Developing an Action Learning Community Advocacy/Leadership Training Program for Community Health Workers and Their Agencies to Reduce Health Disparities in Arizona Border Communities

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ABSTRACT

Community health workers (CHWs) make unique and important contributions to society. They serve as patient advocates, educators, and navigators in our health care system and a growing body of research indicates that they play an important role in the effective delivery of prevention and treatment services in underserved communities. CHWs also serve as informal community leaders and advocates for organizational and community change, providing valuable insiders' insights about health promotion and the interrelatedness of individuals, their community, its institutions, and the surrounding environment. Accíon Para la Salud or Action for Health (*Acción*) is a CDC-funded community-based participatory research (CBPR) project addressing the social determinants of health affecting health-related behaviors with the ultimate goal of creating a model in which community advocacy to address the systems and environmental factors influencing health is integrated into the role of CHWs working in chronic disease prevention. Kingdon's three streams theory and the social ecological model provide an overarching conceptual framework for Acción. The curriculum and training are grounded in the theory and principles of action learning, which emphasizes learning by doing, teamwork, real-world projects, and reflection. The curriculum was delivered in four workshops over thirteen months and included longitudinal

team projects, peer support conference calls, and technical assistance visits. It is now being delivered to new groups of CHWs in Arizona using a condensed two-day workshop format.

Keywords: community health workers, community advocacy, action learning, training, social ecological model, health disparities

INTRODUCTION

The term Community Health Workers (CHWs) describes a diverse group of community health aides and advocates who are trained and work in the communities in which they live (Lehman & Sanders, 2007). They typically share the same culture, race/ethnicity, language, and socioeconomic status as the people they serve, and often see themselves as leaders in their communities (Sabo, Ingram, Reinschmidt, Schachter, Jacobs, Guensey de Zapien, Robinson, & Carvajal, 2013; Viswanathan, Kraschnewski, Nishikawa, Morgan, Honeycutt & Thieda, 2009). CHWs working in Mexican American communities along the Southern Arizona border, as well as in many other Latino communities, are also called Promotores de Salud, Spanish for "Health Promoters". Promotores de Salud (often shortened to "Promotores" or when solely women in these roles, "Promotoras") are typically bicultural, bilingual or monolingual Spanish speaking, health workers who serve as a cultural bridge between their communities and the health care system. They are experts at recognizing cultural, linguistic, educational, social, and economic barriers to care and calling upon formal and informal community resources to overcome these barriers (Olney, Warner, Reyna, Wood & Siegel, 2007; Ingram, Reinschmidt, Schachter, Davidson, Sabo & De Zapien, 2011).

CHWs have long been a mainstay of primary health care delivery systems internationally. Their various roles have included serving as patient advocates, educators, and service providers in primary care settings; and as community outreach and education providers (Bhutta, 2010; Singh & Chokshi, 2013). CHWs are increasingly being recognized as important members of the U.S. health care workforce (Rosenthal, Wiggins, Ingram, Mayfield-Johnson & De Zapien, 2011). At the University of Arizona Prevention Research Center (AzPRC), we have a history of collaboration with community health workers (CHWs) and the agencies that employ them on chronic disease prevention. Nationwide, chronic disease is the most common health issue that CHWs work on, often through individual advocacy and health education (Ingram, Reinschmidt, Schachter, Davidson, Sabo & De Zapien, 2011). The project described in this article, Accíon Para la Salud or Action for Health (Accíon), was developed with a different focus than that more common model.

CHWs also have a tradition of service as community advocates, leaders, and change agents. These roles are closely tied to the concepts of social justice, human rights, and empowerment (Viswanathan, Kraschnewski, Nishikawa,

Morgan, Honeycutt & Thieda, 2009). CHWs are uniquely suited to be advocates, leaders, and change agents because they live in the communities they serve, have directly experienced or witnessed social injustice, and often have both the training and experience to navigate one or more levels of the social ecological model – i.e., the individual, interpersonal, organizational, community, society/policy, supranational/policy levels (Kok, Gottleib, Commers & Smerecnik, 2008). Kent and Smith (1967) attributed the role of "neighborhood organizer" to CHWs and described it as involvement in social action projects arising from mutually recognized community needs. In 1998, the National Community Health Advisor Study also identified community advocacy as a key role for CHWs (Rosenthal, Wiggins, Brownstein, Johnson, Borbon & De Zapien, 1998). In the literature describing specific CHW projects, researchers have recognized aspects of CHW organizational and community advocacy. For example, in their analysis of the implementation of an agency-based program for pregnant women, Beam and Tessaro (1994) noted the unrealized potential of its CHWs to empower the community to act for change. Witmer, Seifer, Finocchio, Leslie & O'Neil (1995), while embracing the importance of CHW involvement in the health care workforce, stated that CHWs could advance other social agendas by empowering communities to act.

Fittingly, CHWs see themselves as community advocates leaders, and change agents. In a survey of CHWs in Arizona, 63% of respondents reported being involved in some type of community advocacy at the federal, state, local and/or organizational level in the past 12 months (Ingram, Sabo, Rothers, Wennerstrom & De Zapien, 2008). Research demonstrates some CHW organizational and community advocacy and leadership successes. In Texas, CHWs promoted organizational change within a community clinic that increased access to care for a Latino community in Texas (Williams, 2001). In a Wisconsin public housing community, CHWs recruited and trained well-respected residents to serve as leaders and advocates for health and community issues with the result of higher levels of community engagement and participation following the intervention (Wolff, Young, Beck, Maurana, Murphy, Holifield & Aitch, 2004). After being trained in local politics, governance, advocacy, and community organizing; CHWs in Oregon formed racially/ethnically diverse groups of community members who engaged in community advocacy on important issues such as police and gang violence (Farquhar, Michael & Wiggins, 2005). These and other community advocacy and empowerment interventions share a common goal of improving conditions recognized by the World Health Organization as the social determinants of health (Felix, Burdine, Wendel & Alaniz, 2010), including environmental, educational, economic and access to care disparities within and between communities.

While CHWs may have several work roles and responsibilities, the literature is not very forthcoming on how, and with what curricula, they are trained for those roles (Koskan, Friedman, Brandt, Walsemann & Messias, 2012).

Two recent articles about CHW training provide some insights. In the first, a recent mixed methods analysis of 12 disease-specific training curricula, community advocacy, social justice, health equity, or systems thinking were not mentioned (Koskan, Friedman, Brandt, Walsemann & Messias, 2012). The authors did note that training was critical in preparing CHWS to provide health education and recommended more attention to readability levels of patient health information, early program evaluation, and feedback. In the second, Wiggins, Kaan, Rios-Campos, Gaonkar, Morgan & Robinson (2013) detail their more than 10 year experience training CHWs in multiple roles, including roles as change agents and community organizers; using a training philosophy and methodology informed by "popular education". The authors conclude that it is important for CHWs develop the skills to engage the community in identifying problems and root causes, and developing and implementing solutions (Wiggins, Kaan, Rios-Campos, Gaonkar, Morgan & Robinson, 2013).

In *Acción*, we sought to design a CHW-led intervention that targets the social determinants of health (Sabo, Ingram, Reinschmidt, Schachter, Jacobs, Guensey de Zapien, Robinson, & Carvajal, 2013) affecting health behaviors and overall well-being, with the ultimate goal of creating a model in which community advocacy to address the systems and environmental factors influencing health is integrated into the role of CHWs working in chronic disease prevention. In this paper, we describe the CHW community advocacy/leadership training curriculum we developed toward that ultimate goal.

KEY THEMES INFORMING THE DEVELOPMENT OF THE ACCÍON TRAINING PROGRAM

We relied on two overarching concepts in developing Acción's training thematic content – the social ecological model, which underscores the need for CHWs to address systems and environmental influences on community health; and Kingdon's three streams theory, which provides a framework for how they might do so.

Social Ecological Model. Health can be viewed as a function of both the individual and the environments in which that individual lives. These environments or ecosystems typically start at the level of the individual and expand outward – adding levels, e.g., interpersonal, organizational, community, society, and supranational. Depending upon the authors and the context, the names of the levels may vary from one model to the next; though the underlying meaning – that there are multiple levels of influence, which can act on an individual and on which an individual can act, and that the levels are interconnected and affect each other – does not. The interconnectedness of higher levels of influence described in the social ecological model can also be described as systems thinking. The social ecological model and systems thinking are powerful concepts, helping learners shift their focus from the prevailing ideas of individual responsibility and behavior change to the societal and environmental (sociocultural and physical) forces influencing health, and making an a priori case

for the importance of community advocacy, leadership and empowerment. Baker, Bouldin, Durham, Lowell, Gonzalez, & Jodaitis (1997) note the interconnectedness of many factors affecting the lives and health of individuals and the community, and stress the importance of CHW programs taking a holistic and ecological approach to encourage more complete and integrated health services.

Kingdon's Three Streams Theory. When CHWs operate within the social ecological model to influence the social determinants of health; Kingdon's three streams theory provides an important theoretical basis for the role of community advocacy and CHWs in policy change. Kingdon proposes a conceptual framework for the policy process in which he describes three largely independent, yet overlapping streams – problem, policy, and political (Kingdon, 2003; Oliver, 2006). Kingdon's "problem stream" includes the issues presented to policy makers, which are identified and defined by indicators (or data) describing a particular problem, public opinion on an issue, feedback on the effects of existing programs, and/or dramatic events increasing awareness about an issue. The "policy stream" includes the ideas generated about an issue by experts, academics, and policy makers. Community members may also develop policy ideas as experts on their conditions and needs. The "political stream" includes those factors favoring, or not, the implementation of a specific policy – e.g., national or local mood, the level of opposition and its influence, and administrative or legislative turnover (Kingdon, 2003).

Kingdon posits that policy change is most likely to occur when conditions in all three streams are favorable, which he calls an open "policy window" (Kingdon, 2003). Would-be change agents can attempt to open policy windows and/or use those that have opened to influence policy change. In planning *Acción*, we fit Kingdon's theory to our local context by recognizing that CHWs trained in advocacy and leadership could potentially take on meaningful roles in all three streams to help open policy windows and/or use those that open to influence policy change. For example, a CHW might conduct a community survey to identify issues of concern to her community in the problem stream, hold a community forum to work on possible solutions in the policy stream and develop a stakeholder group to present a proposal for change to the local jurisdiction in the political stream.

Action learning. While the social ecological model and Kingdon's three streams theory provided an overarching conceptual framework and guided thematic content selection and development, the execution of the curriculum was based on adult learning principles and an educational model known as "action learning". Adult learning emphasizes active learning, participatory learning, and applied knowledge. Action learning adds challenging real world projects that participants accomplish individually or in teams away from the classroom, just-in-time learning to aid project accomplishment, and self and team reflection. (Raelin, 2006) In contrast to traditional learning, which can be described as the individual

acquisition of new concepts, action learning arises from the interactions and questioning that take place among learners as they work together to resolve complex and unfamiliar problems (Raelin, 2006). Leadership development programs in the U.S. and internationally, including the public health sector, are increasingly employing the action learning model (Leonard & Lang, 2010).

CURRICULUM DEVELOPMENT

Acción curriculum development began with the formation of a training committee composed of academic partners, community-based program managers, and experienced CHW educators and trainers. Early on, committee members articulated four key principles for our curriculum development: (1) the need to address social and environmental determinants of health to eliminate health disparities in chronic disease; (2) the importance of empowering communities to identify and address their health-related issues; (3) the unique role of CHWs as informal community leaders and advocates for health; and (4) the critical importance of community engagement in social and environmental change.

In addition, the training committee made two decisions that influenced curriculum and program development throughout the project. The first was to identify available, culturally appropriate community advocacy and leadership training resources to build upon. To that end, we surveyed our training committee members and reviewed the literature for relevant advocacy and leadership curricula in current use. We identified thirteen curricula and resource materials based on their apparent strengths in leadership skills, engagement of CHWs or community members, and interactivity (See references) We used seven evaluation criteria to analyze the curricula – cultural relevance, interactivity, replicable materials, skill-building modules, advocacy framework, leadership framework, and evaluation tools – and developed four to six indicators for each criterion. With these indicators, we evaluated each curriculum's content and used the results to guide which activities and exercises to choose for the workshops. Table 1 outlines the steps the training committee took in developing the program.

Table I: Program Development Methods Used by Training Committee

	Steps:
1	Collected and reviewed existing advocacy curricula and selected for relevance
2	Developed "best practices" criteria to evaluate curricula in seven different categories
3	Rated eleven selected curricula from 1-5 in each of those categories with "1" being the lowest and "5" the highest score
4	Developed six "core competencies" and key knowledge, skills, and abilities for each
5	Created binders with "best practices" activities and resources for all six core competencies
6	Met face-to-face to plan every workshop using binders as a resource
7	Prepared materials, made assignments, and facilitated four workshops
8	Sought and used feedback from participants at the end of every workshop to help plan successive workshops
9	Made "partner" visits to the organizations, CHWs, and supervisors participating in the workshops to encourage participation, introduce new concepts and tools, and consolidate knowledge
10	Phased in monthly CHW Peer Support Conference Calls for participating CHWs and one facilitator to provide social support and encourage the free exchange of ideas through discussion of successes and challenges

The second was to develop core competencies for community advocacy and leadership to help structure the training. We used the results of our aforementioned curriculum analysis as well as our committee members' pooled knowledge and experiences in their development. For each competency, we included a simple question to enhance accessibility and a brief listing of critical knowledge, skills, and abilities (KSAs). Table 2, in Training below, lists the six core competencies, the simple questions, and the KSAs.

TRAINING
Acción training partners. Seven health agencies self-selected to participate in Acción. Three agencies use the CHW model as key to their chronic disease prevention and control efforts. Participating agencies were located in three geographically distinct communities along the Southern Arizona border and included three community health centers, one county health department, and two community-based organizations. Two to three CHWS from each agency (16 CHWs total) participated with their immediate supervisors. We paid each agency a percentage of each participating CHW's salary to support the integration of community advocacy and leadership into the CHW's daily activities,
Acción training implementation. We delivered the *Acción* curriculum through four workshops, agency-specific activities or projects, peer support

conference calls, and technical assistance visits. The four workshops were spaced over 13 months – three in the first six months and the fourth approximately seven months later. In each workshop, our goal was to recognize and build on preexisting and previously covered KSAs while "teaching" relevant new KSAs in appropriate core competencies. Table 2 shows in which workshops each core competency was delivered.

Table 2: Training program advocacy/leadership core competencies

Core competency	Representative question	Knowledge, skills, abilities	Delivered in
1. Identifying community values, culture, and leadership styles	Who are we and who is our community?	Self-care, values and culture, leadership styles, personal growth, and recognizing diversity within community	Workshops 1& 2
2. Identifying community needs and issues	What does our community want?	Identifying issues, resources, and assets; and systems thinking	Workshops 1, 2 & 3
3. Developing a shared vision	How do we start?	Visioning, planning, and engaging the community	Workshops 1& 2
4. Identifying and maintaining community partners	Who do we need to work with?	Identifying partners and coalition-building	Workshops 2 & 4
5. Skills building and tools: advocacy and leadership	How do we make our community vision a reality?	Advocacy/leadership, media skills and methods, research, and implementation	Workshop 1, 2, 3 & 4
6. Celebration and evaluation	How do we know it worked?	Evaluation, quality improvement, and recognizing and honoring partners	Workshop 3 & 4

Workshops were participatory and activity oriented. CHWs were recognized as experts in their field and encouraged to participate. They were given progressive homework assignments leading to the eventual development and implementation of individual or team advocacy projects in their organizations or communities. CHWs presented and discussed their assignments at successive workshops and during technical assistance visits conducted by bilingual AzPRC faculty and staff after the third workshop. CHW learning and skills acquisition was further encouraged through the use of monthly CHW Peer Support Conference Calls beginning about two-thirds of the way through the training

program. Participating CHWs, a bilingual student facilitator, and an occasional guest were the only invited participants.

  <u>Acción training curriculum</u>. The finalized *Acción* training curriculum is available on the AzPRC website and can be downloaded in English or Spanish under the heading Acción Para La Salud at: http://azprc.arizona.edu/resources/curricula

  <u>Acción sample activities</u>. Below, we briefly describe several training workshop activities and their connection to *Acción's* overarching conceptual framework. A more complete description of each activity including all materials and handouts is available in English or Spanish using the aforementioned curriculum link:

  Community wall. This activity, which was adapted from the Kellogg Foundation's Building Community Toolkit Basic History Wall Exercise is an exercise in creating a shared vision of a community's history and developmental milestones (Kellogg Foundation, 2008, in Curriculum Training Resources). Participant teams identified historical events and cultural characteristics that defined their communities, and strengths and challenges that could influence their advocacy efforts. Competencies 1: "Who are we and who is our community?" and 2: "What does our community want?" were addressed with this exercise. One team discussed the role of mining in the cultural and economic development of the community and the effects of its closing, a second team reflected on the history of agriculture and the experience of the migrant worker in their community. And a third team examined the growth of the fast food industry and its influence on health. In this exercise, participants demonstrated the ability to critically reflect upon historical antecedents and their effects on health; thus advancing their knowledge of Kingdon's problem stream, the social and environmental determinants of health (the social ecological model), and the need for effective community advocacy.

  Who has the power? For this activity, participants were asked to read their local newspapers, listen to the news, etc., to identify the individuals in their communities who were empowered to make or influence decisions. The purpose of this activity was to help participants identify loci of power and influence as well as reflect on how community members can empower themselves to influence policy and politics – two of Kingdon's three streams. One team identified the political influences in a current effort to overturn a statewide initiative to support early childhood development, a second team analyzed anti-immigration legislation and how it might be reversed, and a third team reflected on the role of political corruption in their community and its impact on community engagement. In this exercise, participants demonstrated their ability to define the political stream and its impact on the policy process.

  The strategy map. This exercise was adapted from a methodology developed to guide and evaluate community-driven policy and environmental change initiatives as part of the Northwest Community Changes Initiative

(Zakocs, Dobson, Kabel, & Briggs, 2010, in Curriculum Training Resources). The strategy map tool helps users plan, evaluate, and communicate the policy, environmental, and/or systems change they wish to achieve in their community. It also helps them identify potential allies and opponents, and the steps needed to achieve the desired change. CHWs and their supervisors were introduced to the strategy map during our technical assistance visits about halfway through the training program. CHWs then used this tool to help choose, develop, and implement their individual and/or team advocacy projects. The action learning projects they pursued in their communities or organizations demonstrated their awareness of community needs, three streams theory, and the social ecological model. They included increasing clinic hours to accommodate the needs of a large migrant farmworker population, improving a rural community's public transit system, decreasing or prohibiting the sale of energy drinks to minors, increasing youth access to recreation programs, and improving a service network for victims of domestic violence.

EVALUATION

Training evaluation forms requested that each participant rate workshop activities and provide their thoughts about what was useful about the workshop, the influence of the training on how they thought about themselves as CHWs, and how what they learned might applied to their work. In the evaluations, CHW participants indicated through numerical ratings that they were generally quite satisfied with both the individual training activities and the overall workshops. On a scale of 1 to 4, with four being the highest score, the most frequent scores were 3s and 4s.

Some examples of written comments include the following CHW responses to a question on how their feelings about advocacy and leadership were influenced by Workshop 2, included: "It is important to know what you personally can advocate for what the community wants" and "To be a better leader for my community." CHW responses to the same question at the end of Workshop 3, included: "To know how to go fighting for an idea or rights of the community" and "Better equipped to advocate; I have more tools now."

We also conducted interviews with 14 of the original participants one year following completion of the training to better understand what aspects of the training CHWs found most useful, which tools they continued to use, and whether (and how) they used the training for their advocacy projects.

During those interviews, CHWs commonly referenced the *Strategy mapping* activity, as helping them develop clear advocacy goals. One stated, "I feel like [the strategy maps] gave me a guide. Because I had imagined my strategy more or less, but as it was reflected on paper and how it tells you step by step, how to break it down, in different categories, then it gives you the opportunity to see better the steps you have to take to follow first, after, and so forth, to be able to achieve your objective."

The *"Who has the power?"* activity was similarly cited by CHWs as helping them better understand how to address social and health inequalities in their communities. In the words of one CHW, "The [activity] that said, this is where the power is…when [the trainer] was showing us, I didn't understand very well, but then I began to analyze it, and well, it's true. You have to know what position everyone is in to be able to see where you need to go."

The relevance of Kingdon's policy stream was underscored by CHWs' common refrain on the importance of articulating policy solutions to achieve community advocacy goals with comments like: "Now I see more clearly that it isn't just to go and ask for things and yell and demand. Since [training] I have learned that one also has to bring solutions."

CHWs described moving from understanding to action – of becoming engaged in community and civic advocacy following the training. One CHW recounted her experience this way: "We began to go to the council meetings in [our city], and we went to the council meetings in [our county], and we made banners, we made signs, we went there and we began to invite people from the community so that they were also present and so that they realized the…type of problems that were happening."

CHWs also shared how they used their natural roles as leaders and advocates to encourage sustained community-based engagement. One CHW reflected on a community coalition that she had initiated by stating, "If I wasn't doing it; it wouldn't have gotten started. So, the role of the promotora (CHW) is to get it started so that the community takes the power and does it themselves."

CHW requests for additional training fell primarily within core competencies 5 and 6, and included learning more about how to change municipal policies, secure funding to support advocacy goals, analyze a representative example of a successful advocacy project from start to finish, and gain insight into the dynamics of a mature community coalition.

DISCUSSION

In past research, the AzPRC and many other groups have demonstrated the effectiveness of CHWs as health promoters/health educators working with individuals, families and groups in chronic disease prevention. From that research, both the need and the ability of CHWs to address structural and environmental barriers to healthy behavior became increasingly evident (Reinschmidt, Hunter, Fernandez, Lacy-Martinez, Guernsey de Zapien, & Meister, 2006). *Acción's* advocacy/leadership training program was developed in collaboration with community partners knowing that, to varying degrees, CHWs were already engaged in community and organizational advocacy and leadership; though they might not recognize it as such. Our training goals were to assist CHWs in improving the knowledge, skills, and abilities they needed to become more effective community advocates and leaders; to assist them and their organizations in integrating community advocacy and leadership into their work

in chronic disease prevention; and to help them develop and implement community or organizational advocacy projects. We have been encouraged by the progress we observed during the training workshops and our technical assistance visits, and by the feedback we received immediately after the workshops and in the interviews conducted approximately one year after the fourth workshop. We are also encouraged by the continued demand for the training, which two members of our AzPRC team are now delivering a condensed two-day format to CHWs around the state.

Training program challenges include identifying meeting times that worked for our very busy training committee members, identifying workshop dates that worked for participating CHWs and their organizations, finding funds for simultaneous translation, ensuring that all workshop materials were translated and available in both English and Spanish, and encouraging our very busy CHW participants to stay engaged in their community advocacy assignments between sessions. Weaknesses include the lack of long term follow-up, a self-selected organizational/participant pool, the inherent difficulties in measuring effectiveness of advocacy/leadership training programs, and the small sample size. Long term follow-up of participants in both the 13 month and the condensed training could offer additional insights regarding effectiveness.

CONCLUSION

Individual advocacy and health education are important roles for CHWs. However, though they are not by themselves sufficient to eliminate the pervasive health disparities affecting residents of underserved minority communities. There is growing evidence that CHWs trained in community advocacy and leadership can help their communities more effectively confront underlying systems and environmental causes. In this work, we have shared the conceptual foundations of our *Acción* training model's framework, and those themes and models guiding the full curriculum's development and implementation. In *Acción*, we have shown that CHWs engaged in chronic disease prevention can, with training, demonstrate the use of community advocacy and leadership competencies in their work roles. We encourage CHW employers, both public and private, to consider similarly training and empowering their CHWs.

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