# Lay Health Advisor Intervention Strategies: A Continuum From Natural Helping to Paraprofessional Helping

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## INTRODUCTION

When a population is described by the public health profession as *hard to reach*, it often means people who are hard for health care providers to find, meet, talk with, and, consequently, serve. The articles that appear in this special issue are about a particular intervention strategy to connect communities with a health care system that has been perplexed about how to reach and serve them.

The seemingly straightforward task of determining where hard-to-reach, at-risk communities live can be a challenge for professionals. Finding Latino farmworkers, for example, requires countless hours and miles of driving to locate migrant camps. For a breast cancer screening program to identify rural households with African American women 50 years of age and older, a significant budget is needed to conduct a door-to-door census. Sophisticated technology and consideration of confidentiality issues are required to geographically map a computerized database of addresses for those testing positive for a sexually transmitted infection. School policies and regulations surrounding parental consent may thwart professionals' attempt to identify and contact sexually active adolescents.

It can be equally difficult for professionals simply to meet with hard-to-reach communities in their natural settings. This requires flexible schedules to work evenings and weekends in order, for example, to visit people when they are home; to get on the agenda of the Ladies Missionary Society, which meets "every third Wednesday evening of the month"; or to interact with migrant farmworkers at the one place and time they gather socially—a Sunday flea market. Some settings, however, are less open to professionals or any outsider and, hence, require great sensitivity and attention to issues of privacy and safety. An older woman at home alone or with her young grandchildren would be less

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likely to respond to an unexpected knock on her door or an unfamiliar voice on the phone. In neighborhoods where some residents are undocumented workers or engaged in illegal activities, the approach of an unknown vehicle could raise a reverberating alarm of suspicion.

Nevertheless, professionals who are able to meet with members of a hard-to-reach community may still find it difficult to hold meaningful discussions about health problems that those members fear, such as cancer, or that those members do not consider important, such as pesticide exposure. The problem of language can certainly make it hard for professionals. Yet, it is not only a matter of being fluent in the same language. Of equal importance is an understanding of a community's cultural context for health and illness as well as its history of interactions with the service delivery system. Lived memories of a segregated health system, for example, can exert a powerful influence on older African American women's decisions about seeking services. Hence, it can be hard for most professionals, whose past and current life experiences are distinctly different from those they are trying to reach, to elicit explanations for why things are the way they are.

## LAY HEALTH ADVISORS HELPING CONTINUUM

Certainly, not all professionals have a hard time finding, meeting, and talking with communities considered hard to reach. A growing number of professionals, however, are exploring the strategy of working through *lay health advisors* (LHAs) as a means for reaching such communities and establishing meaningful linkages to the service delivery system. LHA intervention strategies are the focus of this issue.

The basic definition of an LHA is an individual who is indigenous to his/her community and consents to be a link between community members and the service delivery system.[1] Examples of terms for LHAs used by health promotion and disease prevention programs are *community health advisors*, *community health workers*, *health aides*, *natural helpers*, *navigators*, *paraprofessionals*, *peer educators*, *promotores*, and *outreach workers*.[2] LHA intervention strategies, in general and as described in the articles in this issue, share the following principles of public health practice:

- A basic assumption is that a natural resource available in most communities is the existence of social networks through which community members offer and receive *social support* among one another.
- The role of the practitioner is to recruit, train, and support community members who can directly reach and offer social support (i.e., information, advice, referrals, emotional support) to those in need.
- The role of the recruited and trained community members is to serve as a bridge between agencies' formal service delivery system and communities' informal social support system.

Public health professionals are implementing LHA intervention strategies at such a fast pace that the Centers for Disease Control and Prevention has created a computerized public-access database of community health advisor programs throughout the United States and has published a two-volume directory.[3,4] The programs included in this directory are systematically reviewed in the Jackson and Parks article to examine the

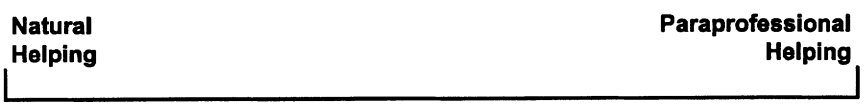


**Figure 1.** Continuum of lay health advisor helping.

methods used to recruit and train LHAs, particularly to reach African Americans. Jackson and Parks also include a historical perspective on LHA recruitment and training, providing a valuable reminder that the importance of indigenous support systems has long been recognized in public health.

Consequently, as time passes and the number of LHA programs accumulates, notable differences have emerged among LHA intervention strategies. We find it useful to conceptualize these differences arrayed along a continuum of informal to formal helping (see Figure 1).[2] At the formal end of the continuum is the *paraprofessional* LHA intervention strategy. These LHAs are extenders of the service delivery system, performing tasks that would normally be carried out by practitioners. Hence, paraprofessional LHAs must meet minimal qualifications (e.g., literacy level, bilingual, drivers license) and at the completion of training must demonstrate an acceptable level of standardized competencies to become a certified LHA. Since these LHAs are fulfilling a set of professional responsibilities, they are often paid by an agency and required to complete time sheets and reimbursement forms for expenses, such as mileage. An advantage for the paraprofessional LHA is the opportunity for employment and the possibility of career advancement. A disadvantage for the community is that the talents and accountability of paraprofessional LHAs are shifted to the service delivery system.

At the informal end of the continuum is the *natural helping* LHA strategy.[5,6] Natural helper LHAs are not paid by an agency and do not need to meet the qualifications set by an agency. Rather, the qualifications of a natural helper have been set by a community. They are specific individuals who have a reputation in their community for good judgment, sound advice, a caring ear, and being discreet. Their natural helping is so much a part of their daily lives that it is often not recognized by natural helpers themselves.[5] For the natural helping LHA strategy, the roles of the LHAs are (1) to assist people in their social networks with needs that cannot be met by the health system, (2) to negotiate with professionals for support from the health system, and (3) to mobilize the resources of associations in their community to sustain support from the health system.[2] The advantage is that the natural helping of these LHAs provides a community-based system of care and social support that complements the more specialized functions of health professionals. The disadvantage is that not everyone can be natural helper LHAs, requiring an agency to take special care in identifying and recruiting those specific individuals who are natural helpers.

## HOW THIS LHA SPECIAL ISSUE IS ORGANIZED

The articles in this issue reflect the full range of our continuum and are sequenced to demonstrate the fluidity of the differences. Jackson and Parks offer a mini–case study of

a natural helping LHA program that was pioneered by Eva Salber in 1973 in North Carolina.[1] They lay out the intricate steps involved in identifying, recruiting, and training natural helpers in a rural African American community. Twenty years later in the eastern part of the state, Earp et al. apply the natural helping LHA strategy in a large-scale demonstration research project to increase breast cancer screening among rural, low-income, older African American women. They describe five phases of implementation and discuss the evaluation strategies and tools to assess natural helping processes and impact.

The evaluation submitted by Booker et al. defines and assesses change in personal empowerment among LHAs themselves. They are migrant and seasonal farmworkers in Arizona, Florida, and New Jersey. Called *camp health aides*, they are connected to but not staff members of a migrant health center. Much of their role places them closer to the natural helping end of the continuum. Similarly, the qualitative work by Schulz et al. explores how LHAs themselves understand and experience the relationship between their role and a sense of self and community. Their role as African American *village health workers* in Detroit is to work with the health department as volunteers, not for the health department as paid staff. Emphasis was placed on recruiting individuals who are active in the life of their communities; some of whom may be natural helpers, but this was not essential.

Berkley-Patton et al. present the methods of and findings from a rapid formative evaluation of a youth LHA program that is based in a midwestern high school. To reach adolescents, the LHA strategy is an interesting combination of natural helping and peer counselling that can be formal (i.e., within a school setting) as well as informal (i.e., outside the school).

Moving closer to the paraprofessional end of the continuum is Baker et al.'s formative evaluation of a "collaborative LHA approach." Focussing on a Latino neighborhood in Massachusetts, two residents were hired by a public health coalition to work as full-time outreach workers. Their role was (1) to provide residents in need with education and information about community health and human service agencies and (2) to assist the community in navigating the rapid changes occurring in the service system. Finally, Love et al. conducted a survey of 197 health care agencies in eight Bay Area counties in California and found that 26% employ a total of 504 LHAs as frontline paraprofessionals. It is projected that 110 new positions will be created during the next three years. County health departments are the largest employers, followed by community-based organizations. The LHA skills most valued by agencies are multicultural competence, community outreach, and conflict resolution.

In sum, these seven articles provide compelling evidence for the range of helping that LHAs can give to a range of communities in a range of settings. Practitioners and researchers can move beyond debating what is or is not an LHA intervention or which is the best LHA intervention strategy. Rather, as evaluation findings from the various LHA intervention strategies are compiled, the field can move to making informed choices in selecting an LHA strategy that is most appropriate for the situation at hand.

## SPECIAL RECOGNITION

To our guest editorial board, we extend our sincerest gratitude. Their high-quality reviews of equally high quality articles made this issue possible. We also want to recognize the loss of a strong and dedicated voice for LHA programs in the United States. Robert

Lingafelter died in October 1996. Robert left with us the vision and legacy of his work with community health advisors in the Partners for Improved Nutrition and Health Project.[7] He contributed greatly to our knowledge of how to implement and evaluate LHA interventions.[8] His energy, creative skills, and unwavering commitment to reaching hard-to-reach communities will be missed profoundly.

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