their clients is intense and involves coordinating "all the people in the client's life," according to their supervisor. Therefore, it is not surprising that when asked to define her role, one of the RAs answered, "It would be the same as a case manager. We have various cases and manage them." Ruth Abad, who formerly provided technical assistance to CHA programs on behalf of the Washington State Department of Health, feels that case management is a "good role" for CHAs.

While the term case manager does not apply to all CHAs, almost all the CHAs with whom we spoke play a role in assuring that clients obtain the services they need. This role can be divided into four principal functions.

*A) **Case-finding.*** Whether CHAs consider themselves to be *Outreach Workers* or *Lay Health Advisors* or any of the various gradations in between, they tend to have closer, more continuous, and more intimate contact with community members than most other health care workers. Therefore, they are in a unique position to recognize as-yet-undiagnosed symptoms of illness in community members and connect them to the health care system. *Case-finding* is the first step in assuring that people obtain needed services.

B) Making referrals. Once CHAs have identified people who need health or social services, their knowledge of the service systems enables them to make referrals to appropriate sources of aid. Consonant with their broad definition of health, CHAs refer clients to a broad range of health and social services, including clinics, hospitals, welfare offices, food banks, and churches. As one New Mexico CHA observed, "there have been cases of people who can't pay their rent or their telephone, so we look for places that can help them."[11] CHAs also tell people where they can buy needed items, such as money orders, and advise people about services for which they qualify.

C) Motivating and encouraging people to obtain care. Often, it is not enough to simply refer a client to a service. The formidable barriers to care faced by many of the people with whom CHAs work often make it necessary for CHAs to take a more aggressive approach in helping people obtain services. One of the barriers that CHAs help clients overcome is their own resistance to obtaining care. Clients may put off going to the clinic because they do not want to miss work and lose wages. In this case, CHAs stress the greater costs that may be incurred because of delay. New immigrants and others may find dealing with a complicated system in a new language frightening and intimidating, and therefore avoid it. When clients face these barriers, CHAs may need to take a number of actions. "Sometimes," stated a CHA in Michigan, "one also offers . . . to make the appointment for them if they don't want to do it. . . . Find them transportation and sometimes take them oneself."[12]

D) Taking people to services. For a variety of reasons, many CHAs in both urban and rural areas physically accompany people to obtain services. Frequently, they go along to lend moral support. (This accompaniment function will be discussed further under Role 4: Social Support.) In some programs, supervisors or agency staff specifically request that CHAs bring clients in for appointments. In urban areas, clients may need help negotiating bus or subway systems. And in both urban and rural areas, the lack of public transportation may oblige CHAs to transport clients in an agency car or in their own cars.

This function is also a controversial one. In many communities, public transportation is limited or non-existent, private cars are scarce, and licensed drivers are few. CHAs in these communities often want the right to transport program participants to events and classes. They may come into conflict with program administrators concerned about liability issues. On the other hand, viewing CHAs as chauffeurs can lead to inappropriate requests from both program staff and clients. One CHA put the problem this way: "The [CHAs] are out in the community every day and yet [clients] want us to transport them to the hospital all the time . . . and all that transportation takes away from [the CHAs] being in homes or out in the community doing other things." In any given situation, CHAs themselves are usually in the best position to decide whether it is necessary and appropriate for them to provide transportation.

E) Providing follow-up. Having found people who need services and helped them to obtain them, CHAs promote continuity of care by providing follow-up. The types of follow-up CHAs provide, according to our respondents, include tracking pregnant women to make sure they get prenatal care, locating people who need lab results, and delivering messages and prescriptions to remote rural areas without phones. By so doing, says June Robinson of MMHIO, "[they] make the lives of the clinicians a lot easier in a lot of ways."

Role 4: Providing Informal Counseling and Social Support

Members of the underserved communities where most CHAs work face a variety of risk factors for mental health problems. Poverty, discrimination, cultural and physical isolation, unemployment and

underemployment, lack of formal education, and teen parenthood are only a few (Amaro & Russo, 1987; Belle, 1984; Ladewig, McGee & Newell, 1990; Lyons-Ruth et al., 1990; Miranda, 1980; Vega et al., 1986). At the same time, these communities tend to lack culturally appropriate and accessible mental health services. (Belle, 1984; Espin, 1987; Lyons-Ruth et al., 1990; Muñoz, 1980; Ramirez Boulette, 1980; Sena-Rivera, 1980).

A plethora of literature has demonstrated the importance of social support in preventing mental health problems and improving physical health outcomes (Berkman, Leo-Summer & Horwitz, 1992; Leon, et al., 1984; Lyons-Ruth et al., 1990; Miranda, 1980; Sena-Rivera, 1980). The literature about CHAs, especially literature coming from the Lay Health Advisor school, has focused on CHAs' important role in providing social support and helping to shore up existing social networks and create new ones (Eng & Young, 1992). The CHAs and supervisors with whom we spoke affirmed that CHAs in urban and rural areas of the U.S. and in many racial/ethnic communities help protect and improve mental and physical health by providing informal counseling and social support via two primary functions.

*A) **Providing individual support and informal counseling**.* Conditions of poverty, unemployment, discrimination, and isolation in many of the communities where CHAs work mean that the coping resources of individual community members are often stretched to the limit. Relatives and friends, facing many of the same obstacles, are frequently unable to offer support in times of need (Belle, 1984). Under these conditions, the supportive individual relationships CHAs can build with their clients are crucial. "When we come into their lives," commented Gail, a Research Advocate from Seattle, "sometimes they even want to have us as a friend instead of a case manager . . . because . . . they've built a relationship with us that they never even had with another woman. Sometimes not even with family, mom, or whatever." CHAs commonly used words like "friend" and "mother" to describe the role they play in clients' lives.

In the role of friend and family member, CHAs offer support in a number of ways. They accompany clients to medical and social service appointments. They serve as labor coaches for women as they give birth. They provide reassurance and mediate conflicts between parents and children. Perhaps the most important function for the teens who participate in a New Orleans peer counseling program is simply "talking to people about their problems." The therapeutic value of this talking was emphasized by one of the teens. "Doctors," the youth commented, "can give you medicine . . . to heal your body and stuff like that. But we're . . . talking with them and are one-on-one with them. You know, we get in their minds and are helping them. That's where your real healing comes from."

Similar to the situation with case management, the question of whether CHAs can or should act as "counselors" is a sensitive one. A Boston-area CHA who participated in one of our group interviews stressed the inevitability of CHAs working as counselors. "When someone came to talk to you because they are emotional, depressed . . . what I believe is nobody can stop you to console people and to say no worry about, you going to be okay, we are here to support you. That's what I think." Yet other CHAs from the same program were clearly aware of the associated danger of taking on too much. They emphasized the need to set limits and refer appropriately so that the entire burden does not fall on one person.

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CHA supervisors are familiar with this dilemma; some experience it as a conflict between their traditional training and the realities they come to know working in a CHA program. Beth Gengler, a CHA supervisor trained as a social worker, put it this way:

"I mean, it is a fine line because . . . they are not counselors per se, really they are not. And . . . I feel really strongly that they should not be doing substance abuse counseling, they shouldn't be doing sexual abuse [counseling] . . . On the other hand, [for] the women they work with . . . trust is such an issue and it is so difficult to develop, [that] when they develop trust with their advocate then they don't want to go to a counselor and so the advocates end up doing much more counseling than probably they should. But then they can also be a bridge to those other professionals."

Table 5
"What activities do CHAs in your program most frequently carry out?"

Activity	Frequency	% Res*	Role #
Individual health education	146	52	2
Making referrals	112	40	3
Home visiting	105	37	2/4
Presenting in schools, churches, neighborhoods	103	37	2
Case-finding/outreach/handing out information	102	36	3
Leading support groups	97	35	4
Clinical services	89	32	5
Teaching classes	85	30	2
Health fairs	75	27	2
Followup/phone contact	68	24	3
Assessment	55	20	10
Connecting people to services	45	16	3
Case management	44	16	3
One-on-one counseling	42	15	4
Health screenings	40	14	6
Data collection/documentation/ office work	40	14	8
Translation/interpretation	38	14	1
Transportation	37	13	3
Community organizing	37	13	7
Collaborating with other agencies	37	13	9
Peer education/mentoring	32	11	7
Fundraising/grantwriting	26	9	8

*Percentage of respondents mentioning this activity. This statistic is not exact, as there may have been some doublecounting of respondents whose similar responses were coded in the same category.

(n respondents = 281)

Certainly, a part of the answer to this dilemma lies in how broadly or strictly "counseling" is defined. In their article, "Lay Health Advisors as community change agents," Eng and Young identify counseling as an appropriate role for CHAs, but define it as "an extension of the natural exchange of advice and feedback given to people who know and trust them" (Eng & Young, 1992). Just as all of us act from time to time as teachers, all of us also act as counselors with our friends and family. CHA counselors do the same, with the added advantage of training and on-going supervision.

Another part of the answer may rest in the realization that, along with their supervisors and program administrators, CHAs are involved in creating culturally competent mental health services. And culturally competent mental health services will not always look like or follow the same rules as traditional mental health services. A Research Advocate with Seattle's Birth to Three Program reflected on her experience of going back to school to take classes as a chemical dependency counselor: "I sat through these classes [where] I learned a lot. But it also become real apparent to me that the rules for doing [counseling] . . . are set up by middle class white people and the people who respond to these rules best are middle class white people . . . Middle class white people say, 'Yes, it makes perfect sense. I have an appointment at 3 o'clock to go see my counselor and sit across the desk and talk.' [But] when you start getting out of the middle class white people you are not effective with the people you want to be effective with."

Once again, as we have seen in the context of other roles, the situations in which CHAs work sometimes require them to go beyond the boundaries of traditional health and social services to do things in new and innovative ways. Unquestionably, the boundaries must be breached carefully, and for compelling reasons. But when well-trained supervisors and CHAs work together, the new ways of working they create can be uniquely effective in protecting and improving clients' mental and physical health.

B) Leading support groups. As well as providing informal counseling and social support to individuals, CHAs also organize and facilitate support groups. In fact, *leading support groups* is among the ten most

common activities for CHAs according to those who responded to our survey (see Table 5). Among the wide range of CHA-led support groups mentioned in our interviews were a support group for homeless women, support groups for survivors of domestic violence, support and health education groups for young people, and the *cooking class support group* for diabetic women mentioned above. In addition, male health promoters from *La Familia Sana, Inc.*, have participated in special training enabling them to direct a treatment group for men arrested for domestic violence.

Role 5: Advocating for Individual and Community Needs

With their understanding of communities and their knowledge of the health and social service systems, CHAs are uniquely placed to advocate for community and individual needs within the service systems. At the most basic level, CHAs act as ***spokespersons*** for clients. This function is clearly related to their work as literal and figurative translators (Role 1). At a second level, CHAs serve as ***intermediaries*** between clients and sometimes immobile bureaucracies. A particularly common situation in which CHAs act as intermediaries concerns bills from hospitals and other creditors. Outreach Workers at the Boston TB Clinic reported that clients frequently ask them to help resolve problems with erroneous or overdue bills. A CHA in Oregon engaged in protracted negotiations with a hospital about a client's bill; and, as a result of her efforts, the bill was forgiven entirely. CHAs involved in domestic violence prevention and intervention advocate for women in the court system, helping them to obtain restraining orders, and in the social service system, aiding them in finding housing, employment, and other services.

CHAs in Seattle's Birth to Three Program are called "Research Advocates" in recognition of their role as advocates within a university-based research project. When asked how she views her role, one of the RAs answered, "I absolutely think of myself as an outreach worker, but I also think of myself as an advocate because we do advocate for these women. We advocate for them in housing, we advocate for them in court, we advocate for the family with CPS [Children's Protective Services]."

As well as ***advocating for individuals***, CHAs also ***advocate for the needs and perspectives of entire communities.*** Advocacy for communities may involve specific issues and have discrete goals, such as negotiating with the housing authority to improve conditions in a migrant labor camp. Or it may be on-going and directed at changing systems to make them more responsive and culturally appropriate. This function is obviously related to the function of educating the health and social service systems about community needs discussed under Role 1 (Bridging Cultural Mediation Between Communities and the Health and Social Services Systems). CHAs who become actively involved in the development, implementation, and evaluation of their individual programs also are advocating for their communities, since their involvement assures that program goals will be more responsive to community needs and that methods will be tailored to specific populations.

Role 6: Providing Direct Services

CHAs around the country help to promote health, prevent disease, and ameliorate illness by providing clinical and basic services in their communities. As well as being necessary in its own right, providing services helps CHAs develop the credibility that is a prerequisite for playing many of their other roles. Direct service activities are organized around two primary functions.

*A) **Providing clinical services.*** In the developing world, many CHAs provide a wide range of clinical services in their communities. In the U.S., with its relatively greater ratio of clinics, hospitals, and medical personnel, CHAs' role in providing clinical services is reduced. Yet, especially in remote rural areas, U.S. CHAs are able to provide much needed basic services, thus reducing the burden on other personnel and making services accessible.

In Michigan's Camp Health Aide Program, for example, CHAs are trained to provide first aid to migrant and seasonal farmworkers who often live far from population centers. This includes recommending and providing over-the-counter medications and treating simple injuries. Another important activity for many CHAs is

conducting screening tests. As part of their efforts to promote children's health, CHAs assess growth and nutrition by measuring heights and weights; conduct vision, hearing, and dental screening, and take blood pressures and temperatures. They also teach parents to use thermometers so that they can determine whether a child's illness requires medical attention. Related to their role in helping people manage chronic illnesses, CHAs monitor blood sugar levels for diabetic clients and blood pressure for clients with hypertension. In some programs, CHAs have been taught to administer and read tuberculin tests. Finally, CHAs pass on their knowledge by teaching people to conduct self-screening measures, such as breast self-examination.

B) Meeting basic needs. The CHAs with whom we spoke stressed that, before they can share specific health promotion information, they often must make sure that people have the basic determinants of good health: enough food, adequate housing, clothing, and employment. A CHA attending the New England Maternal Outreach Worker Conference explained it this way:

"[In] order for me to get to my job, I have to do that [social work] job first. If it's food, if it's heating, if you're hungry, I don't care what service I'm coming there to offer you, you can't hear me, because your mind and your belly is telling you something else. Now if I can help you to get food, then I can concentrate on what it is that needs to be done."

When resources exist, CHAs help people meet basic needs by referring them or taking them to the appropriate agencies. When resources are not available, CHAs often will try to meet these needs themselves. There are probably few CHAs who have not at some time shared their own food, clothing or money with clients. CHAs also provide other types of instrumental support.[13] A CHA from Hattiesburg, Mississippi, described her activities as "visiting the sick, going to the store, doing their wash."

Once again, with so many needs to be met and, in many areas, social services limited or non-existent, the potential is great for CHAs to become overextended and try to do too much themselves. In the words of a Native American CHA, "I feel there's a limit to what CHAs should have to do . . . We shouldn't have to clean houses . . . I don't think that is one of the things we should have to do. We should be out there providing more education to the people."

The dilemma is clear. Because of their understanding of the basic determinants of health, CHAs will inevitably try to help people meet their basic needs. If this function can be limited to referring clients to existing services, it should not interfere with CHAs' other important work. But when adequate community resources do not exist, and CHAs (like other health professionals) try to meet those needs themselves, it is possible and even likely that CHAs will become overextended and their other work will suffer. Thus, it seems natural and appropriate that CHAs become engaged in helping communities to build the capacity and resources they need.

Role 7: Building Individual and Community Capacity

Many of the roles and functions outlined above — facilitating patient-provider communication, sharing culturally appropriate health education, increasing access to appropriate care, promoting continuity of care, providing social

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support — are crucial to promoting health and preventing disease in underserved communities throughout the U.S. Yet, as managed care organizations and other providers of care are becoming increasingly aware, until communities and individuals address the basic determinants of health, fundamental shifts in the health status of populations cannot occur.

Werner and Bower have pointed out that many of the root causes of ill health involve behavior — the behavior of individuals and communities towards themselves and towards one another (Werner & Bower, 1982). Traditional medical interventions cannot influence the basic determinants of health because they cannot change behavior. In order to change group and individual behavior, it is necessary for individuals and communities to become actively involved in promoting their own health. CHAs play a unique role in promoting the community participation and empowerment that can result in substantial, long-lasting changes in health status. They do this by building capacity in both individuals and communities.

A) Building individual capacity. CHAs increase the capacity of individuals to protect and improve their health in a variety of ways. As discussed under Role 2 (Providing Culturally Appropriate and Accessible Health Education and Information), CHAs share valuable information about how people can prevent illness. But they do more. They also teach people *concrete skills* essential to maintaining good health. As part of AIDS prevention activities, CHAs teach clients how to use condoms. To enable them to use the health care system appropriately, CHAs show people how to make medical appointments. CHAs accompany clients to grocery stores and help them select food and later demonstrate how to cook low-fat, low-salt meals. So that parents can monitor their children's health, CHAs teach parents to use thermometers. These measures, which may appear simple, can reduce costs in a variety of ways. First, clients no longer need to call on health workers to do things they can do themselves. They are able to make more informed decisions about when and where to seek care. And taking preventive measures may mean that they never become ill at all.

Perhaps the most important way in which CHAs build *individual capacity* is by actively helping clients to change their behavior. Behavior change is a complex process about which much remains to be learned. But it is clear that CHAs make important contributions to the process. (For a discussion of how CHAs promote behavior change, see Appendix H5.)

The results of CHAs' work in promoting behavior change are evident in a quotation from a focus group conducted by researchers at the University of New Mexico (UNM) Division of Community Medicine (Robert Wood Johnson and Henry J. Kaiser Family Foundations Opening Doors Community Health Worker Evaluation Project). Describing the changes that had taken place in one client since the *promotoras* first began to work with her, a *promotora* stated:

"She's more independent now, and when we first met her, she wouldn't say a word . . . if we never would have been there she would have probably still been sitting at home right now. She can drive and she goes into town and does all her things for herself now . . . and it's because we gave her a little shove here and there, and *she did it.*" (Emphasis added.)

By teaching concrete skills and promoting behavior change, CHAs help clients build the capacity to take more control over their own health.

B) Building community capacity. According to the CHA model developed and promoted by the World Health Organization, one of the CHA's primary responsibilities is to bring about *community participation in health*. This means involving communities in defining their own health problems, identifying the causes, and actively developing and implementing solutions. In certain political contexts, such activity is seen as a threat to existing power structures, and, as a result, CHAs have been captured, tortured, and killed. And yet many CHAs and CHA advocates continue to agree that the role of organizing communities to improve their own health is "the essential concept of community health work" (Witmer et al., 1995).

How do CHAs go about doing this? Primarily, CHAs promote community capacity-building by acting as *community leaders*. Ronald Heifitz, author of *Leadership Without Easy Answers* and a lecturer at Harvard's Kennedy School of Government, has defined leadership as "influencing the community to face its own

problems," and "mobilizing people to tackle tough problems." Heifitz defines *mobilizing* as "motivating, organizing, orienting, [and] focusing attention," and stresses that leaders are defined not by their position or status, but by their ability to mobilize people to bring about change (Heifitz, 1994).

Respondents to our survey provided several examples of how CHAs are involved in bringing about community-wide change. In one community, CHAs have helped families to form support groups that then advocate with the school system for program changes. In another, *promotores* have fostered changes in the corrections system by serving on a police review board. Several respondents mentioned that they are involved in voter registration efforts and in helping clients become U.S. citizens. One CHA stated that "it doesn't matter who they vote for, but that they vote, and become citizens." Many CHAs also act as community leaders by representing their communities and programs on local, state and national boards, commissions, and task forces, and by organizing coalitions of service agencies.

C) Assessing Individual and Community Needs. Members of the Advisory Council of the NCHA Study suggested that *Assessing Community Strengths and Needs* be added as a discrete role category. Based on this recommendation, we returned to the data to determine whether such a change was warranted. It was our judgment that, rather than being a discrete role category, the function of assessment runs through many of the role categories already identified. For example, assessment is an integral part of the individual and group educational activities outlined under Role 2 (Providing culturally appropriate and accessible health education and information.) In order to assure that people get the services they need, it is essential first to determine what those needs are. When providing informal counseling and social support, CHAs are constantly assessing the resources and needs of their clients. Although it is essential to many of the roles CHAs play, we have chosen to locate the assessment function under Role 7 (Building individual and community capacity) because of the close link between assessment and capacity building. Effective capacity building in individuals and communities depends on a careful and ongoing inventory of the strengths and needs present in the individual and the community. CHAs carry out this type of assessment as a routine part of their work.

Survey Results

The twenty most common activities conducted by CHAs, as reported in our survey, are presented in Table 5. These activities correspond to the functions grouped together under each role category. As the Table demonstrates, five of the ten most commonly mentioned functions relate to CHAs' role as educators (Role 2). The role with the greatest number of functions mentioned in the list (a total of six) is Role 3: Assuring that People Get the Services They Need. (It should be noted here that the functions as coded in the survey are not necessarily mutually exclusive. For example, there is obvious overlap between "connecting people to services" and "case management.") Despite the fact that the codes for this question were created previous to obtaining or coding the data from the interviews and discussion groups, all but four of the functions mentioned in the list correspond well to one of the seven role categories arising from the qualitative data. This consistency between the survey and the qualitative data provides reassurance about the reliability of the data.

Core Competencies of Community Health Advisors in the U.S.

Both our qualitative and quantitative data suggest that the combination of qualities, skills, and knowledge Community Health Advisors need in order to be effective in their roles does not fit neatly into a traditional competency-based framework. This is not surprising when one considers how the role of the CHA has traditionally been conceptualized and practiced. One of the few defining characteristics of CHAs that has been widely agreed upon over time and throughout the world is *membership in the community in which they work*. Community membership can be defined in various ways. But none of the definitions of "community membership" is analogous to what have traditionally been defined as competencies. While it can imply a number of concrete skills, community membership is essentially a characteristic or quality. Competencies

have been defined as things that people are able to do that can be objectively measured. A more flexible, less traditional definition of "competency" is required to fit a flexible, less traditional field.

A concrete example of the difficulty of using a traditional framework for describing the competencies of CHAs comes quickly to hand from our surveys and interviews. Based on our past experience working with CHAs and on informal field testing, we knew that using the word "competencies" in the interviews and survey would not produce useful data. Therefore, we chose to ask about "qualities" and "skills and abilities," concepts we knew would be more commonly understood. In the survey, we asked two separate questions, one about qualities and the other about skills. We made the mistake of not defining our terms, which results in some mixing of the concepts on both questions. In the interviews and discussion groups, we initially asked about "qualities and skills" at the same time, to allow respondents to answer in their own terms. Overwhelmingly, throughout the U.S., in both urban and rural areas, the majority of the initial responses concerned qualities and not skills. So we probed further, specifically requesting skills, which we defined as "things that people are able to do because they have learned." And still participants tended to emphasize qualities over skills.

Table 6
Qualities of CHAs Rated as "Very Important"

Quality	% Respondents
Commitment to serve community	87.5
Is a caring person	86.8
Respected by peers in the community	78.6
Shares values and experience of the people being served	71.2
Member of the community being served	66.9
Bilingual/bicultural (in communities where English language is not dominant)	66.5
Seen as a leader by community	36.7

(n respondents = 281)

There are at least two possible explanations for this emphasis on qualities. One is that because of their generally disempowered position within society and the health care system, CHAs do not recognize all the skills they actually possess. They are regarded by so many other health and social service workers as "unskilled" that they may have internalized this view and come to think of themselves as unskilled. Or alternately, CHAs may know what they are able to do, but not think of these abilities as "skills," per se. Both of these explanations are likely true to some extent.

Another explanation is that, because of the holistic, relational work that most CHAs are called on to do, adaptive qualities such as patience, a desire to learn and grow, and respect for the opinions of others are in fact among the "competencies" most needed in their work. This does not obviate the need for skills. It simply means that both kinds of competencies must be taken into account, though they may be used in different ways.

The information about "qualities" provided below will probably be most useful for the process of *recruiting and hiring* CHAs. The skills outlined below can serve at least two distinct purposes. First, they can be used to determine the basic content of CHA training and capacitation courses. (Other specific topics will need to be added based on the issues facing individual communities and the program focus.) Second, these measurable skills can serve as the basis for the development of the CHA certificate of competence, which is discussed at length in the chapter on career advancement of CHAs. The CHAs and supervisors who participated in our interviews and responded to our survey have provided valuable guidelines that, while by no means definitive, point the way toward a competency profile that is holistic and true to the nature of CHA work.

Qualities of Community Health Workers

In our survey, respondents were first presented with a list of seven qualities and asked to rate them as "very important," "somewhat important," or "not important" regarding the effectiveness of a CHA. The amounts and percentages of respondents rating the qualities as "Very Important" are presented in Table 6. All seven

qualities were rated as either very important or somewhat important by more than 50% of respondents. "Commitment to serve the community" was rated as very important by the largest percentage of respondents (87.5%). Compared to other qualities, "being seen as a leader by the community" was rated as very important by the smallest percentage of respondents (36.7) "Seen as a leader" was also the only quality that was rated "not important" by more than 10% of respondents. A total of 6.8% of respondents felt that the quality of being bilingual and bicultural (in communities where the English language is not dominant) is not important. Aside from these two qualities, no other qualities were rated as "not important" by more than 3% of respondents. Based on these data, we can conclude only that none of these qualities is unimportant when recruiting and hiring CHAs.

Table 7a
"What skills and abilities does a person need to have or develop in order to be an effective CHA?"

Quality	Frequency
Friendly/outgoing/sociable/personable/like people/ *llevarse bien con la gente*/able to develop rapport	82
Patient	56
Open-minded/non-judgmental	55
Possessing initiative or motivation/selfdirected/self starter/independent/hard worker/*activa*	50
Caring	44
Empathetic	44
Committed/dedicated	43
Respectful	41
Honest	39
Open/eager/able to grow/change/learn	31
Dependable/responsible/reliable	31
Compassionate	28
Flexible/adaptable	26
Desire to help people and/or community	24
Persistent	23
Creative/resourceful	23

*Ten spaces were provided for answers to this question; some respondents provided more than ten. Percents are not reported because of occasional double-counting of respondents.
(n respondents = 281*)

The open-ended survey question about "skills and qualities" needed by CHAs produced more revealing information. As noted above, many respondents gave responses to this question that fit our definition of "qualities." A list of the most frequent responses is provided in Table 7a. A constellation of similar qualities, including friendliness, sociability, and the ability to get along with people, garnered the largest quantity of responses (82). Other qualities mentioned frequently by survey respondents included patience, open-mindedness, and initiative.

The consistency between the qualities included in Table 7a and the qualities mentioned by interview participants was notable. Thus, the interview data allow us to better understand what survey respondents meant when they mentioned certain qualities and, to some extent, why these qualities are important.

Interview participants (especially CHAs) agreed that CHAs need to be *friendly and outgoing*. A CHA from Michigan defined a friendly person as "the kind of person, [when] you walk into a grocery store and you see them, they'll say, 'Hello!'" The CHA felt that this quality was necessary since many of her clients are shy and would not approach the CHA. A CHR from the Laguna Pueblo stressed the importance of friendliness in building a helping relationship. "[You have to] put aside a bad morning, put on a smile, and be friendly. Only in that way [are clients] going to feel better about having you there."

CHAs and supervisors from around the country emphasized that CHAs must be *open-minded and non-judgmental*. "Some issues we might not personally like," said a teen peer counselor from New Orleans, "but we still have to understand." Several program administrators noted that, once people assume the CHA role, they must be willing to relate to community members with whom they did not previously associate. If CHAs are perceived as judgmental, interview participants told us, they will not be able to develop the kinds of trusting relationships essential to many of their roles.

The words *committed* and *dedicated* came up often in our discussions about the qualities of CHAs. Most often, participants mentioned the need for a commitment to the community in which one works. One Washington, D.C. outreach worker stated definitively, "If you don't have [commitment], there is no place for

you in this work." A *promotor de salud* from Oregon felt that a commitment to the community is something CHAs can develop in the course of their work. Tori Booker, a Program Coordinator with the Midwest Migrant Health Information Office, feels that CHAs also need to be committed to the philosophy of the program in which they are working.

Willingness and ability to grow, change and learn was another quality mentioned frequently in our interviews. A *promotora de salud* described this quality as "the ability to make changes when it is necessary, as much in one's personal life as in the family and at work."[14] One Seattle outreach worker stated that CHAs should not just be willing to grow; they should have "the *need* to grow." And another *promotora* felt that a CHA should have, "a mind for changes, positive changes in both the system and the community."[15] When CHA programs capitalize on this willingness to grow, changes in CHAs' personal and family lives can be one of the measurable outcomes of CHA programs.

Although they stated it in a number of ways, both CHAs and supervisors agreed that CHAs need to possess *initiative and a capacity for independent work.* "You have to want to do a good job to be good at it," said a teen peer counselor, echoing a common sentiment. Some CHAs stated that a high degree of motivation is necessary because of the many institutional and personal barriers they have to overcome in their work. (The same reason was given for the need for the qualities of creativity, resourcefulness, and persistence.) Motivation and self-direction are also necessary because, CHAs cannot be closely supervised. "The advocates are out in the field all day," stated one CHA supervisor. "I don't know what they are doing really. I mean, I do go on visits occasionally, but they could be at the mall, going to McDonald's, having tea at Nordstrom's. I don't know." In order to be effective, CHAs must be able to work independently.

Interview participants also agreed that a *desire to help individuals and the community* is a necessary quality for a CHA. For various youth and adult CHAs with whom we spoke, their motivation comes from a desire to help others avoid difficulties and situations they themselves have experienced. A generalized concern "about the community, about what is going on and wanting to do something about it," was mentioned as important by a Mississippi CHA.

Only two qualities not found in Table 7a were mentioned frequently in our interviews. These qualities were community membership and personal health and strength. We suspect that community membership was not mentioned because it was explicitly included among the possible responses to the previous survey question. In the interviews, CHAs defined community membership variously as living in the community, wanting to be in the community, and coming from the community. CHAs also described the relationship in terms of shared experience with community members. "[We] need to have lived, to have experienced what the community has lived."[16] Others stated that CHAs should be sensitive and accountable to the community.

An intimate relationship to the community in which one works has various results. "[As] an outreach worker, you come from your community and people look at you as a model," stated a community organizer from Seattle. Another result is a knowledge of community needs. "[We] are in the same area and the same level as the people we are helping," said Gracie Camarena. "We are not coming . . . from these high offices, you know, telling them what do you need, or what can I help you with. . . We know what they need because we've been there. Probably we are still there."

Definitions of "community membership" varied among different groups of respondents. The most important fault line divides urban CHAs and administrators from those working in rural areas. While rural programs tend to define community membership strictly as being of the same race/ethnicity and class as community members, urban programs and their staff generally place less importance on community membership as such, and more on the ability to relate cross-culturally, fit into one's surroundings, and use appropriate language. This position is well-stated by Pat Norman, Executive Director of San Francisco's Institute for Community Health Outreach.

"We do not see [CHAs] as natives with innate skills. We see them as professionals who have skills that enable them to be culturally competent so that they can work with diverse communities. For instance, certain sex industry workers may need a woman outreach worker, or new immigrants may need someone who is a

fluent speaker of their language. But gay/lesbian Asian Americans may be more comfortable talking to someone from outside their community because the outreach worker may know their families."

This comment was echoed by an African American outreach worker from Connecticut, who said that Latina clients sometimes prefer to work with her rather than with a Latina worker. Other urban CHAs gave other examples of instances where they were able to work effectively across cultures. The Research Advocates from the Birth to Three Program must have "something in their background . . . that allows them to directly relate to . . . clients." But that something may be the experience of being a recovering alcoholic; clients are not assigned to advocates on the basis of race/ethnicity in the Birth to Three Program.

Table 7b
"What skills and abilities does a person need to have or develop in order to be an effective CHA?"

Skill/Ability	Frequency
Communication skills (general and speaking skills)	192
public speaking skills	
conflict resolution skills	
ability to use appropriate language	
interviewing skills	
Listening skills/attentiveness	173
Knowledge about health issues and/or the health care system	72
Writing skills	63
ability to fill out forms	
ability to write reports	
ability to keep records	
Ability to identify and access resources	54
Capacity-building skills	54
leadership skills	
empowerment skills	
Cultural sensitivity/ability to work with diverse classes and cultures	52
Bilingual skills	50
Knowledge about the community	48
aware of needs, problems, issues, dynamics	
Organizational skills	44
ability to set goals/priorities	
ability to plan	
time-management skills	
Preparation/being well-trained	36
Ability to maintain confidentiality/discretion	31
Ability to work in a group/as a team member	30
Clinical skills	27
ability to take vital signs	
ability to recognize signs of illness	
ability to administer first aid	
Networking/coalition-building skills	22

*Ten spaces were provided for answers to this question; some respondents provided more than ten. Percents are not reported because of occasional doublecounting of respondents.

(n respondents = 281)*

The explanation for this different emphasis is fairly obvious. Rural CHAs tend to work in isolated, homogenous communities. The majority of community members in a given rural program may be immigrants from just three or four Mexican states. The situation in most urban areas is vastly different. The Outreach Workers at Seattle's People of Color Against AIDS Coalition (POCAAN) work with clients who are Native American, African American, Latino, Anglo, as well as other races/ethnicities. It is simply impossible for a given outreach worker to work only with people of his or her race/ethnicity, even were that desirable, which, as the statements above show, it sometimes is not. Another shared characteristic may be more important to the CHA's relationship with clients than his or her race/ethnicity.

As is typical of CHA programs, divergent emphases have their roots in the different realities of diverse communities. Thus, while it seems clear that an intimate relationship with the community is vitally important if CHAs are to be effective in many of their roles, the particular aspects of this relationship will necessarily differ, depending on the characteristics of the community.

The final quality that many CHAs, supervisors, and administrators feel contributes to CHA effectiveness is personal health. By this, they mean that in order to carry out work that can be extremely demanding and often frustrating, CHAs need to be able to call on reserves of personal strength and courage. Strength is necessary

because of the situations CHAs face. "There are times that you go and you visit [people] and they have a big problem," said a CHA from Shelby, Michigan. "The [CHA] has to be strong to listen to them and not sit down to cry with them."[17] Another CHA from Anthony, New Mexico, said something strikingly similar. "[You have to be] in a good mood [because] sometimes we arrive at homes where the families are crying and we have to make ourselves strong."[18]

Other CHAs stressed the need to remain calm in the face of harassment from clients or community members. "[You] must have a healthy attitude and strong self-esteem," said an outreach worker from Seattle, "because you are going to get people who want to curse you out, you got people who want to jump you, you got people that are going to flip you out, people who are going to walk away, and you cannot." A similar sentiment was expressed by a teen peer counselor. "[Sometimes] you might get a person . . . and they might be having a bad day and . . . they might try to take it out on you, but you've got to understand and hold your peace, you know?"

A final aspect of the strength and health CHAs need is the ability to stand up for who they are and what they believe. An outreach worker from POCAAN stated it this way: "[You] have to have a lot of courage . . . not so much about being in physically threatening areas as having the courage to speak up in your respective community that you are a gay person, a lesbian person." Personal health, strength, and courage allow CHAs from around the country to provide support for community members, withstand intimidation, and promote cultural sensitivity and understanding.

Core Skills of Community Health Advisors

The same question that produced the "quality" responses provided in Table 7a also elicited a list of skills and abilities needed by CHAs. This list is found in Table 7b. Frequencies in this table should be compared to those in Table 7a to obtain an idea of the relative frequency of qualities versus skills and abilities. Far and away the largest group of responses can be categorized under the term, "communication skills." If all responses corresponding to this category were grouped together, they would account for 363 out of the 833 responses reported in the table. This category includes the sub-categories of speaking skills, listening skills, writing and literacy skills, and bilingual skills. Other prominent categories include "Knowledge about health issues and/or the health care system," "Ability to identify and access resources," and "Capacity-building skills," (which include empowerment and leadership skills). As mentioned above, we cannot report between-group differences for these responses.

Once again, there is marked correspondence between the responses to this survey question and the responses to the similar question used in our interviews and discussion groups. Based on both the qualitative and quantitative data, and with input from this Chapter's Working Group and the Study Advisory Council, we have developed eight "skill clusters" necessary for CHAs working in a variety of situations. These are presented graphically in Figure 1 and explained in detail below.

1) Communication Skills. The emphasis our interview participants placed on the importance of a variety of communication skills can hardly be overstated. This emphasis crossed boundaries of geography, race/ethnicity, location, health issue focus, age, and role in program (i.e. CHAs vs. supervisors and administrators). Virtually all respondents agreed that in order to work effectively as a CHA, people need good communication skills.

The first kind of communication skills CHAs need is *the ability to listen.* Listening skills were seen as essential for a variety of functions. They are necessary for providing social support, as a teen peer counselor noted: "[Everybody] don't need lectures. You know, everybody don't want you to comment, they just want you to be there to listen. . . . So sometimes you have to try to hold back your comments and just listen to the whole issue." The ability to listen also helps CHAs build the helping relationships that are crucial to their success. "You have got to know how to start relationships," said a Washington, D.C., CHA. "If you don't know how to listen, people will see through you and they will decide you don't have their best interest in mind." Finally, listening skills are essential for assessment. To be able to assess, CHAs often must "listen beyond" the immediate problem. "The problem may not be, 'Oh, my head just hurts," says a Michigan CHA. "It may be

something else that is making it hurt and you have to sit there and listen and then you kind of figure out what is going on."

Along with the ability to listen, CHAs also need *the ability to use language confidently and appropriately.* The most important aspect of this skill is being able to speak the language of the community, both literally and figuratively. CHAs in Washington, D.C., and Seattle stressed the need to know the appropriate "slang or code words" and be able to "express that in really quick terms with people chilling out, like thirty seconds sometimes to talk." Being able to "answer questions on their feet" was also seen as important by an urban program director. Rural CHAs, working in a different atmosphere, tended to state simply that CHAs need to be able to talk to people, and be willing to talk to people they don't know.

In some programs, being able to speak the language of the community means speaking a language other than English. In a number of rural programs where almost all clients are Spanish-speaking, fluency in English is not a program requirement. In general, participants agreed that while *bilingual skills* are always an asset and certainly facilitate networking with other agencies, they are not necessary in all situations. It is more important that CHAs be completely fluent in the language spoken by the majority of their clients.

The importance of *written communication skills* was rated more prominent in the survey than in the interviews, perhaps due to the greater percentage of supervisors in the survey sample as opposed to the qualitative sample. There was some agreement, however, that CHAs need to be able to read and write well enough to document activities, which usually means filling out forms. Pat Norman, Executive Director of the Institute for Community Health Outreach in San Francisco, which counts "ethnographic skills"[19] among the skills needed by CHAs, believes CHAs need to be able to "translate what they do into good field notes." Norman adds that "if workers' literacy levels are low, they can give information to a supervisor on tape or in person." For CHAs to move into administrative positions within their programs, additional literacy skills, such as the ability to write reports and grant applications, are necessary.

2) Interpersonal Skills. Clearly, the line between "qualities," which can be enhanced but not taught, and "skills," which are things people know how to do because they have learned, is a fine one; occasionally it is invisible. This is the case with many of the "skills" in the Interpersonal Skills cluster. Many of the "qualities" listed in Table 7a could be termed "interpersonal skills." Most obviously, the qualities of *friendliness and sociability* are also interpersonal skills. Several other types of skills emphasized by our interview participants fall into this category. The first are *counseling skills,* which include the ability to develop rapport and maintain confidentiality. The listening skills included under the previous category also are clearly essential for providing informal counseling.

A number of other interpersonal skills needed by CHAs can be grouped together under the heading *relationship-building skills.* These include the ability to gain or develop trust, the ability to make people feel comfortable, and the ability to "meet people where they are." Qualities such as being open-minded, non-judgmental, respectful, empathic, and compassionate enhance one's ability to build relationships.

Two additional types of interpersonal skills were seen as essential for CHAs: the ability to work as a team member and the ability to work appropriately with diverse groups of people. While the latter skill is especially important for urban CHAs who of necessity will work with clients from many cultural groups, the ability to understand and respect a variety of perspectives also is essential to CHAs' role as mediators between communities and the health care system. Qualities closely related to this skills category are respect and open-mindedness.

3) Knowledge Base. According to CHAs and their supervisors, CHAs need three types of knowledge in order to be optimally effective. First, CHAs need broad *knowledge about the community.* This involves an understanding of community norms, needs, problems, issues, and dynamics. Some urban CHAs used the term "street smarts" to describe the sort of community knowledge CHAs need. While most participants assumed that CHAs should come to their work with a knowledge of the community, at least one program administrator felt that community knowledge could be acquired.

CHAs also need *knowledge about specific health issues.* Obviously, to some degree the type of knowledge needed will depend on the focus of the program. CHAs who work primarily in maternal and child health will need knowledge about prenatal care, nutrition, breast feeding, infant care, and other areas. The need for specific knowledge was stressed by a *promotora* from Anthony, New Mexico. "If I go to a person who has problems with diabetes," she stated, "and I want to talk to her about her questions, within my limitations I must be well-informed."[20] A teen peer counselor from New Orleans also emphasized the importance of having good information. "[When] somebody comes to talk to you . . . you can't just tell him anything; you've got to be educated and tell him the smart thing." If CHAs do not know the answer to a question, they need to be able to admit it and consult appropriate sources to find an answer. The ability to find information may be the most important skill of all, since once CHAs develop trust with clients, they will inevitably be asked about a wide variety of issues.

Finally, CHAs need *knowledge of the health and social service systems.* This knowledge enables CHAs to mediate between communities and systems, and assure that people receive the services they need.

4) Service Coordination Skills. The first of the service coordination skills is *the ability to identify and access resources.* It is dependent on the knowledge of service systems just mentioned. At its most basic level, this means knowing what services are available, where they are located, when they can be obtained, and who is eligible. But CHAs also need to develop an active referral network, and this involves *the ability to network and build coalitions.* A first step in building a referral network is to go to the agency and introduce themselves. Next, CHAs must maintain "open communication with other service providers to explain [their] role . . . so that there isn't this sense of territory issues or walking over people's boundaries" (Beth Gengler, Birth to Three). Appropriate use of a referral network depends on CHAs understanding the limitations of their own role, and when they need to make referrals to other providers. Given the tenacity of the problems many clients face, the paucity of services, and the barriers to obtaining services that often exist, the qualities of creativity, resourcefulness, and persistence enhance CHAs' ability to access resources and build networks.

Finally, good service coordination depends on *the ability to provide follow-up.* Providing follow-up can be as simple as returning phone calls, or as complicated as sticking with clients despite opposition and hostility. Inconsistency among family members and service providers has made many of the clients with whom CHAs work wary of trusting people. Therefore, "if you promise someone you will get information, you need to do it," said a *promotora* from Anthony, New Mexico.

5) Capacity-Building Skills. In order to help individuals and communities take more control over their own health and their lives, CHAs need a variety of capacity-building skills. One sub-category within this cluster can be defined as *empowerment skills.* Empowerment is related to assessment in that, as a first step in the empowerment process, CHAs must be able to help people identify their own problems. Many CHAs emphasized the need to "work with the ideas of the people," and "the ability to . . . not arrive and say, 'Well, you are going to do this, this and this because I know more than you.'"

Empowerment is related to assessment in that, as a first step in the empowerment process, CHAs must be able to help people identify their own problems. Many CHAs emphasized the need to "work with the ideas of the people,' and 'the ability to . . . not arrive and say, 'Well, you are going to do this, this and this because I know more than you.'"

Along with identifying problems, CHAs need to work with clients to identify strengths and resources. This requires that CHAs view clients as capable people, and not as victims. Having identified problems and resources and developed an action plan, CHAs must then walk the "fine line between enabling and empowering," according to one CHA supervisor. Walking this line involves setting limits and refusing to be manipulated. Finally, in the words of a CHA from New England, CHAs must know when to say, "Okay, I've actually helped this family enough, and if I proceed to help them anymore, I'm going to hinder their growth instead of helping them to grow." The ability to identify problems and strengths and then help enough but not too much are essential skills for the empowerment process.

Other skills essential for capacity-building are *leadership skills*. Consonant with Heifitz' model of leadership presented above, leaders need to be able to influence communities to face their problems and then mobilize them to deal with these problems. According to Marshall Ganz, a community organizer who worked for many years with Cesar Chavez and the United Farmworkers and who now teaches at Harvard's Kennedy School of Government, leaders move their followers from disorganization to organization by exercising six skills: the ability to strategize, the ability to motivate, the ability to build relationships, the ability to deliberate and interpret experience, the ability to create an action program, and the ability to accept responsibility. Interestingly, four of the seven qualities of leaders mentioned by Ganz also figure prominently among the qualities of CHAs: a sense of humor, imagination, empathy, and courage. Ganz also stresses the importance of listening skills for leaders; the same is true for CHAs (Ganz, 1997). What all this seems to suggest is that CHAs are aptly fitted for leadership.

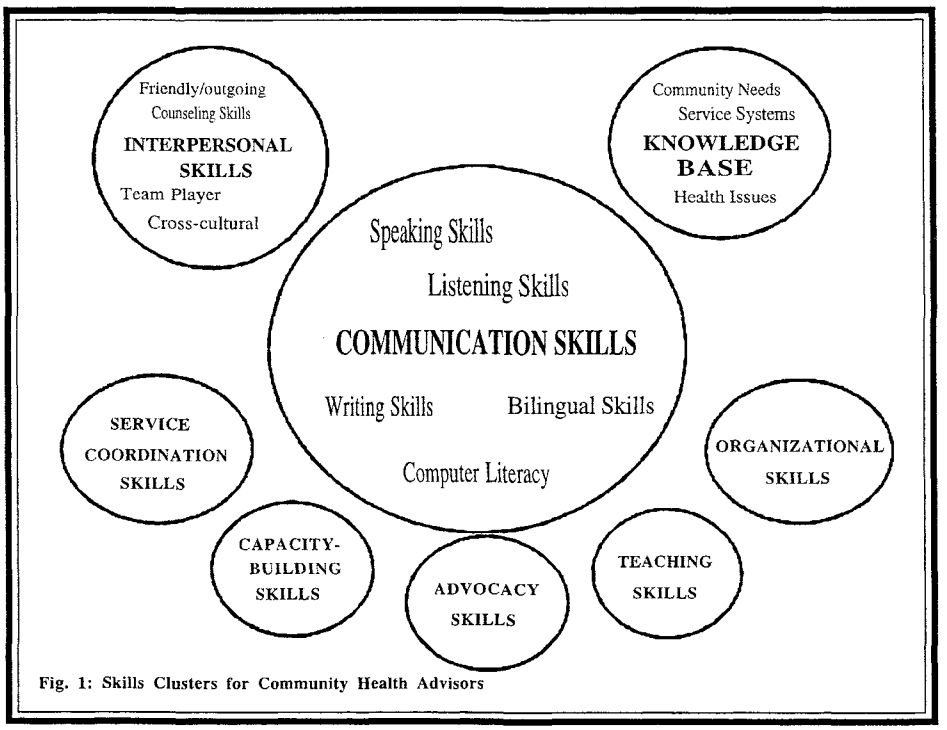

Fig. 1: Skills Clusters for Community Health Advisors

6) Advocacy Skills. Many of the qualities mentioned under the category of personal strength and courage also are valuable advocacy skills. Perhaps the most important is the *ability to speak up for communities and individuals and to withstand intimidation*. Communication skills such as the *ability to use language appropriately* also are essential for effective advocacy. Finally, advocacy requires persistence and the *ability to overcome barriers*. "When we are with a client and run into a brick wall at some other agency or situation," stated a Research Advocate from Seattle, "our job is to find a way to get around that brick wall."

7) Teaching Skills. Because they share education in a variety of settings, CHAs require a variety of teaching skills. In order to provide education in the context of home visits, CHAs need to be able to share information one-on-one, respond to questions about a variety of topics, admit it when they do not have the answer, find the requested information, and bring it back to the client. This kind of education is closely related to counseling in that much depends on the ability to build a trusting relationship.

To teach effective health education classes, CHAs must master the content of the class and then develop a plan for sharing it. An effective lesson plan will include an initial assessment, from which the CHA will learn how much participants already know about the topic. In a Popular Education class, the initial assessment also serves the purpose of building self-efficacy by showing participants that they already know a great deal. The lesson plan will incorporate various interactive methods such as brainstorms, games, skits, and role plays. CHAs need to understand something about the nature of learning and retention to understand why these methods work better than traditional lectures. The lesson plan will conclude with some review and an evaluation of what worked and what did not work. The CHA will use this evaluation to continuously improve the quality of his/her classes. Other skills useful in this context are the ability to make participants feel at ease and motivate participation by all group members.

Many of these same concepts and skills are important for large group presentations, either in the community or at conferences. But in addition, CHAs must be able to speak confidently in front of a large group and use techniques — such as cooperative learning and skits — that are well-suited to large groups.

*8) **Organizational Skills.*** The final skills cluster that arose from our qualitative and quantitative data was organizational skills. According to those who participated in our discussion groups and interviews, organizational skills important for CHAs include the ability to set goals and develop an action plan. CHAs also need to be able to juggle priorities and manage time wisely. "They have small caseloads in the greater scope of the world," stated a CHA supervisor. "But one of these clients could take 40 hours a week."

Discussion

For this chapter of the Study we conducted a review of the national and international literature about CHAs and qualitative and quantitative research to determine the core roles of CHAs with associated functions. We defined seven core roles of CHAs with associated functions. Our definition of competencies included both qualities and skills because both were seen as vitally important by CHAs and their supervisors. Within the competency section, we grouped the necessary skills into eight skill clusters with related abilities.

A number of other studies of the roles and competencies of CHAs are currently being conducted or have recently been completed The consistency of results from these studies strengthens the belief that, despite the wide variety of CHA programs, there is a core of roles and skills that cross programmatic, geographic, racial/ethnic, and other lines. Where do we go from here?

Standards of Practice

Some of the future work indicated by the current research already is underway. Growing out of a two-day task-analysis (DACUM) workshop conducted with 12 experienced CHAs, staff from the Community Health Training and Development Center (CHTDC) (formerly the Community Health Worker Training Program) based at San Francisco State University and City College of San Francisco currently are developing a standards of practice manual for CHAs in California. This manual will define both competencies and proficiency criteria. Such proficiency criteria or "performance indicators" clearly are needed; having identified the skills CHAs need, we now must identify or develop ways to build these skills and then measure them.

Once ways of measuring the competencies have been developed, it will be possible to take another step. In a somewhat naturally occurring experiment, changes in the effectiveness of programs that choose to implement and measure the competencies can be compared to programs that do not. Obviously, in order to carry out such an experiment, it will be necessary to determine baseline effectiveness criteria, so that *changes* in effectiveness can be measured.

Characteristics of Effective Programs

One additional area for further research suggests itself. Individual CHAs may have a clear understanding of their roles and possess an exemplary set of skills and qualities. But if the program in which they work is

ineffective, not supportive, or lacking in leadership, CHAs' effectiveness will be impaired or even negated. Therefore, we need to look beyond the characteristics of effective CHAs to the characteristics of effective programs. Valuable direction in this enterprise can be gained from Chait et al., who studied boards of trustees *as a group* rather than as a collection of individuals.

Multi-issue Programs

Based on data we collected, we can identify two essential program characteristics: *multi-issue programs and flexible scheduling for CHAs*. The first was aptly expressed in the World Health Organization's 1987 statement:

"The debate over whether these workers should be multipurpose or concerned with single issues is *no longer relevant*. If CHAs are to be vehicles for primary health care they cannot restrict their activities to single issues. However, diversity in the ideal range of activities of a multipurpose worker must not lead to the tasks expected of them being left ill-defined (WHO, 1987)." (Emphasis added.)

Lagging the international scene by several years, the CHAs and CHA advocates who participated in the Study appear to have reached a consensus that categorical CHA programs (i.e. programs funded to deal with a specific health issue) are unrealistic at best and counterproductive at worst. Therefore, to make optimum use of CHAs' skills, programs need to be structured and training programs geared to take advantage of CHAs' ability to do holistic health promotion.

Flexible Scheduling of CHA's Time

The second program characteristic that clearly makes CHAs effective is flexibility in scheduling. The need for flexible schedules came through in our survey, our interviews and discussion groups, and in the focus group conducted by the University of New Mexico's Division of Community Medicine. The reason was stated succinctly by a participant in the UNM focus group: "people don't get sick on schedule." Because of their commitment to their communities, most of the CHAs with whom we spoke are willing to work odd hours. "Always I make my time sheet Monday to Friday," stated one Boston outreach worker, "but maybe Saturday and Sunday I'm doing home visit without pay and I have tried to cut this out but I can't because people for me is important so if I can't see people during the week I'll try to see during the weekend." Other CHAs talk about the obvious impossibility of telling a client who is in crisis that "I'm sorry, I've already done my 40 hours this week."

To truly increase access to care, CHAs need to be available to clients outside the boundaries of a nine to five workday. This requires that programs make allowances for flexible schedules and occasional overtime. It also requires that supervisors strive to understand the realities in which CHAs work. When CHAs come into the office at ten o'clock, supervisors should not immediately assume that they are late. Some clients are available only in the early morning hours, and the CHA may well have been at a home visit since seven a.m. This is an example of how supervision based on a trusting relationship, rather than on strict control of activities, allows CHAs to be optimally effective.

"Community Health Advisors are skilled and knowledgeable health care workers who make unique and valuable contributions to protecting and improving the health of underserved communities."

Core Training and Continuing Education

There are other ways in which programs and supervisors need to *listen to CHAs* in order for them to make their greatest possible contribution to the health of their communities. A core curriculum based on the skills outlined here should provide CHAs with a good grounding for their work. But many programs have found that, once initial training is completed, CHAs themselves are the authorities on what additional training they need. This was the case in Oregon's *El Niño Sano* program. The program's mission was to increase access to well-child care, so initial training focused on teaching the *promotores* to conduct the screening tests for a well-child check. But once the *promotores* began to work in the community, they quickly realized that many other problems were affecting children's health, problems like parental depression, alcoholism, and domestic violence. The *promotores* began to request training on these issues as well. Responsiveness to their requests made the *promotores* not only more effective, it also increased their sense of ownership over and dedication to their program. This in turn contributed to retention of the *promotores* in the program.

Clear Role Definition and Boundaries

Community Health Advisors are skilled and knowledgeable health care workers who make unique and valuable contributions to protecting and improving the health of underserved communities. Yet much of their effectiveness depends on the way that their role is conceptualized and put into practice. The role must be crafted so as to take advantage of their intimate understanding of community norms and realities and their holistic and thoroughgoing approach to health. This means clearly defining their role and then respecting that definition, so that they are not constantly called on to do work that does not utilize their full range of skills and knowledge. It also means not limiting the role to more prosaic activities such as making referrals and conducting screening tests. In 1992, Harlan et al., warned of the tendency to emphasize some parts of the CHA role while forgetting others. "Unfortunately, the view of the LHA role as empowering to the communities involved often is lost and its value is reduced to that of improving 'compliance' or saving money" (Harlan, Eng & Watkins, 1992).

Working with Communities Benefits All

CHAs have tremendous potential to help cut health care costs by providing or facilitating accessible, appropriate health care and education, by teaching the medical system how to "work smart" with patients from underserved communities, and by helping clients learn to use the medical system so that their needs are met and undue costs are not incurred. But the true "value added" in the CHA model comes when CHAs are allowed and encouraged to work with communities to address the major determinants of health. Only people with an intimate understanding of the community can mobilize community members to take more control over their own health. As health care workers who combine an intimate understanding of communities with knowledge of health issues and the health care system, CHAs are uniquely suited for this crucial role.

Goal I: To Define CHA Core Roles and Competencies

Recommendation I.1) Adopt and Refine CHA Core Roles and Competencies

We recommend the adoption of the following core roles and competencies by those working in the CHA field. We also recommend that practitioners and researchers further refine and validate these roles and competencies.

Recommendations

The following recommendations are based on data from three sources: interviews and discussion groups conducted with Community Health Advisors (CHAs), CHA supervisors and program administrators, a survey

of CHAs and CHA supervisors, and feedback and suggestions from the Core Roles and Competencies Working Group of the Study's Advisory Council. (For more information, see *Chapter Two: Study Methodology.*)

Recommended Roles of Community Health Advisors

The following roles were identified as encompassing the most important functions that CHAs carry out within their communities and within the health care system. Each role is followed by the functions which correspond to it. Not all CHAs play all the roles. The specific roles they play depend on the unique needs of the communities where they work. We recommend that these roles be used in concert with a community needs assessment when designing CHA programs. CHAs can use these roles to explain their work to those outside the field. The roles also can be used for policy development in the CHA field.

I. Bridging Cultural Mediation Between Communities and the Health and Social Service Systems
- A. Educating community members about how to use the health care and social service systems
- B. Educating the health and social service systems about community needs and perspectives
  1. changing the services which the system offers
  2. changing the way in which services are offered
  3. changing attitudes and behaviors
- C. Information gathering
- D. Interpretation and translation

II. Providing Culturally Appropriate and Accessible Health Education and Information
- A. Teaching concepts of health promotion and disease prevention
- B. Helping to manage chronic illness
- C. Training other CHAs

III. Assuring that People Get the Services They Need
- A. Case-finding
- B. Making referrals
- C. Motivating and encouraging people to obtain care
- D. Taking people to services
- E. Providing follow-up

IV. Providing Informal Counseling and Social Support
- A. Providing individual support and informal counseling
- B. Leading support groups

V. Advocating for Individual and Community Needs
- A. Acting as spokespersons for clients
- B. Acting as intermediaries between clients and the health and social service systems
- C. Advocating for the needs and perspectives of communities

VI. Providing Direct Service
- A. Providing clinical services
  1. administering basic first aid
  2. administering screening tests (i.e. heights and weights; vision, hearing, and dental screening; blood pressure; temperature; blood glucose)
- B. Meeting basic needs (i.e. assuring that people have the basic determinants of good health, such as food, adequate housing, clothing, and employment)

VII. Building Individual and Community Capacity
- A. Building individual capacity
- B. Building community capacity
- C. Assessing individual and community needs

Recommended Competencies of Community Health Advisors

These competencies include both the *qualities* and the *skills* that CHAs need in order to be effective. We define *qualities* as "personal characteristics that can be enhanced but not taught," while *skills* are "things which people know how to do because they have learned." Competencies do not correspond directly to roles; rather, many competencies are useful in playing a variety of roles.

Qualities of Community Health Advisors

We recommend that the following list of qualities be used by program staff when recruiting and hiring CHAs.

1. Relationship with the community being served (i.e. a member of the community and/or possessing shared experience with community members)
2. Personal strength and courage (i.e. healthy self-esteem and the ability to remain calm in the face of harassment)
3. Friendly/outgoing/sociable
4. Patient
5. Open-minded/non-judgmental
6. Motivated and capable of self-directed work
7. Caring
8. Empathetic
9. Committed/dedicated
10. Respectful
11. Honest
12. Open/eager to grow/change/learn
13. Dependable/responsible/reliable
14. Compassionate
15. Flexible/adaptable
16. Desire to help the community
17. Persistent
18. Creative/resourceful

Skills of Community Health Advisors

Capacity-building programs for CHAs should provide opportunities for developing and enhancing the following skills. Some basic level of competency in these areas should be a prerequisite for formal certification as a CHA. Each skills cluster is followed by the specific abilities that fall within that cluster.

I. Communication Skills

- A. Ability to listen
- B. Ability to use language confidently and appropriately
- C. Ability to speak the language of the community being served
- D. Ability to document work

II. Interpersonal Skills

- A. Friendliness and sociability
- B. Counseling skills
  1. ability to develop rapport
  2. maintain confidentiality
- C. Relationship-building skills
  1. ability to gain or develop trust
  2. ability to make people feel comfortable
  3. ability to "meet people where they are"

D. Ability to work as a team member
E. Ability to work appropriately with diverse groups of people (i.e. cross-cultural sensitivity)

III. Teaching Skills

A. Ability to share information one-on-one
B. Ability to use appropriate and effective educational techniques
C. Ability to plan and conduct a class or presentation
D. Ability to respond to questions about a variety of topics
E. Ability to find requested information and bring it back to the client

IV. Knowledge Base

A. Knowledge about the community
B. Knowledge about specific health issues
C. Knowledge of the health and social service systems

V. Service Coordination Skills

A. Ability to identify and access resources
B. Ability to network and build coalitions
C. Ability to make appropriate referrals
D. Ability to provide follow-up

VI. Advocacy Skills

A. Ability to speak up for communities and individuals and to withstand intimidation
B. Ability to use language appropriately
C. Ability to overcome barriers

VII. Capacity-Building Skills

A. Empowerment skills
   1. ability to help people identify their own problems
   2. ability to work with clients to identify strengths and resources
B. Leadership skills
   1. ability to strategize
   2. ability to motivate
   3. ability to build relationships
   4. ability to deliberate and interpret experience
   5. ability to create an action program
   6. ability to accept responsibility

VII. Organizational Skills

A. Ability to set goals
B. Ability to develop an action plan
C. Ability to prioritize
D. Ability to manage time wisely

Examples/Next Steps:

The list of core roles can be used in concert with a community strengths and needs assessment when designing CHA programs. It also can be used to explain CHA work to those outside the field. Finally, it can be used for policy development in this field.

We recommend that program staff use the list of qualities when recruiting and hiring CHAs. We encourage supervisors, trainers, and co-workers to find ways to value and enhance these qualities.

Training programs for CHAs should provide opportunities to develop and enhance the skills we have identified. Some basic level of competency in these areas should be a prerequisite for formal certification as a CHA.

Endnotes

[1]A "convenience sample" is a subset of a larger group that is chosen because it is easily accessible.

[2]unit of observation: the group from which we collect information

[3]qualitative methods: methods such as interviews and observation that attempt to capture the *quality* of an experience or situation rather than its *quantity* (which is captured with quantitative methods, such as surveys.)

[4]A variety of studies of the competencies of certain groups have used qualitative methods similar to our own. Notable among these is Chait and colleagues' 1993 study of the competencies of effective Boards of Trustees of institutions of higher education (Chait et al., 1993). Specifically, our Study is similar to the Chait study in that we relied heavily on *those currently in the field* to tell us what competencies they need to carry out their work.

[5] frequencies: simple counts of the data

[6]"*Los doctores no van a las casas y a escucharlos.*"

[7] "*. . . si la partera no puede sacar un tipo de información, algo que le preocupa a ella de un paciente, nos dice y nosotros somos las intermediales y si lo logramos.*"

[8] "*Un ambiente de Educación Popular es donde todos sabemos mucho, donde a todos se nos valora porque tenemos buenas ideas, un ambiente donde nos vamos a enriquecer nosotros y luego vamos a enriquecer a la comunidad. Es una manera especial de trabajar con la comunidad.*"

[9] "*[Porque] lo que se pudo curar en casa, si no se atiende, puede ocasionar gastos mayores al sistema de salud.*"

[10] "*Y luego le digo yo, 'estás tomándote las pastillas para el diabetes y haces bastante trabajo piscando y por eso te tiembla el cuerpo, porque te baja el azucar y tienes que comer algo. Carga todo el tiempo contigo un dulce, un peanut butter and jelly sandwich, orange juice or apple juice'. . . Y así le digo, ¿verdad? 'Y todo el tiempo carga algo para que comes cuando sientes así en el labor.' Y si, si lo hace.*"

[11] "*. . . han habido casos de gente que no puede pagar su renta o el teléfono, entonces buscamos donde pueden ayudarla.*"

[12] "*A veces uno les ofrece tambien . . . de hacerles la cita si ellos no quieren hacer la cita. Uno mismo hacerles la cita . . . Conseguirles transportación y a veces traerles uno mismo.*"

[13]instrumental support: support expressed through concrete acts of assistance such as washing dishes or buying groceries; it is contrasted to emotional support such as listening or accompanying.

[14] "*la habilidad de hacer cambios cuando sea necesario, tal como en la vida personal y en la familia y tanto como en el trabajo*"

[15] "*una mente de cambios, cambios positivos tanto entre el sistema y an la comunidad*"

[16] "*Necesitamos haber vivido, haber experimentado lo que ha vivido la comunidad.*"

[17] "*Hay veces que vas y los visitas y tienen un problema bien grande . . . Tiene que ser fuerte la persona para oirlas y no sentarse a llorar con ellas.*"

[18] "*[Hay que] estarse en buen humor [porque] a veces llegamos a casas . . . donde están las familias llorando y tenemos que hacernos fuertes.*"

[19] ethnographic skills: "the ability to get to know a community from the perspective of its members" (ICHO)

[20] "*Si yo voy a una persona [que] tiene diabetes y yo quiero hablarle de . . . las preguntas, dentro de mis limites tengo que estar bien informada.*"