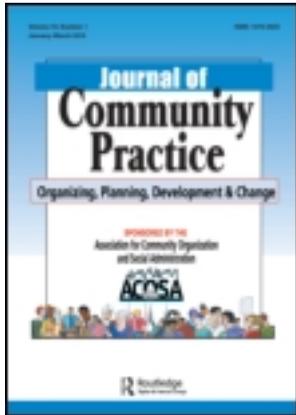


This article was downloaded by: [Noelle Wiggins]

On: 06 September 2013, At: 14:44

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Community Practice

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wcom20>

Preparing Community Health Workers for Their Role as Agents of Social Change: Experience of the Community Capacitation Center

Noelle Wiggins^a, Samantha Kaan^a, Teresa Rios-Campos^a, Rujuta Gaonkar^a, Elizabeth Rees Morgan^a & Jamaica Robinson^a

^a Multnomah County Health Department, Community Capacitation Center, Portland, Oregon

Published online: 05 Sep 2013.

To cite this article: Noelle Wiggins, Samantha Kaan, Teresa Rios-Campos, Rujuta Gaonkar, Elizabeth Rees Morgan & Jamaica Robinson (2013) Preparing Community Health Workers for Their Role as Agents of Social Change: Experience of the Community Capacitation Center, *Journal of Community Practice*, 21:3, 186-202

To link to this article: <http://dx.doi.org/10.1080/10705422.2013.811622>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

FROM THE FIELD

Preparing Community Health Workers for Their Role as Agents of Social Change: Experience of the Community Capacitation Center

NOELLE WIGGINS, SAMANTHA KAAAN, TERESA RIOS-CAMPOS,
RUJUTA GAONKAR, ELIZABETH REES MORGAN,
and JAMAICA ROBINSON

*Multnomah County Health Department, Community Capacitation Center,
Portland, Oregon*

Current efforts to better integrate Community Health Workers (CHWs) into the health and social service systems are promising, but may be less effective if they fail to support the role of CHWs as social change agents. The way CHWs are trained influences the roles they play. In this article, we review the literature on CHW training and summarize lessons learned to date. We describe how the Community Capacitation Center in Oregon uses a combination of content, methodology, and values to prepare CHWs to make an optimal contribution to health. Recommendations for CHW training programs and policy makers are provided.

KEYWORDS *Community organizing, community capacity building, grassroots leadership, social change, social justice, community building*

We would like to recognize Samantha Kaan for her special contributions to this article.

The opinions expressed here are those of the authors and do not necessarily reflect the positions of the Multnomah County Health Department.

Address correspondence to Noelle Wiggins, EdD, MSPH, Director, Community Capacitation Center, Multnomah County Health Department, 10317 E. Burnside Street, Portland, OR 97216. E-mail: ninanoelia@msn.com

Community health workers (CHWs) are skilled community members who work with communities to improve holistic health and well-being through a variety of strategies (Rosenthal, Wiggins, Ingram, Mayfield-Johnson, & Guernsey de Zapien, 2011). A profession that is at once ancient and emerging, the CHW model has its roots in natural helping systems that have existed in all human communities throughout history (Jackson & Parks, 1997). In both the United States and the developing world, these systems became formalized in areas where large sectors of the population lacked health care and the conditions for good health (Wiggins & Borbón, 1998). As such, since their inception, CHW programs represent efforts to address and eliminate social and health inequities (Gonzalez Arizmendi & Ortiz, 2008).

Although CHWs in the United States today play multiple roles (Wiggins & Borbón, 1998), studies have suggested that CHWs' roles as community organizers and agents of social change are among their most important roles (Eng & Young, 1992; Farquhar, Michael, & Wiggins, 2008; Spencer, Gunter, & Palmisano, 2010). As trusted community members who also understand the health and social service systems, CHWs are uniquely placed to work with communities to address the social and structural determinants of health (Gonzalez Arizmendi & Ortiz, 2008; Ingram, Sabo, Rothers, Wennerstrom, & de Zapien, 2008; Wiggins & Borbón, 1998). CHWs share with social workers "a common value base of social justice; client and community empowerment; and commitment to culturally appropriate, effective, and sustained change" (Spencer et al., p. 169). Current efforts (spurred largely by the Affordable Care Act of 2010) to better integrate CHWs into the health and social service systems are welcomed by CHWs and their advocates, who have been working for such integration for more than 40 years (Rosenthal, 1998). However, if current efforts lead to the CHW role being narrowly defined as increasing access to existing services, then the historic role of CHWs as community organizers who work for social justice could be lost (Rosenthal et al., 2011).

The content, methodology, and values of CHW training programs determine, to a large degree, the roles that CHWs will play and how they will play these roles. Although many CHWs come to training programs having already worked in their communities, the content to which they are exposed in training shapes their perceptions of what roles they should and should not play (O'Brien, Squires, Bixby, & Larson, 2009). Because people tend to teach as they were taught (Lortie, 1975), methodology is also of crucial importance. If trainers take a top-down, hierarchical approach, then most likely, so will the CHWs they train. Finally, whether intentionally or unintentionally, training programs communicate and inculcate values. If trainers do not value the life experience that CHWs bring to training, including cultural traditions and worldviews, then CHWs will be less likely to draw on this crucial knowledge as they work in their communities and to validate this knowledge in other community members.

For over 10 years, the Community Capacitation Center¹ (CCC) at the Multnomah County Health Department in Portland, Oregon, has used a combination of content, methodology, and values to train CHWs to play multiple roles, including roles as change agents and community organizers. The model the CCC has developed, an innovative partnership with local community-based organizations and higher education institutions, successfully prepares CHWs for multiple roles within communities and the health and social service systems, while staying true to the social justice underpinnings of the CHW profession. The model is based on popular education, a philosophy and methodology that seeks to create settings in which people who have historically lacked power can discover and expand their knowledge and use it to eliminate inequities (Wiggins, 2012). In this article, we first provide a brief overview of the history of CHW training programs and identify some principles and practices of effective CHW training. We then describe the history, current status, and outcomes of the CCC model, before concluding with general recommendations for CHW training. Our goal is to enable other training programs to adopt key aspects of our model so that they can, in turn, prepare CHWs to play a full range of roles, including roles as community organizers and agents of social change. By so doing, CHWs will be better able to assist communities to achieve health and social equity.

BACKGROUND

Training programs for CHWs and their progenitors have existed for more than 300 years. In Russia in the 17th century, lay people known as *feldshers* underwent a 1-year training program to prepare them to care for civilian and military populations (Fendall, 1976; Wiggins & Borbón, 1998). After the Chinese revolution in 1949, lay people who came to be called *barefoot doctors* were trained to provide healthcare in fulfillment of Mao's promise to bring care to rural areas (Fendall, 1976; Wiggins & Borbón, 1998). In the 1970s and '80s, church groups and popular organizations throughout Latin America trained *promotores de salud* (health promoters) to provide basic health care and raise consciousness about the roots of ill health (Capps & Crane, 1989; Wiggins & Borbón, 1998).

In the United States, documented examples of CHW training programs date to the 1960s (Wiggins & Borbón, 1998). For many years, most US CHWs were trained on-the-job within their own programs. Eighty-three percent of

¹ The word *capacitation* is derived from the Spanish *capacitación*, which means, "the process of building capacity." We use *capacitation* in preference to the word *training*, which to us signifies a top-down process that does not acknowledge, draw out, or build on the knowledge and skills that all adults bring to any educational situation. In this article, we use both words interchangeably.

survey respondents in the 1998 National Community Health Advisor (NCHA) Study reported that they had received their training on the job (Rosenthal, Wiggins, Brownstein, & Johnson, 1998). On-the-job training, although practical and relatively easy to provide, had many drawbacks, both for CHWs and their employers. First, it conferred no credential or academic credit, and thus was not portable when CHWs moved from one organization to another. A lack of standardization meant that employers could not count on CHWs having a consistent set of skills and abilities. In many cases, insufficient time was provided for CHWs to learn complex skills. Finally, CHWs trained in individual programs lacked the peer networks that all professionals need (Love et al., 2004). The limitations of on-the-job training led, in the early 1990s, to the creation of training centers where CHWs from around a geographic area could come together to participate in training, professional development, and networking. This trend was endorsed in 1998 by the CHW-led Advisory Council of the NCHA Study (Rosenthal et al., 1998).

National studies of the CHW field have identified principles and practices of effective CHW training programs. As well as endorsing regional training centers, the NCHA Study recommended conferring academic credit for training, providing paid on-the-job training, developing standard training curricula, and providing training for CHW supervisors (Rosenthal et al., 1998). Based on the first 10 years of their experience providing a college certificate program for CHWs, staff at San Francisco's Community Health Works highlighted the value of a core curriculum, the use of performance-based evaluation methods, and the incorporation of popular education (Love et al., 2004). The CHW National Education Collaborative (CHW-NEC), in which the CCC participated, identified addressing multiple learning styles and use of adult learning methods and popular education as promising practices related to curriculum design (CHW-NEC, 2011). An evaluation conducted on behalf of the National Heart, Lung, and Blood Institute reaffirmed the importance of skill-based (as opposed to disease-specific) training and the use of adult learning methods and popular education (Calori, Hart, Tein, & Burren, 2010). As we show in the following, many of the recommendations of these national studies have been put into practice at the CCC.

CHW TRAINING AT THE COMMUNITY CAPACITATION CENTER

The model used at the CCC for building CHW capacity is based on lessons learned by program staff in a variety of settings over the course of more than 20 years. In this section, we describe the process that led to creation of the current model, the role of popular education at the CCC, how the CCC works with other organizations that employ and support CHWs, and outcomes associated with CHW training at the CCC.

Development and Content of the CCC Curriculum

The groundwork for the CCC's curriculum and approach was laid between 1990 and 1998, during which time the CCC's two founders (the first and third authors) were employed by a CHW program serving migrant and seasonal farmworkers, involved in the previously mentioned National Community Health Advisor Study, and exposed to models such as the Community Health Education Center (CHEC), located in Boston, Massachusetts. Foundational elements of the CCC's eventual model that were developed during this period included the use of popular education; the provision of academic credit through partnerships with institutions of higher education; the practice of involving experienced CHWs as trainers for new CHWs; and the practice of bringing CHWs together from multiple programs to network, develop solidarity, and provide peer support.

In 1998, the first author was hired by the Multnomah County Health Department (MCHD) in Portland, Oregon, to lead an expansion of the role of CHWs within MCHD's home visiting program for pregnant and parenting women and families. A stakeholder team at MCHD that included experienced CHWs identified the development of a training program as crucial to an enhanced role for CHWs. They were able to link to an existing effort to develop a training center led by the CHW Committee of the Oregon Public Health Association. The group engaged partners at community-based organizations that also employed CHWs, as well as staff from Portland Community College (PCC).

Pursuant to the recommendations of the NCHA Study (Rosenthal et al., 1998), the content of the CHW training curriculum was based on the eight skills clusters identified in the study, adapted to meet the unique needs expressed by CHWs working in multiple communities in the Portland metropolitan area. These skills clusters include capacity-building (e.g., organizing) skills and advocacy skills (Wiggins & Borbón, 1998). The curriculum is divided into three components: skill base, orientation to the health and social service system, and health issues. Following the model at CHEC in Boston, the curriculum development committee engaged content experts to develop individual class sessions. A day-long train-the-trainer session prepared consultant trainers to use popular education in their sessions.

Small-scale pilots of the curriculum were conducted in 1998 and 1999. In 2000, 12 CHWs newly hired into the home visiting program at MCHD participated in the full 240-hr curriculum, which took place over 6 weeks and conferred 16 hours of academic credit from PCC. In light of the difficulty for employed CHWs of engaging in 240 hours of training, the curriculum was subsequently scaled back and an 80-hr version of the curriculum was approved for academic credit by the Oregon State Board of Education in 2004. This curriculum served as the basis for all training series conducted

between 2004 and 2013; information about recent changes to the curriculum is provided below. Currently, academic credit can be provided through an agreement with Portland State University.

In 2001, the CHW Capacitation Center (subsequently renamed the Community Capacitation Center) was recognized as a special project of MCHD. The mission of the CCC is to support constituents both inside and outside the Health Department to develop the skills and knowledge they need to promote health and reduce health inequities by addressing the social and structural determinants of health. In addition to providing capacitation for CHWs and technical assistance for organizations that desire to establish or strengthen CHW programs, the CCC also conducts a variety of other activities in pursuit of this mission.

Methodology and Values of the CCC Curriculum

The philosophy and methodology that underpins CHW training at the CCC is popular education, also referred to as empowerment education and Freirian education. With antecedents going back more than 200 years (Bralich, 1994; Crowther, 1999), and informed by the work of educator/organizers like Paulo Freire and Myles Horton, popular education seeks to bring about more equitable social conditions by creating settings in which people can identify and solve their own problems (Wiggins, 2010).

Values such as compassion, discipline, and love for the cause of the people are at the heart of popular education (Caldart, 2004). Methods such as *dinâmicas* (social learning games), *sociodramas* (social skits), brainstorming, simulations, and problem-posing are important in popular education not only because they increase participation, but also because they embody the values of popular education and prefigure the type of society popular educators aim to create. A recent review of the literature suggests that popular education has been used successfully around the world to improve health and increase empowerment across a variety of levels (Wiggins, 2012).

Popular education and the CHW model grow out of similar historical roots and are based on many of the same principles. For example, both emphasize that the knowledge people gain through life experience can be just as useful as the knowledge gained through formal schooling, and that people affected by a particular issue or problem are the experts about causes of and solutions to that problem (Wiggins, 2011, 2012). Thus, popular education is an effective approach for preparing CHWs to fulfill their roles as agents of social change (Pinto, Bulhões da Silva, & Soriano, 2012).

Popular education has been used widely in the context of community organizing efforts (Chang, Salvatore, Lee, Liu, & Minkler, 2012; Martinson & Su, 2012; Sen, 2003). It has also been combined with organizing and

participatory research to create hybrid models (Castelloe, Watson, & White, 2002). The use of popular education supports an empowering approach to organizing, in which the goal is not just to achieve a high turnout for organizing actions, but also to develop organizing leadership and assure that organization members are genuinely involved in all stages of the organizing process (Gonzalez Arizmendi & Ortiz, 2008). Whereas organizing in the Alinsky tradition tends to use top-down, hierarchical teaching methods, use of popular education is consistent with feminist models of organizing and organizing models developed in communities of color (Gutiérrez & Lewis, 2012).

Sen (2003) has pointed out some of the advantages of using popular education for training community organizers. These include “greater engagement of participants in the material, more opportunities to build community among members, and more opportunities to raise participants’ confidence by stressing internal knowledge” (p. 105). Examples of community organizing efforts influenced by popular education include the Adolescent Social Action Program in New Mexico (Wallerstein, Sanchez-Merki, & Dow, 1999), efforts to organize immigrant restaurant workers in San Francisco (Chang et al., 2012), and the Women’s Institute for Leadership Development in Massachusetts (Sen, 2003).

To demonstrate how popular education is used to prepare CHWs at the CCC, we briefly describe a 3.5-hr class designed to enhance knowledge about public health. This class, like all CCC classes, begins with an introduction, during which facilitators welcome participants and review the agenda and objectives for the class. The introduction is followed by a *dinámica*, which aims to build trust among participants and which usually involves movement. Next, participants brainstorm the first thing that comes to their mind when they hear the phrase *public health* and facilitators provide a definition. This activity is followed by a simulation of “The River Story,” which contrasts medicine’s focus on curative care with public health’s focus on prevention. The reflection that follows provides an opportunity to introduce the three core functions of public health. After a break, participants work in pairs and play a game titled, “Players in the Public Health System.” Next, participants brainstorm examples of curative care, harm reduction, and prevention, and dialogue critically about the current distribution of health resources in the United States. Following a brief introduction to the concept of health promotion, participants work in cooperative learning groups. They read a story about a Latina immigrant woman who wants to control her diabetes but faces multiple environmental and social barriers. Addressing the balance between individual and societal behavior, they seek to answer the question, “Whose behavior needs to change?” A final major activity, conducted either in pairs or small groups as time allows, asks participants to identify a health problem common in their community and then develop a plan to solve it, using a

public health approach. The class ends, as do all CCC classes, with a group evaluation.

How the CCC Works With Other Organizations

Generally, other organizations come to the CCC when they are in the process of establishing a CHW program. Staff members at the CCC provide technical assistance regarding recruitment and hiring of CHWs, development of CHW job descriptions, and support and supervision of CHWs, as well as a variety of other issues. Based on the role that a particular organization envisions for its CHWs, staff from the organization and the CCC work together to design an initial training curriculum, selecting courses from the established curriculum and creating additional courses as needed. Initial training curricula can be as brief as 18 hours or as long as 240 hours; the length depends on the complexity of the work CHWs will be expected to conduct, availability of the CHWs for training, and the resources of the contracting organization. The CCC always recommends that organizations provide follow-up training for CHWs for as long as they continue to act as CHWs, and most organizations contract with the CCC to provide follow-up training. Since 1998, CCC staff members have designed and conducted multisession CHW capacitation series for a total of 30 programs and over 620 CHWs have participated in training. Nine programs have contracted with the CCC to provide multiple years of capacitation for their CHWs. We often dedicate substantial effort toward involving CHWs who have been trained during previous years as cofacilitators for courses in subsequent years. This practice concretely demonstrates the value we place on CHWs' skills, knowledge, and worldviews.

In the context of health care reform in Oregon, staff from the CCC has participated with the Oregon Health Authority Office of Equity and Inclusion and a wide range of stakeholders from around the state to create standards for CHW certification and approval of CHW training programs. Administrative rules that are temporary as of this writing create three inter-related pathways to certification for CHWs, one of which is participation in an 80-hr course at an approved training program. The temporary rules also identify desirable characteristics in training programs, such as use of popular education, employment of experienced CHWs, and active partnership with community-based organizations. Staff at the CCC has adapted our existing 80-hr curriculum to include all the competencies named in the temporary rules; a current list of all the courses included in the basic curriculum is provided in Figure 1. In addition, the CCC is helping to build capacity to train CHWs in other areas of the state by training trainers and licensing our curriculum to other programs. Like this article, those efforts seek to support CHWs around Oregon to play their historic role as agents of social change

Skill Base	Orientation to the Health and Social Service System	Health Issues
Assessing Individual and Community Needs	Access to Care	Addictions and Recovery
Communication Skills	Introduction to Public Health and Health Promotion	Disease Processes I and II
Community Organizing and Community Building Skills	Orientation to the CHW Role	Mental Health Promotion
Counseling Skills	Working with Multi-Disciplinary Teams	Role of Nutrition and Exercise in Promoting Health
Cross-Cultural Skills		Social Determinants of Health
Leadership and Advocacy Skills		
Outreach Skills		
Self-Care Skills and Trauma-Informed Care		
Service Coordination and Collaboration Skills		
Teaching Skills (Introduction to Popular Education) I and II		

FIGURE 1 Community Capacitation Center basic curriculum courses.

by assuring that training programs are equipped to share necessary content using effective methods.

Evaluation of the CCC Curriculum

The effectiveness of a CHW training program can, and should, be measured in a variety of ways. Objective assessment of CHW skill and knowledge development and participant satisfaction with training are important measures of CHW training programs. Also important are the perceptions of CHWs and supervisors about the impact of training on CHWs. Thus, after an overview of outcome evaluation of the CCC model, we share perceptions of partners at three different agencies about how CHWs have used their newfound skills.

Outcome evaluation. Participants in all CHW training sessions at the CCC complete a participant evaluation form, which assesses satisfaction with the session; strengths and weaknesses of the session; and variables that are of special interest to the CCC, such as the degree to which facilitators used popular education and included information about diverse cultures. Responses drawn from 1,007 participant evaluation forms collected since 2007 reveal that 95.13% of respondents feel their participation in CCC training increased their ability to promote health in their communities. Although acknowledging

the limitations of self-report measures conducted immediately after training, these results support the effectiveness of the CCC curriculum.

Two community-based participatory research (CBPR) studies have assessed the proximal and distal outcomes of the CCC's approach to training CHWs. *La Palabra es Salud* (The Word is Health) used a quasi-experimental design and mixed methods to compare popular education and conventional education as methods for increasing health knowledge and empowerment among parish-based CHWs. Two groups of new CHWs participated in a 14-week training course jointly designed by the CCC and the Parish Health Promoter Program, a partnership between Providence Health and Services and Catholic Charities' *El Programa Hispano* (The Hispanic Program). Trainers for one group used popular education (as defined by the CCC); trainers for the other group used conventional, lecture-based education to share the same content. Members of a Latino parish located on the other side of the metropolitan area served as controls.

Outcome variables were assessed before new CHWs began their training and immediately after the training was complete via a questionnaire. In addition, in-depth interviews and participant observation were conducted to understand changes associated with the two methodologies from the perspective of the participants. Although results derived from the quantitative data were equivocal (with members of both groups making statistically significant improvements in health knowledge compared to members of the control group), the qualitative data suggested broader and deeper increases in both empowerment and health knowledge among members of the popular education group. The integrated results suggest that popular education can help participants develop a deeper sense of empowerment and more multifaceted skills and understandings, with no accompanying sacrifice in the acquisition of facts and knowledge (Wiggins, 2010, in press).

Poder es Salud/Power for Health, a CBPR study funded by the Centers for Disease Control and Prevention, aimed to improve health and decrease health inequities in the Latino and African American communities in Portland, Oregon, through the intervention of CHWs who used popular education (Farquhar et al., 2005). In addition to initiating and managing this project and training the project CHWs, the CCC was the grantee and played a bridging role between two culturally-specific community-based organizations that employed the CHWs and academic partners based at two universities. In this project, CHWs chosen from subcommunities within the African American and Latino communities adapted a model for church-based community organizing described by Nash (1993). First, they identified existing groups within their communities or organized new groups. Using popular education, they worked with these groups to identify pressing health issues and explore the underlying social and structural causes of these issues. They then developed and implemented plans to address the prioritized health issues, which ran the gamut from violence affecting youth of color to diabetes to environmental

health and safety. Finally, they presented preliminary results of the research back to community members and involved them in analyzing those results.

Pre- and post-surveys with a random sample of members from participating communities revealed that the project was associated with statistically significant improvements in self-reported health status and decreases in depressive symptoms (Michael, Farquhar, Wiggins, & Green, 2008). Project CHWs expressed that their use of popular education contributed to increases in self-esteem, sense of personal potential, level of community involvement and participation, quantity and quality of leadership, and sense of community solidarity (Wiggins et al., 2008). A separate set of in-depth interviews explored the various roles that the CHWs in this project played and suggested that CHWs valued their multiple roles, including roles as members of the Community Steering Committee and community organizers (Farquhar et al., 2008). Although fraught with limitations, such as small sample sizes and inability to follow participants over time, these studies suggest that the popular education methodology used by the CCC, in combination with the content of the curriculum, equip CHWs to effectively promote health in their communities.

Reflections of our partners. CHWs who have participated in training at the CCC have reported using their newfound skills in a variety of ways. For example, participants in the Women with Disabilities Health Equity Coalition reported that use of popular education helped to build trust and relationships in their group. They shared that, as a result of the training, they were able to be educators and leaders, and were able to show people outside of the disability community that people with disabilities can play these roles. Finally, they related they were able to do advocacy, not just about breast health (the health topic of their training) but also around other health issues that affect people with disabilities, such as diabetes and mental health.

CHWs from the VOZ Workers' Rights Education Project, a day-laborer organization, stated that after their initial training they were able to teach using popular education, listen to the people, have patience, do health projects, be leaders in the community, and support each other to continue learning. Finally, CHWs from the Village Gardens Program reported that facilitators' use of popular education helped them to open their minds and realize that they knew more than they thought they knew. It encouraged them to participate, feel valued, learn from each other, and come up with solutions together.

DISCUSSION

Lessons learned at the CCC over the course of more than 10 years reinforce the findings of other studies of CHW training and the CHW field. In the following, we present these lessons learned in the form of recommendations.

CHW Training Curricula Should Include Both Skill Development and Training on Health Issues

This message, communicated clearly by CHWs interviewed for the 1998 NCHA Study (L. Rosenthal et al., 1998), has been reinforced in multiple studies. The study by Love et al. (2004), mentioned previously, emphasized the importance of balancing “critical process competencies” such as care coordination, with “topical and system knowledge,” such as social and economic determinants of health (p. 422). In a CHW program to support diabetes self-management in the African American community, trainers modified their didactic, diabetes-content-focused training to include a supplemental, participatory training focused on skill reinforcement and self-efficacy after CHWs identified these training needs (Hill-Briggs et al., 2007). The 2010 study by Calori and colleagues concurred in this recommendation. Including skill development in CHW training supports CHWs to become agents of change in their own lives and communities, rather than simply sharing canned health facts.

Both the Philosophy and Methodology of CHW Training Should be Informed by Popular Education

Far from being simply a method or a bag of participatory tricks, popular education is a deeply-rooted philosophy that emphasizes the value of experiential knowledge and the wisdom of those most affected by health and social inequities. Popular education also provides concrete techniques for building community and a process for undoing the debilitating messages which members of marginalized communities have received about their own capacity. For this reason, various studies have endorsed it as an ideal approach to CHW training. A program focusing on diabetes in the Mexican American community designed a training using Freirian education that built on the life experiences of CHWs while training them in topics ranging from “understanding diabetes” to “social support” (Swider, Martin, Lynas, & Rothschild, 2010, p. 100). In a program to raise awareness of intimate partner violence in the Latino community, CHWs were trained using a curriculum based in Freirian education that contextualized a range of violence-related topics in the lived experience of participants and others in their community (Kelly, Lesser, Peralez-Dieckmann, & Castilla, 2007). The Getting on Target with Community Health Advisors (GOTCHA) program used popular education methods not only in training CHWs in rural Mississippi about cardiovascular disease prevention and care, but also in forming positive and empowering relationships with community members (Story et al., 2010). Both the CHW-NEC (2011) and the study by Calori et al. (2010) supported the use of popular education for CHW training.

Experienced CHWs Should be Deeply Involved in Designing and Conducting CHW Training

The CCC has made a practice of involving CHWs in choosing training topics and training new CHWs. Other studies have documented the process of CHWs moving into positions as cofacilitators. In a program in Atlanta in which formerly homeless men were trained to share education with others in their community, the participants became actively involved in setting the agenda, identifying the topics, deciding what methods would be used, and sharing leadership (Conner, Ling, Tuttle, & Brown-Tezera, 1999). Immigrant women involved in a clinic-based health promotion program in Norway formed and planned their own health education groups with some support from staff. Two years into the project, 80 women were participating in health education groups, many of them facilitated by the original participants (Aambo, 1997). It should come as no surprise that both the program in Atlanta and the program in Norway were influenced by popular education. By blurring the boundaries between teacher and student, helping participants develop facilitation skills, and then consistently and intentionally turning over leadership to them, popular education supports CHWs to take on the additional role of trainer.

CHWs Should be Prepared and Supported to Play a Full Range of Roles

Our experience at the CCC supports the idea that, when their training enables them to do it, CHWs can play a variety of important roles, including educator, organizer, ambassador, liaison, advocate, leader, counselor, and policy maker, among others. This experience reinforces the findings of the NCHA Study's chapter on Core Roles and Competencies, which identified seven core roles for CHWs (Wiggins & Borbón, 1998). Included among these roles were "building community and individual capacity," and "advocating for individuals and communities" (p. 46). Several studies have explored the benefits of training CHWs to play a full range of roles, including roles as agents of social change. In a Honduran program that used popular education to train village women as *promotoras de salud* (health promoters), participants began to participate more in land reform and land recuperations initiated by the formerly all-male Campesino Leagues (Minkler & Cox, 1980). In a program in Mexico that aimed at improving nutrition and increasing child survival, the training of the *promotores* used popular education and included an initial diagnosis of practices and concepts by the *promotores* themselves, an analysis of structural causes of the problems, and a return to practice, to plan actions to address problems. The *promotores* involved in the program eventually took over an epidemiological surveillance program in child nutrition and initiated a series of actions to improve child nutrition (Arenas-Monreal,

Paulo-Maya, & López-González, 1999). Following training by the *Iniciativa Frontera* program, *promotores* in rural, unincorporated *colonias* along the US/Mexico border organized a variety of community events and participated in lobbying efforts and meetings with government officials (Gonzalez Arizmendi & Ortiz, 2008). Based on a survey of Arizona CHWs, Ingram et al. (2008) suggested that training that combines mentorship/shadowing with experienced CHWs and leadership training may increase the likelihood that CHWs will conduct community level advocacy.

CONCLUSION

Our experience at the CCC over the course of more than 10 years has reaffirmed our belief that CHWs can make a significant contribution toward reducing health inequities and creating a more just and equitable society, if they are trained and supported to play a full range of roles, equipped to use popular education, and supported to value their own wisdom and worldviews. Although it is of crucial importance that CHWs be able to effectively help community members navigate the health care system and access services, it is also crucially important that they be skilled in bringing community members together to identify problems and root causes and develop and implement solutions. The model for CHW training used at the CCC combines content, methodology, and values to prepare CHWs to realize their full potential.

REFERENCES

- Aambo, A. (1997). Tasteful solutions: Solution-focused work with groups of immigrants. *Contemporary Family Therapy*, 19, 63–79.
- Arenas-Monreal, L., Paulo-Maya, A., & López-González, H.E. (1999). Educación popular y nutrición infantil: experiencia de trabajo con mujeres en una zona rural de México [Popular education and child nutrition: experience of work with women in a rural area of Mexico]. *Revista de Saúde Pública (Journal of Public Health)*, 33, 113–121.
- Bralich, J. (1994). *Educación popular: historia y conceptualización* [Popular education: History and conceptualization]. Montevideo, Uruguay: Ediciones Populares para América Latina.
- Caldart, R. S. (2004). *Pedagogia do Movimento Sem Terra [Pedagogy of the landless movement]*. São Paulo, Brazil: Editora Expressão Popular.
- Calori, C., Hart, J., Tein, N., & Bures, S. (2010). *Exploring the Integration of CHWs as Integral Team Members of the Public Health Workforce: A Brief Summary*. Washington, DC: National Heart, Lung, and Blood Institute, National Institutes of Health, US Department of Health and Human Services.
- Capps, L., & Crane, P. (1989). Evaluation of a programme to train village health workers in El Salvador. *Health Policy and Planning*, 4, 239–243.

- Castelloe, P., Watson, T., & White, C. (2002). Participatory change: An integrative approach to community practice. *Journal of Community Practice, 10*, 7–31.
- Chang, C., Salvatore, A. L., Lee, P. T., Liu, S. S., & Minkler, M. (2012). Popular education, participatory research, and community organizing with immigrant restaurant workers in San Francisco's Chinatown: A case study. In M. Minkler, (Ed.), *Community organizing and community building for health and welfare* (pp. 246–268). New Brunswick, NJ: Rutgers University Press.
- Community Health Worker National Education Collaborative. (2011). *Homepage*. Tucson, AZ: University of Arizona, Arizona Area Health Education Centers Program. Retrieved from <http://chw-nec.org>
- Conner, A., Ling, C. G., Tuttle, J., & Brown-Tezera, B. B. (1999). Peer education project with persons who have experienced homelessness, *Public Health Nursing, 16*, 367–373.
- Crowther, J. (1999). Popular education and the struggle for democracy. In J. Crowther, I. Martin, & M. Shaw (Eds.), *Popular education and social movements in Scotland today* (pp. 29–40). Leicester, England: The National Institute of Adult Continuing Education (NIACE).
- Eng, E., & Young, R. (1992). Lay health advisors as community change agents. *Journal of Family and Community Health, 15*, 24–40.
- Farquhar, S. A., Michael, Y. M., & Wiggins, N. (2005). Building on leadership and social capital to create change in two urban communities. *American Journal of Public Health, 95*, 596–601.
- Farquhar, S. A., Wiggins, N., Michael, Y. L., Luhr, G., Jordan, J., & Lopez, A. (2008). "Sitting in different chairs:" Roles of the Community Health Workers in the *Poderes Salud/Power for Health* project. *Education for Health, 21*(2), 1–8.
- Fendall, N. R. E. (1976). The barefoot doctors: health workers in the front line. *Round Table: Commonwealth Journal of International Affairs, 264*, 361–369.
- Gutierrez, L. M., & Lewis, E. A. (2012). Education, participation, and capacity-building in community organizing with women of color. In M. Minkler (Ed.), *Community organizing and community building for health and welfare* (pp. 215–228). New Brunswick, NJ: Rutgers University Press.
- Gonzalez Arizmendi, L., & Ortiz, L. (2008). Neighborhood and community organizing in *colonias*: A case study in the development and use of *promotoras*. *Journal of Community Practice, 12*, 23–35.
- Hill-Briggs, F., Batts-Turner, M., Gary, T. L., Brancati, F. L., Hill, M. N., Levine, D. L., & Bone, L. R. (2007). Training community health workers as diabetes educators for urban African Americans: Value added using participatory methods. *Progress in Community Health Partnerships, 1*, 185–194.
- Ingram, M., Sabo, S., Rothers, J., Wennerstrom, A., & de Zapien, J. G. (2008). Community health workers and community advocacy: Addressing health disparities. *Journal of Community Health, 33*, 417–424.
- Jackson, E. J., & Parks, C. P. (1997). Recruitment and training issues from selected lay health advisor programs among African Americans: A 20-year perspective. *Health Education and Behavior, 24*, 418–431.
- Kelly, P. J., Lesser, J., Peralez-Dieckmann, E., & Castilla, M. (2007). Community-based violence awareness. *Issues in Mental Health Nursing, 28*, 241–253.

- Lortie, D. (1975). *Schoolteacher: A sociological study*. Chicago, IL: University of Chicago Press.
- Love, M. B., Legion, V., Shim, J. K., Tsai, C., Quijano, V., & Davis, C. (2004). CHWs get credit: A 10-year history of the first college-credit certificate for community health workers in the United States. *Health Promotion Practice, 5*, 418–428.
- Martinson, M., & Su, C. (2012). Contrasting organizing approaches: The “Alinsky tradition” and Freirian organizing approaches. In M. Minkler, (Ed.), *Community organizing and community building for health and welfare* (pp. 59–77). New Brunswick, NJ: Rutgers University Press.
- Michael, Y. L., Farquhar, S. A., Wiggins, N., & Green, M. (2008). Findings from a community-based participatory prevention research intervention designed to increase social capital and build capacity in African American and Latino communities. *Journal of Immigrant and Minority Health, 10*, 281–289.
- Minkler, M., & Cox, K. (1980). Creating critical consciousness in health: Applications of Freire’s philosophy and methods to the health care setting. *International Journal of Health Services, 10*, 311–22.
- Nash, F. (1993). Church-based organizing as participatory research: The Northwest Community Organization and the Pilsen Resurrection Project. *American Sociologist, 24*, 38–56.
- O’Brien, M. J., Squires, A. P., Bixby, R. A., & Larson, S. C. (2009). Role development of community health workers: an examination of selection and training processes in the intervention literature. *American Journal of Preventive Medicine, 37*, S262–269.
- Pinto, R. M., Bulhões da Silva, S. B., & Soriano, R. (2012). Community health workers in Brazil’s unified health system: A framework of their praxis and contributions to patient health behaviors. *Social Science & Medicine, 74*, 940–947. doi:10.1016/j.socscimed.2011.12.025
- Rosenthal, E. L. (1998). Strengthening the community health advisor field: A career in development. In *Final report of the National Community Health Advisor Study* (pp. 75–106). Baltimore, MD: Annie E. Casey Foundation.
- Rosenthal, E. L., Wiggins, N., Brownstein, N., & Johnson, S. (1998). *The final report of the National Community Health Advisor Study*. Baltimore, MD: Annie E. Casey Foundation.
- Rosenthal, E. L., Wiggins, N., Ingram, M., Mayfield-Johnson, S., & Guernsey de Zapien, J. (2011). Community health workers then and now: an overview of national studies aimed at defining the field. *Journal of Ambulatory Care Management, 34*, 247–259.
- Sen, R. (2003). *Stir it up: Lessons in community organizing and advocacy*. San Francisco, CA: Jossey-Bass.
- Spencer, M. S., Gunter, K. E., & Palmisano, G. (2010). Community health workers and their value to social work. *Social Work, 55*, 169–180.
- Story, L., Mayfield-Johnson, S., Downey, L. H., Anderson-Lewis, C., Young, R., & Day, P. (2010). Getting on Target with Community Health Advisors (GOTCHA): An innovative stroke prevention project. *Nursing Inquiry, 17*, 373–384.
- Swider, S. M., Martin, M., Lynas, C., & Rothschild, S. (2010). Project MATCH: Training for a promotora intervention. *Diabetes Educator, 36*, 98–108.
- Wallerstein, N., Sanchez-Merki, V., & Dow, L. (1999). Freirian praxis in health education and community organizing: A case study of an adolescent prevention

- program. In M. Minkler (Ed.), *Community organizing and community building for health* (pp. 195–211). New Brunswick, NJ: Rutgers University Press.
- Wiggins, N. (2010). *La palabra es salud* (The word is health): A comparative study of the effectiveness of popular education vs. traditional education for enhancing health knowledge and skills and increasing empowerment among parish based community health workers (CHWs). Retrieved from *Dissertation and Theses* (AAT 3407867).
- Wiggins, N. (2011). Critical pedagogy and popular education: Towards a unity of theory and practice. *Studies in the Education of Adults*, 43, 34–49.
- Wiggins, N. (2012). Popular education for health promotion and community empowerment: A review of the literature. *Health Promotion International*, 27, 356–371. doi:10.1093/heapro/dar046
- Wiggins, N. (in press). La palabra es salud (The word is health): Combining mixed methods and CBPR to understand the comparative effectiveness of popular and conventional education. *Journal of Mixed Methods Research*.
- Wiggins, N., & Borbón, I. A. (1998). Core roles and competencies of community health workers. In *Final report of the National Community Health Advisor Study* (pp. 15–49). Baltimore, MD: Annie E. Casey Foundation.
- Wiggins, N., Johnson, D., Avila, M., Farquhar, S. A., Michael, Y. L., Rios, T., & López, A. (2008). Using popular education for community empowerment: perspectives of Community Health Workers in the *Poder es Salud*/Power for Health program. *Critical Public Health*, 19, 11–22.