Application and Management of the Community Health Educator Model

A Handbook for Practitioners

Nuffield Institute FOR HEALTH

AMCHEM

Service Adoption Programme

AMCHEM

AMCHEM Handbook for Practitioners

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Preface

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The Community Health Educator Model was introduced to colleagues in the National Health Service at a national dissemination conference, after the completion of the project - Communicating Breast Screening Messages to Minority Women - Constructing a Community Health Education Model - in 1993. The conference was attended by over 120 delegates, the majority of whom came from health promotion departments across the United Kingdom. What was special about the conference was that it was perhaps the first time that women from minority ethnic communities had stood up and presented their own experiences of involvement in the project, for example: what it meant to be a Community Health Educator in their own community; how much they were involved in putting together the health education materials and the photo-stories.

In 1998, six Community Health Educators from different minority communities also shared their experiences on the same platform as their professional colleagues in primary care. The excitement surrounding this occasion was generated by the critical lessons learnt on the project- both the participants in the project and conference delegates realised that the Community Health Educator Model heralded a new movement in the development of health promotion in primary care. The project was 'Woman-To-Woman: promoting cervical screening among minority women in primary care'. The Community Health Educators in this project not only worked with women from their own communities, but also worked closely with nurses and doctors in general practices. This experience has demonstrated the flexibility of the Model in tackling new issues and in adapting to new settings.

In the last two years, the Model has made a tremendous advance by taking on board inequality issues of disadvantaged groups other than the minority ethnic communities. The recently completed project “Straight Talking - Communicating Breast Screening Information in Primary Care” has sought to address the information and communication needs of low-income groups with regard to cancer screening. The Model, at this juncture, is being adopted by Doncaster Primary Care Trusts to improve access to cancer information for residents who live in socio-economically deprived wards.

A recent survey conducted by the WNCCC (Women's Nationwide Cancer Control Campaign) [1] has shown that the CHE model has been adopted, albeit in different forms and not necessarily bearing this precise label, by various health promotion departments across the U.K. Some general practices have begun to employ CHEs to facilitate access by minority women to their services. In the mid 90s, I had the privilege of supporting the establishment of two CHE schemes in the London area by offering consultation and training.

1 The WNCCC was dissolved in December, 2001.

More than a decade since its inception, interest in the model has not waned. I frequently gave advice and support to colleagues about the Model, either by talking to them through issues over the phone or sending them papers, journal articles and reports. Such demands suggested the need for a handbook to encapsulate the practical knowledge gained from accumulated experience of applying the model to different issues and settings that need has now finally been fulfilled through the AMCHEM (Application and Management of the Community Health Educator Model) project.

This handbook is the result of an exciting process. The excitement has come from the recognition of the Model, not only by the National Cancer Screening Programmes but also by the Equality Programme of the Department of Health which generously provided funding for its further dissemination through the AMCHEM project. This funding has enabled the first wave of the Service Adoption Programme to be organised. This Programme aimed to support organisations that wished to adopt the model using an action-learning approach. Adopters were taken through the process of setting up the Community Health Educator Service in real-time. Twelve organisations were enlisted, and took part in three workshops between March and May, 2002. Experiential learning within the action-learning framework is the main approach of these workshops. Participants were also encouraged to consider their actions using appropriate theories that underpin the Model. The Chapters in this handbook represent the integration of theory and practice, research and action. It is hoped that practitioners and managers will find it illuminating, informative and above all practical.

CHAPTER 1

The Development of the Community Health Educator Model

An overview

The Community Health Educator model is an empowering health promotion model in which lay members of the minority ethnic communities[2] are trained and recruited to participate in the delivery of health promotion initiatives in Primary Care. The model often requires a multi-agencies approach with the support from Local Public Health and Health Development/Promotion Agencies. It was based on three successful participatory action research projects funded by the National Health Services Cancer Screening Programme between 1999 and 2002. They are:

1.Communicating Breast Screening Messages to Minority Ethnic Women - constructing a community health education model (1990-1993)

The objective of this first project was to construct a community health education model for dissemination of breast screening messages to minority ethnic women. Eight minority language groups were involved. The Community Health Educator Model emerged as an outcome of this project (Chiu, 1993). In addition, the project resulted in the publication of the first Breast Screening Training Pack for Minority Women in the U.K (Chiu, Knight & Williams, 1993). The results of the project and the dissemination of the training pack through a national conference in 1993 provided the impetus for many health promotion colleagues to set up their own CHE schemes. The Training Pack has been widely used in the breast screening education of minority ethnic women.

2. Woman-To-Woman: promoting cervical screening to minority ethnic women in primary care (1994- 1997)

The objective of the Woman-To-Woman project was to further test the CHE model in primary care for the promotion of cervical screening. Six general practices and six language groups were involved. The outcomes of this project were: the successful application of the CHE model in the primary care setting; the employment by participating practices of CHEs for health promotion in a number of areas in addition to cervical screening; the publication and dissemination of the Woman-To-Woman Training Pack for Minority Women (Rotherham Health Authority, 1998); the distribution of the research report of this project (Chiu, 1998) to all Public Health Departments in the United Kingdom.

2: The Community Health Educator model has recently been applied to socially and economically disadvantaged groups other than the minority ethnic communities by some health districts.

3. Straight Talking: communicating breast screening messages in primary care (2000-2002)

The recently completed Straight Talking Project has investigated the usefulness of the Community Health Educator in communicating breast health and screening messages to women from disadvantaged backgrounds in collaboration with primary care health professionals in five general practices. The project has provided further understanding of the potential and effectiveness of the CHE model, and insights into the public health and health promotion capacity in the new primary care environment. A research report documenting the process and outcomes of the project is in preparation (Chiu, 2002a). A new and completely revised Breast Screening Pack has also been developed from this project.

The knowledge base of the CHE model

It is good practice when one implements a new practice or establishes a service to ask the question - how do we know if this works? Without going into details of the epistemological presupposition (how do know what we know?) of Participatory Action Research (PAR), or trying to untangle many of the dichotomies in philosophical tradition that have plagued western science for centuries, the knowledge foundation upon which the CHE model has been developed can be presented as follows:

The knowledge of the CHE model came from practice and research as described above. However, the creation of this knowledge has a theoretical underpinning, which, in turn, derives from a particular philosophical and epistemological orientation. Unlike conventional research with its philosophical tradition grounded on Cartisian instrumental rationality (Fals Borda, 2001), the philosophical foundation of Action Research or PAR can be traced back to Renaissance humanists such as Michel de Montaigne, who argued the need for a balance between theoretical inquiry and the creation of knowledge that is practical and concrete (Reason & Bradbury, 2001). The concern to develop practical knowledge that is relevant to people's lives is central to the practice of PAR. Marxian epistemology and Dewey's experiential learning have also both been major influences on the notion of praxis in PAR, where action has primacy over theory.

Empowerment and participation are the two basic values that underpin the research practice of PAR. This particular worldview among PAR researchers has influenced the theoretical resources that they use in their reflective work and knowledge creation (Chiu, 2002b). There is a confluence of influence derived from critical theorists such as Foucault, Habermas (Winter, 1987, Park, 2001), and from the feminist perspective, for example the work of Harding, Hall, Hooks, and others (Maguire, 2001). They and many more contemporary scholars and researchers[3] have all contributed to the development of the groundings of PAR.

The CHE model draws inspiration directly from the teaching of the radical Brazilian educationist Paulo Freire (Freire, 1970). His approach to education and the body of knowledge from critical and feminist theories have furnished the CHE model with much practical and theoretical resource. Therefore, far from the common misconception held among conventional researchers that action research is sloppy, knowledge generated by action research is not only practical and relevant to people's lives but also just as rigorous and well grounded as conventional social research.

3 It is impossible to delineate the entire history and development of action research in which participatory action research is a part. Readers who are interested in the theoretical groundings of action research can refer to the recent publication edited by Reason & Bradbury (2002).

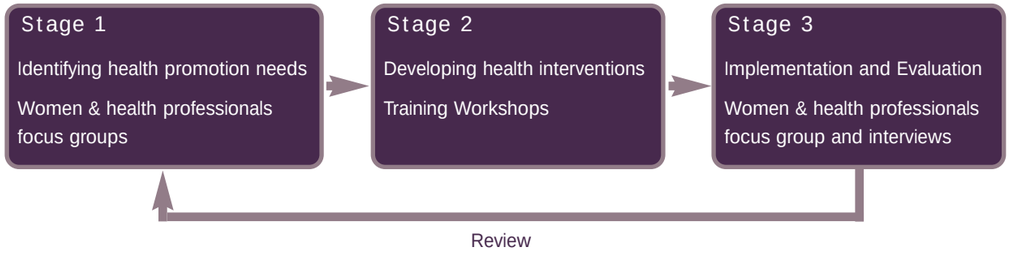
What is a Community Health Educator Model?

As mentioned above, empowerment and participation are two basic values of the CHE model. These values are also at the heart of the new health promotion movement (Robertson & Minkler, 1994). The empowerment principle within this movement acknowledges the need to fully engage people in making their own choices about health as well as recognising the need to tackle the wider social, political and economic determinants of health Therefore, empowerment in this context emphasises building the capacity of people in decision-making and community organising skills through non-traditional methods. Consciousness awareness-raising through critical pedagogy is central to the work of a Community Health Educator. The term Community Health Educator, therefore, does not imply the paternalistic and didactic approach often found in traditional learning. Community Health Educators are members of the community who are trusted by community members, and they take on the role of consciousness awareness-raising through facilitating discussion and critical questioning of issues that concern the community.

Based on these principles and values, CHEs would normally be lay people recruited from the neighbourhood of the target communities. They would be required to undergo a period of intensive training so as to enable them not only to facilitate consciousness awareness-raising, but also to involve community members in defining their own health agendas and the planning and delivery of health promotion activities in their own communities.

In order to tackle inequality of access to health services, the CHE model recognises that barriers exist between communities and services. It therefore incorporates a component of professional development whereby health professionals involved with CHEs will also undergo a training programme to help them understand the model and its practice. This component facilitates the building of partnerships between professionals and CHEs. Members of the targeted communities and health professionals should be systematically involved in all aspects of planning, implementation and evaluation of health promotion programmes. The development of these programmes using the CHE model normally takes place in three stages: Stage 1. Identification of needs; Stage 2. Development of health intervention; Stage 3. Implementation and evaluation (Chiu, in press). The model is outlined in Figure 1.

Figure 1. The Community Health Educator Model in Cancer Screening



Why do we need the three-stage cycle?

Kurt Lewin, who coined the term 'Action Research' (1946), viewed action research as a form of 'rational social management'. He suggested that changes could be brought about through a series of steps that would begin with the examination of the general objective. An overall plan would then be developed to reach the objective. The initial action step taken to reach the objective would be evaluated and modification and re-planning would take place. This forms the rational basis of a cycle of planning, executing, evaluating, spiraling towards improvement of organisational practices (Hart & Bond, 1995). This cyclical nature of action research mirrors the iterative processes of needs assessment, responding and reviewing progress that are required in many programme activities in the NHS (Op. cit.).

The experiences of the three PAR projects have proved that the three-staged cycle is a convenient way of conceptualising the planning, implementation and evaluation of a health intervention programme.

Stage 1 - Problem identification

This is an important Stage that corresponds to some of the parts of the PRECEDE-PROCEED health promotion planning model (Green & Kreuter, 1991) and should not be avoided. It helps health promotion practitioners to consider in detail the local conditions of the intervention (whatever it might be), to gather information and resources, to prepare the communities, to negotiate with stakeholders and, most importantly, to help build relationships between the communities, the hosting organisation and related statutory agencies. The information gleaned from this Stage can be used to focus health promotion programmes, formulate training strategies for both CHEs and health professionals involved, and agree an evaluation strategy and success indicators with stakeholders, according to available resources.

Stage 2 - Solution generation

This Stage requires participants to contribute to the construction and implementation of a health intervention programme. It is one in which CHEs can identify their own knowledge and training needs. It also provides an opportunity for other relevant health professionals to be involved with the CHEs' training programme. If possible, health professionals should also be involved in identifying their role in the health intervention programme and related training needs. For example, health professionals who are involved in the programme might not have the knowledge and skills needed to work with disadvantaged groups on health promotion and education issues. Without appropriate training, it would be difficult for relationships between the CHEs and the health professionals to be established. Training programmes based on the health professionals' own needs can have the effect of changing not only the practice of the professionals but also the development of their organizations, e.g. general practices in tackling the issues of diversity and access, as reported in the Woman-To-Woman project (Chiu, 2001). Sample programmes for such professionals are provided in Workbook 7.

Stage 3- Implementation and Evaluation

Stage 3 provides the health intervention programme with a period for implementation. It is recommended that this period should be clearly defined with a date for review to complete the cycle before the programme continues. At this stage, the day-to-day management activities of the CHE model will be intensified. Health promotion practitioners will require effective leadership and change management skills to support the CHEs during this period. At the same time, good facilitation skills to involve stakeholders and communities are even more important at this stage.

The evaluation of the health programme will best be done in a participatory manner, so that all participants can play a part in collecting evidence of success and identifying areas for improvement, as well as the unmet needs of the communities.

Establish and sustain a CHE service

Short-term funding for many services in the NHS is an unrelenting reality. Many of the CHE services adopted across the U.K. have a hand-to-month existence. It is important for those who are committed to establishing the service to consider how it can be sustained. Many practitioners have felt that mainstreaming of the CHE service is the only way to sustainability. However, the rapidly changing environment of the NHS and the corresponding changes in the social and technological environments mean that all services are subject to change. It is important for practitioners to consider the question of sustainability, strategically and creatively. The details of this issue are discussed in **Chapter 8**.

The COP potential of the CHE model

There are considerable benefits in involving the communities in health promotion initiatives using the CHE model. They include:

The community development potential

Building the capacity of lay people as Community Health Educators who then can resource and support other community members in developing their own capacities for tackling health issues is an essential part of the community development approach. The CHEs who participated in our projects often reported successes in raising awareness of particular health issues and bringing about behavioural changes among members of their communities.

The organisational development potential

The presence of the Community Health Educators recruited from the communities will have an effect on the attitude, knowledge and behaviour of health professionals. The host organisation will not only be able to develop more appropriate, linguistically and culturally sensitive services, thus improving their quality and acceptability of services, but will also be able to improve their general accessibility to a diverse population.

The personal development potential

Personal development is essential for CHEs to become successful brokers between their communities and health agencies. Some of the CHEs who have developed their community leadership skills have reported not only that their confidence in their role has increased but that the development process has also benefited them personally in their day-to-day lives.

It is important to note that the use of the CHE model is by no means confined to minority communities. It is relevant to many, particularly disadvantaged, communities and should be considered whatever the ethnic group.

Adopting the model

In the following Chapters, this Handbook will improve your understanding of how to use the knowledge and many of the skills developed from applying and managing the CHE model through three PAR projects. The writing has incorporated some of the ideas, thinking and experiences of real-life management of the CHE model contributed by the twelve participants at the first AMCHEM Service Adoption Programme.

By sharing the practical experiences, together with insights of those who have adopted the model, and the aspirations of those who wished to adopted it, it is hoped that practitioners can come to realise that there are available, in the literature of the NHS, concepts, frameworks and practical tools that will help them to set up and sustain the CHE model.

The structure of this Handbook is based on a straightforward, developmental approach. **Chapter 2** aims to provide a learning framework to help you to understand and to manage the dynamic nature of the knowledge and management of the CHE model in practice. **Chapter 3** helps you to scan the service horizon, understand local conditions and the key issues and gaps in services where the CHE model can play a part. **Chapter 4** considers the strategy needed to establish a new service or the possibility of re-modelling an existing service to meet new needs and new health agendas. Practical tools and examples are provided to support you in formulating a business case or writng a funding proposal for a CHE service. **Chapter 5** suggests essential steps for implementation and good practice through involving stakeholders and communities. This Chapter also highlights some of the leadership skills that are required to develop and support CHEs and work in partnership with stakeholders. **Chapter 6** deals with the mechanics of recruitment of CHEs and practical issues relating to payments, and suggests how to construct training programmes that maximise the potential of the CHEs and the involvement of related health professionals. **Chapter 7**, the concept of participatory evaluation, is introduced with practical suggestions on how to collect evidence for evaluation. This chapter is closely linked with Chapter 8, which discusses the question of sustainability, by drawing on current literature case examples **(Workbook 7)**.

What happens after **Chapter 8** is up to you. You are the manager/co-ordinator of your CHE service and the person who can realise your vision and aspirations for the project. With many of those who joined the AMCHEM workshops, I think you will find your journey through the Handbook interesting, informative and most importantly to be of practical value.

CHAPTER 2

Building An Action Learning Framework

Reg Revans (1980) has pioneered the concept of action learning in business and industrial management. Action learning means learning from action or concrete experience as well as taking action as a result of this learning (Zuber-Skerritt, 2001). It rests on the premise that there is 'no learning without action and no sober and deliberate action without learning' (Pedler, 1991). Similar to Action Research, it is a cyclical iterative process of action and reflection. Action learning and Action Research shared paradigmatic assumptions and the theoretical framework outlined in **Chapter 1**.

Why should we be interested in it?

Like Action Research, Action Learning can be a valuable tool for achieving desirable changes in our professional practice and bringing about organisational changes. The concept of action learning applied to the National Health Service is not new. The first such project took place as long ago as 1964, when ten large hospitals in and around London participated in the Hospital Internal Communication (HIC) project. The most important conclusion drawn from this was the need to involve both staff and clients in the formulation and delivery of policies (Revans, 1980). Action learning has also been taught in the nursing curriculum as an important tool for improving professional practice. So, when working with health professionals, particularly nurses, the action learning approach will not be unfamiliar to them.

Because action learning requires the learner to work on a real-life project or to resolve a work issue, participants in action learning programmes have to commit their knowing to action, working through the various stages of the project. In the case of the CHE model, the best approach is to learn how to apply and manage the model by setting it up. Of course, this can be quite worrying for someone who has never before set up a service, particularly a service using lay members of community. However, this is precisely the opportunity whereby one can put theory into practice. By reflecting on practice, posing questions about what has been experienced, what problems can occur, what to do differently in the future and so on, one can learn whether or not those ideas applied in real-life are effective and practical. For example, no amount of chalk and talk or reading can one teach how to facilitate the involvement of health professionals and communities and how to empower the communities to take control of their own health.

Action learning approach is systematic, and knowledge creation through this process is critical. It requires participants look not only for confirming but also calling into question evidence of the success

of their efforts, so that they come face to face with challenging issues and uncertainties. By resolving these issues, participants discover their effectiveness in dealing with them.

We are facing a new era of rapid technological and socio-economic change in our increasingly complex world. The NHS is part of this world; it too has become increasingly complex through a series of reforms in the last two decades. Health practitioners have experienced many changes and have to learn faster, more actively and more creatively. Traditional learning that emphasises abstraction and generalisation has become increasingly unable to meet the demands of problem-solving in specific and concrete situations that often emanate from the changing and complex systems of today's NHS.

Action learning requires participants to reflect on their actions by questioning not just the participants' own practice but also organisational practice and ethics. This form of learning can be self-empowering and hence empowering to others. Participants will need to not only ask themselves questions of epistemology - how do I come to know? but also ontological questions, e.g. who am I? They will also need to consider the ethics of their actions, whether or not what they do is right, fair and sustainable.

The Research and Development Imperatives

Since Action Learning and Action Research are closely related, the informal process of action learning is often an important part of Participatory Action Research. By the same token, the process involved in action learning can also be utilised to generate data for existing research processes. The main difference is that Action Learning can be implemented indepently by both individuals and/or groups while PAR requires co-ordination of the participation of concerned parties of individuals or groups.

Reflection is an important process of both action learning and PAR. In the context of adopting the CHE model, it is important for practitioners to understand the significant contributions of self-reflection to individual learning and collective reflection to facilitating actions throughout the three-stage model. The integration of reflective practice into the process of model adoption and the day-to-day management of CHEs is pivotal.

Individual reflection

We all have reflective moments at one time or another. However, in order to improve learning, reflective practice has to be done systematically. Schön distinguishes two types of reflection, reflection-in-action and reflection-on-action (Schön, 1987). The former is the practitioner's application of tacit knowledge in action. Often, the practitioner is unconscious of this reflection, as he/she is immersed in the task in hand. The practitioner is often unable to articulate the tacit knowledge that guides him/her to respond to and negotiate with various issues arising from a situation. Examples of reflection-in-action are the knowledge and skills of a cyclist riding a bicycle, or an architect designing a building.

The latter, reflection-on-action is the process by which the practitioner withdraws from action and reflects on what happened, assessing what he/she has done well and not so well, and what and how he/she could have done differently. Reflection-on-action can draw out tacit knowledge, making it available for the conscious scrutiny by the practitioner and allowing learning to take place. The personal learning log in **Workbook 1** is constructed to support practitioners in practising individual reflection.

Collective reflection

In the process of managing the CHEs, apart from supporting individual CHE's work and meeting with each individually to review her development at regular intervals, practitioners are advised to set up regular group reflective meetings with them. Collective reflection provides learning opportunities for CHEs as a group, where problems articulated by an individual can be addressed and solved collectively. However, collective reflection needs to be done in a supportive environment in which individuals can articulate their problems and share their successes. Moreover, if collective reflection is being conducted in a spirit of trust, it will provide a secure environment where individuals can be supportively challenged to learn new things.

The tools in Workbook 1 have been adopted from the learning logs: Structured Journals That Work for Busy People designed by Williams & Harris (2001) [4]. Practitioners can use the Workbook as it is or adapt it to suit their own purposes.

Why reflect with learning logs?

Admittedly, many of us reflect on our experiences and learn from them. However, we tend to do it haphazardly rather then systematically. The structured approach introduced here is intended to help practitioners and their CHEs to focus their learning on the specific area of the day-to-day application and management of the service.

It is goal-directed

The structured approach is goal directed. So, as a practitioner, you know how you and your CHEs are focussing your efforts. You yourself have to state the goals of your actions, and these actions must ultimately be connected to the primary goal of establishing and developing the CHE service.

It is a method of documenting the process

Keeping a learning log can help you to systematically record your goal-oriented actions, as well as important events and critical incidents that might have derived from these actions. After you have filled in the log you can clearly see how you have achieved or not-achieved what you planned to do and the result of your action and reflection on this observation will help you to plan further actions, thus completing the mini-learning cycle for each sub-goal.

4 Permission has been sought directly with Williams & Harris for their learning logs to be adopted for this publication.

Because you are recording these actions sequentially, you will be able to observe the past and the present more clearly, thus helping you to assess whether or not your original goals are appropriate or still feasible, so that you can adjust these goals and the planning for future actions accordingly.

It is a good way to discipline our logical thoughts

Many of us might feel the time-pressure in our job. We often respond to events particularly critical incidents, without having the time to think through our responses. Under these circumstances our responses are based on the tacit knowledge - they are the best we are capable of, but they might not be the most appropriate solutions. Finding a spare ten minutes to record difficult events can help us to slow down our responses and think of solutions in a more focused way.

Organising regular collective reflection sessions for the CHEs will not only help you to manage any problems arising from their role, but also help them to gain the same benefits of learning described above. However, to optimise the benefits gained from collective reflection, it has to be conducted in a climate of mutual trust and respect. You will need to explain the purposes of collective reflection to CHEs, set ground rules and build trust among the team of CHEs before learning takes place.

CHAPTER 3

Visioning, Mapping & Sketching

We are in the midst of the modernisation process of the NHS (DoH, 2000a). This process is subject to the rapid political, economic, social and technological changes in the environment external to the NHS. Papers 1 and 2 in **Workbook 2** of this handbook outline the main objectives and principles of modernising the NHS and the opportunities and challenges arising from the reform. The modernisation process has created a huge change across the landscape of services. With the dissolution of the Health Authorities, the Health Improvement Programme has become part of the commissioning responsibility of the Primary Care Trusts. This means that there might well be an increase in opportunities to introduce more innovative services at the primary care level. The desire to shift power to the patients is one of the motors for transformation of the service. Giving power to patients began with the Patient's Charter (DoH, 1991), and continues to be the main theme in the recent White Paper - Shifting the Balance of Power (DoH, 2002). Therefore, by understanding the policy context, you will be able to gather strong arguments for the establishment of the CHE model, which is designed precisely to empower users and involve them in service planning and delivery.

What is your vision?

In industries, managers have long been sensitive to the rapidly changing world. Their operative words in the new world order are leadership, change, implementation and results. These are also core procedural elements that are subsumed by the AMCHEM programme of service adoption. Although the programme is a not a leadership programme per se, to successfully apply and manage the CHE model as a progressive service for health improvement does require good leadership qualities and skills.

The qualities of good leaders include the ability to create a vision and, more importantly, the determination to realise their vision. That vision creates a strong sense of purpose and, if shared, can inspire others to support its realisation. The leader needs to articulate this vision, so that it can be turned into concrete strategies and solid management systems. A visioning exercise was carried out with the participants in the AMCHEM workshops. **Workbook 3** presents a few examples of their visions. You can also try this out yourself, preferably with colleagues who have similar aspirations or you may already have a stakeholders group that has expressed a wish to adopt the CHE model as a service in its health district.

Creating a vision

You will need a flipchart and many different coloured felt-tipped pens. You begin by imagining what your new CHE service should be like in three years' time, and express this in graphic form.

It is important that you avoid the use of written words in your vision, although you might allow a motto to sum up the principle of your service. Creating a vision requires you to summon up your power of intuition and imagination. The image of your vision will make a lasting impression in yourself and others. Its symbolic function will create a strong sense of purpose and will motivate you, and keep you going when facing challenging times.

Leadership skills for establishing the CHE service

According to Hersey, Blanchard & Johnson (2000), the competencies of leadership comprise three general skills:

Diagnostic (Scanning & Mapping) skill

You need to have a thorough understanding of the situation you are trying to change.

Adaptation skill

You need to be adaptive and able to easily alter your behaviour and resources for the purpose of the situation and any contingencies.

Communication skills

You need to be able to easily identifying with a whole range of people and can get your messages across clearly.

Scanning & Mapping

Having created a vision of the CHE service, the next important step in making it happen is to establish whether or not there is a need of such a service. You can find out what types of services are needed by scanning the service environment, and identifying whom you can influence by mapping your existing relationships. By relating these relationships to respective organisations you will then be able to sketch out an intra- or inter-organisational map and identify where service gaps are located. These exercises will not only help you to make a diagnosis of the situation at hand, but will also enable you to identify the strengths and weaknesses of your working relationships with other organisations, and who will support your idea within your ogranisation.

Scanning the environment

Once you have created a vision and have a clear idea of where you want to go, the next step is to understand where you are now. This process is about taking stock and examining the internal situation of your organisation and the external context in which it is situated.

The tools for environmental scanning

There are many approaches to environmental scanning. These include:

- Auditing existing activities that purport to address the health improvement programme or inequality of access. For example, are there existing link workers; is there an interpreting service within or external to the organisation?
- Needs assessment reports on the target population which the CHE service will serve.
- Setting up focus groups with stakeholders and users to take stock of their experiences and assessing their needs.

Mapping relationships

Use a flipchart and felt-tipped pens to map your working relationships internally and externally, using different colours to denote strengths and weaknesses of relationships. This map will also be useful in stakeholder analysis in Chapter 5. Note the purpose of the relationships and how they have been established e.g. through day-to-day professional contacts or through committees.

Thinking about relationships will help you to recognise where your influence is located among colleagues and organisations.

On your relationship map, you can start use another coloured pen to write down the organisation to which each person belongs. Once this is complete you will be able to see very clearly with which organisations you have most contact and perhaps influence. However, you will also need to assess the potential cost and trade-offs in building relationships with those organisations with which you have weak links at present. This organisational map will help you to formulate a strategy for inter-agency working and become more purposeful in building partnerships with other organisations.

Sketching out the relationships between organisations will help you to be more aware of the different organisational environments that you need to work in, their inherent cultures and power. This will enable you to become more adaptive when you decide to extend your influence in those organisations that might become key stakeholders in the CHE service. For example, social services, general practices, voluntary organisations and hospital trusts all have their distinctive organisational cultures and practices.

Adaptation skills

In order to adapt to the environment, you need not only to be aware of the current situation that you are trying to influence but also to be prepared to alter your behaviour and mobilise resources that you have to help you close the gaps between what is out there and what you want to achieve.

How adaptive you are will depend on your personality and your competence in adapting different styles of behaviour appropriately to different situations. According to Hersey et al. (2000), effective leader behaviour can be assessed on the

dimensions of task-oriented behaviour and relationship-oriented behaviour. Four basic leader behaviours can be conceptualised along these two axes. Figure 2 illustrates these behaviour styles.

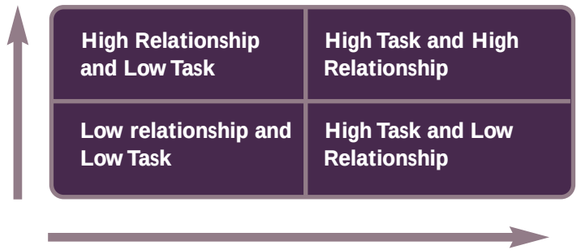


Figure 2. Leadership styles adopted from Hersey et al. (2001)

No one style is more appropriate than another without considering the context in which it is applied. For instance, when you are supervising CHEs' day-to-day organisational skills, high task and low relationship would be more appropriate than the other styles, as this situation requires you to be more directive. However, when you are in the situation of facilitating CHEs' collective reflection, high relationship and low task might be more effective because this style of behaviour is more facilitative of reflective learning. However, the style that combines both high task and high relationship behaviour is often only available to highly skilled facilitators. Those who possess such a high competence in adaptive behaviour are extremely effective in facilitating complex situations such as a stakeholders' conference where the building of relationships is as important as the securing of commitments from participants.

We also need to recognise that it is difficult to be prescriptive in terms of behaviour styles. There is a whole host of factors that affect your effectiveness in different situations. Knowing yourself, knowing others and knowing the situation is the starting point. Your willingness to try out different styles in action and learn from the consequences through reflection could enhance your adaptive skills.

Communication skills

There are many reasons why you should pay attention to and systematise your efforts to communicate. They include:

- Your need to be personally accountable
- Your need to grasp and influence stakeholders' opinions about the direction of your plan to establish the CHE service
- Your organisation's obligation to communicate the reasons for its actions and the way in which it operates.

Planning your communication plan

A communication plan can include:

- A written statement of intent of your plan to establish the CHE service to ensure you communicate the purpose clearly within your own organisation and externally to the stakeholders and communities.
- A provision for internal communication about the progress of the CHE service, e.g. CHE as an agenda item on relevant committees.
- A provision for external communication via the organisation's public relations programme.
- A component for community communications. This involves the setting up of regular updates for community forums.
- A commitment to allocating a realistic budget or resources for communication. For example, money to advertise the recruitment of CHEs, printing annual reports and to cover your own time.

CHAPTER 4

Strategy Planning & Business Case

Strategic planning as a management tool

Strategic planning is a management tool. It is used for the purpose of helping an organisation to focus its energy and resources. It can help to ensure that people in the organisation are working towards the same goals, and are able to keep check on where the organisation is going in response to the changing environment.

Strategic planning is a rational effort to generate decisions and actions that shape and guide the development of the organisation, with a focus on the future. It involves the setting of goals and the development of an approach based on your created vision and your diagnoses of the loci of influence of people and organisations.

Being strategic in planning the CHE service means being clear about the purpose of the service, being aware of its resources and resource requirements, and being consciously responsive to a complex and dynamic environment.

The planning process

The planning process should be disciplined, as it requires order and pattern to keep it focused and productive. You need to raise a series of questions that helps you to examine how the service will work once it is established. The process is about making choices and a set of decisions about why, what and how to achieve the goals of the CHE service.

Because of the complexity of the health systems that the CHE service has to deal with, it is better to be realistic and not to design a service that holds out promises that are impossible to keep. Therefore, planning a CHE service is about deciding on priorities - what are presently the most important issues to tackle, so that the CHE service will be relevant.

The strategic planning process of the CHE service can be complex, challenging and messy, but it always follows the basic principles outlined above.

Previous chapters show that the NHS environment is complex, dynamic and changeable. Good strategic planning will ensure that the CHE service will therefore have the ability to respond successfully to a changing or sometimes hostile environment.

Strategic thinking

The basis for an effective CHE service is its strategic management, which in turn demands clear and strategic thinking.

Strategic thinking requires you to know:

- The purpose of the service
- The environment you operate in
- What forces affect or impede the achievement of the purpose
- How to develop responses to those forces that impede you

In order to strategically manage the CHE service, you have to attend to the 'big picture' and be willing to adapt to changing circumstances.

How to be strategic?

You have to bear in mind that although the empowerment and participation principles of the CHE model are fixed, the purpose of the CHE service need not be constant and unchanging. You need to formulate the future purpose of the service in the light of changing external factors, such as new health policies, rival and complementary services, e.g. interpreters and link workers services; technological developments, e.g. language links or specific telephone helplines; and the changing needs of the communities, e.g. projected change in age structure in communities might mean services to older people will become increasingly important.

You need to develop a competitive strategy to achieve your newly formulated service goals, and to develop structure, organisation and capacity of service to achieve these goals.

To sum up, the CHE service needs to be dynamic, adaptive and relevant.

What strategic planning is not

Strategic planning involves anticipating the future environment but does not attempt to make future decisions. This means that it is about staying abreast of changes in order to make the best decisions at any given point.

It is a tool - but it does not replace good judgement. Ultimately, you must exercise leadership by asking the following questions:

- What are the most important issues?
- How should the CHE service respond?

Data analysis and decision-making tools in strategic management can only support the intuition, reasoning skills and judgment that a leader can bring to the service.

It appears that strategic planning described here is rational. However, the steps leading towards the service goal rarely flow smoothly from one to the next. The process inevitably moves back and forth several times before arriving at the final set of decisions. Therefore, you might sometimes feel as though you are riding on a roller-coaster. If you have your vision and purpose firmly set, you will get there.

Writing a business case or a funding proposal

By now, you will have formulated a goal of the service based on your judgment of priorities and your assessment of the environment. You will next need to secure funding for the service. Writing up a business case or a funding proposal can help you to crystalise what your service is about, how you would run it and at what cost.

Why write a Business Plan?

If you wish to establish a sustainable CHE service, you will need a business plan. It can be an invaluable management tool, if it is well prepared, reviewed, and updated on a regular basis. It can guide you in making decisions on how you would like to develop the service. Increasingly, business plans are a must for secure medium to longer term funding of services.

Funders in the NHS have long used business plans as the first step toward investment decisions. Today, local authority and voluntary sectors are likely to use them as well. Perhaps because of their importance, writing a business plan can be a daunting experience for some practitioners. They envision a tedious academic exercise requiring lots of complexity and business jargon, or they see an explicit commitment to a series of goals as unnecessarily burdensome and a hindrance to the goal of "getting on with the job". As a result, many simply avoid writing business plans to the detriment of the long-term development of their services.

Apart from presenting your prospective funders with a clear picture of the kind of service they are investing in, the business plan is a document that conveys the exciting prospects and potential of the service. Writing a business plan need not be a solitary activity; your managers, colleagues, member of your executive boards, strategic partners even your funders will support you in writing your business plan or funding proposal.

Writing such a plan requires preparation, delegation, refinement, and discipline. The process involves gathering accurate and convincing information and carefully outlining the plan before writing. Practitioners should also determine what kind of plan they need - an outline plan, a full plan, or an operating plan. Suggestions on writing some key sections of a business plan are covered in the **Workbook 4**.

CHAPTER 5

Implementation I Working with Stakeholders

You have scanned your environment and mapped your working relationships both on an interpersonal and organisational level; you have worked with your colleagues or your managers to establish a strategic plan for the CHE service. So, you now have a firm idea of what the service is about and might even have the promise of funding to set up the service. What is the next step? What remains to be done before you launch your recruitment drive and construct training programmes for the Community Health Educators?

From your mapping exercises, you might have become more aware of the ever-increasing circles of influence within the complex and dynamic environment of the NHS. If the CHE service were to aspire to be a key component within the health system - which it ought to be, given its powerful potential to facilitate users' empowerment and participation - its success will depend on how well it can be operated within the system.

Recent research experience in the application of the CHE model in assessing the cancer information needs of Doncaster residents (Chiu, 2002c) has shown that professional barriers to development of the CHE model do exist. These barriers are due partly to the misunderstanding of the role of the CHEs and partly to professionals' concern with boundaries and their perception of the competences of lay people. It is suggested that you formulate a systematic communication plan, within which opportunities should be provided to grasp and influence stakeholders' opinions about the directions of your plan for the CHE service. Although, in this hypothetical journey of establishing the CHE service, you have not yet taken the step of involving stakeholders, in certain circumstances they might need to be involved right from the outset, particularly if joint-funding from different organisations is being sought to finance the service. In thinking about stakeholders for your service, Peter Checkland's Soft Systems Methodolgy was found to be useful (Checkland, 1981). It provides a systematic way of defining and engaging the relevant stakeholders. The following are suggested steps in approaching your stakeholders.

Step 1- Stakeholder analysis

When establishing the service, you need to have the right people involved in the process to ensure that, on the one hand, there is sufficient knowledge of the system and its environment to make informed decisions about the development of the service and, on the other hand, sufficiently powerful membership to enable the

adoption and implementation of the service Stakeholder analysis should be carried out to determine who should be involved. The analysis should consider persons, roles and interests, both internal and external to the organisation, and who can enable or prevent active adoption of the proposed service.

You should be aware of the extent of the influence of stakeholders on your chances of success- what power do they have? It is important to understand the different forms of power that stakeholders possess, e.g. connection power, reward power that legitimate power, information power and expert power etc. (French & Raven, 1974). No matter how well you have chosen your stakeholders, they will not be able to exert influence on every aspect of the service. You also need to recognise the different motivations and interests of stakeholders in using the service to achieve some of their own goals, i.e. 'what is in this for me?'

The proforma in **Workbook 5** will help you to think through some of the issues discussed above.

Step 2- Develop common interests

After you have decided who the stakeholders are, you need to ensure they share your vision by communicating the fundamental principles and the purpose of the proposed service to them clearly. However, from experience, not all stakeholders will grasp the CHE model at once, and not all of them will agree that the purpose of the service fits their own interests or the interests of the organisation. In some circumstances, you might need to identify conflicts, and prepare to negotiate changes and trade-offs. The bottom line here is to help everyone to focus on the common interest that they might have in developing the CHE service.

Step 3 Promote commitment and ownership

Once common interests are identified, you have to discuss openly with stakeholders the kinds and levels of commitment required. These can be funds or other support, such as commitment of personnel, e.g. practice nurses, health visitors and receptionists in general practices. You also need to also estimate the amount of time involved in these commitments. Once these are agreed, be sure to identify individual stakeholders as champions and support them with information you're your communication system i.e. brochures about the service, access to local radio and newspapers etc.

You have to ensure that the stakeholder relationships are formalised by inviting stakeholders to form a project board or steering group or advisory group for the service.

The other practical means of involving stakeholders is through joint-working. For example, the Woman-to-Woman and the Straight Talking projects have invited stakeholders to be involved as contributors to the training programmes. Involving stakeholders in developing the capacity of the CHEs will promote commitment and ownership.

Step 4 - Building trust relationships

Clear communication at all times is vital for building relationships. Trust is built on your ability to be open about the process, and to communicate honestly with stakeholders about the potential gains and difficulties that the service might face. All too often there will be changes in personnel in stakeholders' organisations, you need to be alert to these changes and ensure that someone will be nominated to provide for continuity of involvement.

Transparency over financial matters or other stakeholders' contributions can create openness in the group. You have to create opportunities for working together but beware not to overburden stakeholders' already stretched resources. The steering group or advisory group as well as the training programmes can be structures in which stakeholders can operate. When working with stakeholders, focus on the process and outcomes, and be sure to value and appreciate their contributions.

Step 5 - Monitor, evaluate and review the service

The stakeholders should be involved in the monitoring and evaluation process. It is important to agree practical success criteria with stakeholders, and develop procedures for appraising progress of the service. You can use your communication system to contact frequently with stakeholders and their organisations about how well the service is working. Whenever possible, celebrate successes, and learn from difficulties so that together you can revise the aims, objectives and operating arrangements based on lessons learnt.

CHAPTER 6

Implementation II Recruitment and Training

Recruiting Community Health Educators

If 'trust' as suggested in the previous PAR projects is to be one of the main elements for the success of the Community Health Educator Model (Chiu, 1998), then it is important to adhere to the contiguity principle in recruitment. The CHEs joining your service need to have direct contact with members of their communities and to be readily recognised and accepted by them as part of those communities. Close social identification (as part of the community) and social ties (friends and relations) that a CHE has with her community are powerful influence. They can provide ready access to some of the most difficult to reach groups such as the elderly. It has been learnt from some of the research projects (Chiu, 2002a, 2002b) that failure to adhere to the contiguity principle can be costly. CHEs recruited from outside their neighbourhoods have reported experiencing difficulties in gaining access; consequently they felt demoralised and dejected despite belonging to the same ethnic/language group as the target community. Therefore, it is absolutely essential to recruit Community Health Educators from the targeted neighbourhood.

What do we look for in a CHE?

Characteristics/ qualities

- She needs to be confident, trustworthy, sensitive, sincere, and non-judgmental
- She must respect her co-workers
- She must be empathic to the vulnerable
- She must have integrity and be able to keep confidentiality
- She must be committed to learning, to the project and to her community

Knowledge

- She must have some knowledge of health in general and the use of preventive services
- She must have a good knowledge of the target community language e.g. Urdu/Mirpuri, in both written and verbal forms
- She must know the day-to-day cultural practices of her community and be aware of individual variations
- She must have some general knowledge of the health care system.

Skills

- Organisational and teaching
- Communication (fluency in communicating, both in English and the language of the target community)
- Facilitation
- Group and one to one working
- Interpersonal (ability to get on with people from different walks of life)

The above are the basic requirements of a Community Health Educator. You will need to provide additional training for specific knowledge and skills to meet the purpose of your service, e.g. knowledge of health conditions such as breast cancer and preventive measures such as breast screening.

Workbook 6 contains two sample job descriptions. You can adopt these to suit your needs.

The development of critical awareness is central to community development and fundamental to empowerment. However, in recruiting CHEs, it should not be assumed that the candidates already possess these qualities. Therefore, the training programme should include components that will develop these qualities

Remuneration or payment

While some services offer CHEs a permanent contract on a certain grade, many are fixed-term projects and pay CHEs a sessional fee. **Paper 3 in Workbook 2**, written primarily for participants in the AMCHEM programme provides some pointers to how CHEs can be paid.

The building of trust through developmental activities around the neighbourhood is fundamental. If your CHE service is part of the integrated primary care team, the practice can help to build trust between the CHEs and their patients by legitimising their role through actively promoting them as part of the staff team in the general practice (Chiu, 2001). Therefore, when recruiting CHEs, practice staff with whom they will be closely involved should be invited to participate in the recruitment process.

Constructing a training programme for CHEs

A training programme for the CHEs is normally based on the analysis of the data collected from Stage 1 of the cycle mentioned in **Chapter 1**, where community's needs are identified. However, the following diagram illustrates the general framework, which was used in developing the programme in the first PAR project (Chiu, 1993). Together with the expressed needs of the community, it forms the basis of the content of the training programme.

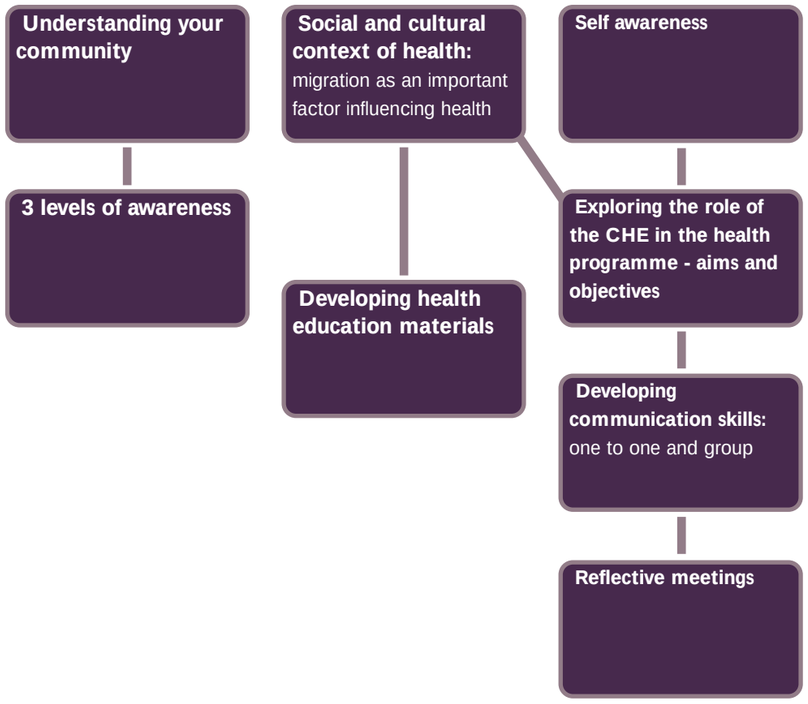


Figure 3 A general framework for constructing a CHE training programme

The training programme will normally consist of three parts, which reflect the knowledge, attitude and skills required by CHEs:

- Core information on the health issue and services
- Critical awareness programme
- Skills development programme

The core information should be programme-specific with knowledge about the issue involved, e.g. breast or cervical cancer, heart health, HIV/AIDS, ante-natal care etc. This part of the training is vital in supporting the information, advocacy and education role of the CHEs. However, they should understand that the purpose of this training is not to turn them into medical experts but well informed lay people who can raise questions and concerns on behalf of their clients.

It is important to involve appropriate health professionals, such as practice nurses, doctors, radiographers, community midwives and public health directors, in this part of the training programme. It has been proven that contributions of professionals' expert knowledge about the specific health issues that the service aims to tackle can build CHEs' confidence. Involving health professionals in training also facilitates their relationships with the CHEs. From our experience, those clinicians who have been involved with the training process often reported feeling more confident in the competence of the CHEs to communicate technical issues to their clients. They, therefore, had more trust in the working arrangements with the CHEs, who in turn were able to develop a deeper involvement with the general practices.

The critical awareness programme aims to develop a general understanding of the attitudes required to work with disadvantaged groups. It covers knowledge about health development in which personal health choices, health communication, needs assessment and empowering health education are explored. Practitioners who are from the health promotion backgrounds will be able to put together training for CHEs around these issues. Both practitioners and trainers can find guidance and materials for critical awareness training in the recently published Breast Screening Training Pack. (2002).

A basic skill development programme aims to develop the organisational and communication skills of the CHEs. It covers the skills required to work in groups and one-to-one. It also provides simple evaluation skills for CHEs to assess their own progress. You can also expand the skills development programme to include some needs assessment skills as required.

Workbook 6 provides samples of training programmes, which you could adopt. The new Breast Screening Pack and the Woman-to-Woman pack together will provide most of the workshops that you will need to put together a training programme. However, please do remember that to develop the capacity of the CHEs requires a continuing programme of training and development. It is, therefore, important to review CHEs training needs from time to time.

CHAPTER 7

Participatory Evaluation

Evaluation has often been seen by practitioners as something that they need to do to prove whether or not things have worked or how well their services have performed. There are many 'how to' books on evaluation for practitioners and the concept of evaluation as part of evidence-based practice in Health Promotion has also been invoked (Wright, 1999). Although naive experimentalism is still much alive in the NHS, changes are afoot. The World Health Organisation has recently published guidance on evaluating health promotion, drawing on know-how of evaluation developed within PAR (Springett, 1999). With such a wind of change, practitioners should feel confident in developing strategies for the evaluation of the CHE service. This Chapter aims not to reintroduce the broad concept of evaluation or the use of different methods but to look specifically at the concept of participatory evaluation in the context of the CHE model and its implication for the sustainability of such a service.

Evaluation of the CHE service needs to take account of empowerment and participatory principles of the new health promotion movement and the action learning and action research approaches that embody the day-to-day practice of such a service. Working within this framework, evaluation becomes a positive process in which the values of learning about the service are emphasised rather than a narrowly focused exercise about the measuring of outcomes.

Although participatory evaluation is different from traditional evaluation, its application to the CHE service is not by any means less robust or credible. To develop a participatory evaluation strategy requires practitioners to develop a clear rationale underpinning the means and ends of the service and to recognise that the purpose of the evaluation is bound up in the broad values and goals of the service and the level of its practice. In addition, it requires all stakeholders and communities to have a shared understanding of these values and practice.

This shared understanding is paramount for the implementation of participatory evaluation because the stakeholders and communities will be involved in the assessment of the service programme(s) collectively.

To hold true to the principle of empowerment, the end-users (communities) are the key actors in the evaluation process and are not 'objects' of evaluation as is often assumed within traditional methods of evaluation.

Why participatory evaluation?

When you consider using participatory evaluation, you need to be clear about its purpose and practice so that you can present to your funder a convincing case for its use. The following questions will help you to systematically clarify the purposes of participatory evaluation.

What is being evaluated?

We know that funders and stakeholders have vested interests in knowing whether or not their investments are sound. Based on this perspective, the central function is to establish accountability so as to ensure that public funds are spent wisely and according to stated aims. However, for a development service such as the CHE service, this perspective is considered to be too narrow and inadequate. This service requires a broader perspective that takes account of the interests not only of the funders, but also of the stakeholders and communities.

Who is carrying out the evaluation?

It is important to consider who will be responsible or have the knowledge and skills to carry out the evaluation. Traditionally, conventional evaluators or consultants may have been brought in to ensure neutrality and objectivity. However, without the understanding of the fundamental principles, empowerment and participation and the development aspect of the model, conventional evaluators may emphasise some of the more obvious outcomes that are of more interest to the funders at the expense of others that are important to other stakeholders and the communities. Participatory evaluation requires participants from all the concerned parties not only to define the issues they wish to examine but also to participate in that evaluation process.

How do they evaluate?

The common use of naïve experimental methods to assess the attainment of goals dominates service evaluation in the NHS. Although other forms of evaluation, such as the qualitative method are present, they are used only to supplement information rather than to gain important insights into the success and failure of the service. Participatory evaluation uses a variety of methods to reflect the complexity of the process of change.

Who are the ultimate beneficiaries of the service?

Participatory evaluation acknowledges that the CHE service is there for the users, and that the communities are the ultimate beneficiaries. Therefore, their perceptions of effectiveness and usefulness are paramount. The following table (Fig. 5) summarises the differences between traditional evaluation and participatory evaluation.

Traditional Evaluation	Participatory Evaluation
Purpose tends to ensue that the money of the funders is well spent value for money	Purpose is to ensure empowerment and participation and building capacity
Methods tend to be abstract and experi-mental e.g. Randomised Control Trial as the gold standard of practice	Use a variety of methods, does not rule out using quantitative methods or trial methods to compare results, but is not restricted to them
Does not take account of the reality in the field	Based on concrete day-to-day situations and practice under local conditions
Evaluation tools are drawn from academic settings and are not adapted to fit the context	Evaluation tools are designed in partnership with end-users (communities) with the support of action researchers and stakeholders[1]
Often lack of dialogue or flexibility	Dialogue opportunities are built into the evaluation process and there is flexibility to adapt different methods when necessary
Success indicators are predominantly based on the worldview of professionals or the funders	Success indicators are agreed by stake-holders and end-users
Evaluation results serve the interests of the funder and/or professionals	Evaluation results serve primarily the inter-ests of the users or communities
Non-reflexive. Limited learning opportunities for communities or professionals involved	Reflexive. Learning for everyone involved, including the professional researcher

5: The differences between traditional evaluation and participatory evaluation

1 The Straight Talking Project has demonstrated the usefulness of involving CHEs and communities in evaluation research where the inappropriateness of expert-developed tools such as the Health Anxiety Questionnaire were challenged

If we accept that the CHE service is a crucial motor for change and a model for addressing inequality, we will have to accept that its operation is necessarily developmental. Therefore, when compared with the traditional evaluation practice, participatory evaluation is not only appropriate but essential.

To sum up, Participatory Evaluation can:

- Build the capacity of the communities to reflect, analyse and take action
- Develop problem solving approaches in dealing with concerns
- Widen accountability, not only to funders but to the communities themselves
- Improve participants' commitment to the learning cycle.

How to implement participatory evaluation

Practitioners need to build-in collective reflection on progress and obstacles using the action learning cycle described in **Chapter 2**.

There should be clear thought-out ways of collecting information about the day-to-day practice of the CHE service, CHEs' verbal and written reports, minutes of meetings with health professionals, records of contacts with communities and professionals, training events etc. This information will help to generate knowledge to shape practice and to suggest corrective actions.

Clear and regular communication with stakeholders and communities is important. Often CHEs' experiences can be fed back to stakeholders and communities so that they can bring about changes in their own practices.

Planning participatory evaluation

Planning meetings should be held with stakeholders and communities to check shared understanding of the model and participatory evaluation, and to introduce the concept of participatory evaluation by using participatory exercises with them.

At these meetings, facilitators should ask the participants to consider the following key questions:

Are they willing to commit themselves to participatory evaluation?

Will there be resources and support to carry out such an approach?

Who, in terms of knowledge and skills, should be involved?

What success indicators should be used?

When should the evaluation take place?

How should training for participatory evaluation take place?

Ask the participants to talk freely about their experiences of evaluation. This exercise can reveal what type of evaluation the participants found most interesting. Facilitators should discuss each of the experiences and help participants to reflect on the differences between traditional evaluation and participatory evaluation.

Participants should also be invited to define a number of issues that they would like to examine in the evaluation process. Time-scale and individual and organisational commitments should also be discussed in these meetings. The meetings can help to demystify the process of evaluation and ensure the early commitment of participants.

Training the participants

Participants who wish to be involved in the evaluation should be provided with training sessions to enable them to understand the differences between participatory and traditional approaches, and what it means when the programme chooses one or the other.

Facilitators need to provide ample opportunities for participants to practice what is learned. For example, in the research projects, many training sessions were provided on research methods, such as focus groups and individual interviews. How these traditional research methods should be adapted in the communities were then discussed. Also provided were plenty of opportunities for participants to test out their learning in real-life. Subsequent reflective sessions focused on this learning were also provided.

Helping participants, particularly members of the communities involved, to map out the current local situations is important. This exercise will help them to become aware of the circumstances that create their concerns e.g. lack of transport for older women can affect their access to services. This in turn helps to pinpoint key areas for intervention and evaluation, and to sort out what values are measurable and what are not.

Encourage participants to use multi-methods for evaluation, e.g. video recording, drawing, small group discussions, force-field analysis, photographic documentary, historical timelines.

Member-checking is a way of ensuring robustness of recorded impressions and their interpretations. Participants should be encouraged to compare with each other in reflective sessions what they have found and whether they agree with the analysis of the findings.

Presenting the evidence

After all the data has been gathered and analysed, the results of the evaluation should be presented at a meeting to decide how best to present it to the funders, the stakeholders and the public at large. It is always important to invite participants (those who have contributed to the evaluation process) to present their own experiences about the process and voice their own judgments about the overall results. This multi-voice approach to presenting the results of the evaluation will accentuate the various meanings and learning attached to the evaluation, and also the multiple realities, interest and values that the participatory evaluation is able to reflect.

Further dissemination of the evaluation results

If possible, wider dissemination of the evaluation results should be encouraged. Although they are based on local contexts and cannot be generalised to the wider population, the learning gained from the process can provide valuable insights for others who wish to practice participatory evaluation. A wider dissemination of results is also a way of showing your participants that their efforts are appreciated and valued.

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CHAPTER 8

The Concept of Sustainability

The lack of long-term funding for community-based intervention programmes in health promotion has made many practitioners feel uneasy about adopting the CHE model. They are rightly concerned about the possibility of raising expectations that cannot be satisfied. It is, therefore, not difficult to understand their concerns about the sustainability of such a service.

"If it is good, why can't we continue?"

"Many projects are too short to show benefits to users."

"Developing capacity in the community takes a long time!"

These are general complaints from practitioners who wished to adopt the CHE model. The aim of this Chapter is not to offer magic formulae for obtaining long-term funding for the service, but to take a look at a broader concept of sustainability. While drawing on current literature on sustainability, this Chapter attempts to integrate practitioners' experiences, so as to examine different ways in which you can work towards sustainability. Some of the AMCHEM programme participants brought their own experiences of their struggle to maintain and sustain their CHE services to the workshops.

What sustainability means

There is little consensus about how sustainability should be defined. The following are different definitions put forward in the field of community development.

- **1st Definition** Sustainability is the capacity to maintain service coverage at a level that will provide continuing control of health problems (Claquin, 1989).
- **2nd Definition** The capacity to continue to deliver intended benefits over a long period of time (The World Bank's definition cited in Bamberger & Cheema, 1990)
- **3rd Definition** Capability to deliver an appropriate level of benefits for an extended period of time after major financial, man agerial and technical assistance from an external donor is terminated. (International Development Agency, 1988).
- **4th Definition** The long term viability and integration of a new programme within an organization (Steckler and Goodman,1989).
- **5th Definition** Through the process of organisational change, new practices become standard in a local agency. (Yin, 1979).
- **6th Definition** Developing a healthy community is to develop the capacity of its people and the health promotion capacity of community health educators is one of the vehicles for such development. Sustainability can be defined as the extent to which a community has been able to access knowledge, skills and resources needed to maintain good health. (Chiu, 1993; Jackson et al., 1994).

The first three Definitions stress the end point of the service - health benefits and outcomes as conditions of sustainability. This is often the **public health perspective**. Definitions 4 and 5 represent the **organisational development perspective**, in which the emphasis is on the establishment of the CHE service within the mainstream services. Mainstreaming the CHE service has the implications of institutionalisation and integration. The downside of mainstreaming could be the routinisation of such a service. The final Definition characterises sustainability as a process occurring at the level of the community as a whole. It is the **community development perspective**. This perspective takes capacity building as the core value for sustainability and for improving the health of the community. It means that the service exists for the sake of building the capacity of the community, rather than for the sake of a health programme or an organisation.

The concept of sustainability is, therefore, multi-dimensional and it is a continuing process with a diversity of forms (Fig 5). Which particular dimension you endorse will influence your thinking and practice.

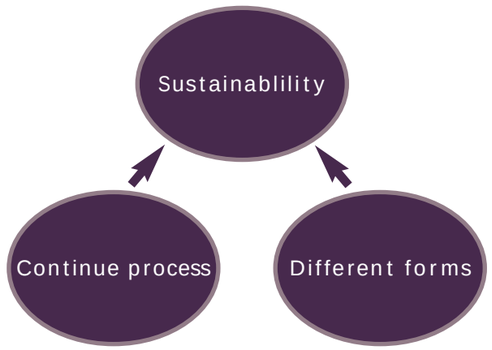

Figure 5 The general concept of sustainability

It is important for the survival of the CHE model that practitioners grasp this general concept of sustainability and that they do not simply equate sustainability with permanence. To interpret sustainability only in terms of permanence runs the risk that the service will become routinised and mechanical. However, one has to bear in mind that in a dynamic and rapidly changing environment such as the NHS, it is not always possible to have the financial security of services. In the final analysis, security may be neither desirable nor achievable.

On the other hand, an interpretation of sustainability within the CHE service in terms of achieving continuation in various forms favours creativity and flexibility. This is a crucial mind-set if any organisation is to survive in a changing environment; the CHE service is no exception. You might remember that in **Chapter 4** - Strategic Planning looked at being responsive to a complex and dynamic environment-

"Being strategic in planning the CHE service means being clear about the purpose of the service, being aware of its resources and being consciously responsive to a complex and dynamic environment."

To be responsive to the environment means that you might have to change the purpose and direction of your service according to the changing political, economic, social and technical conditions around you. On this view, the CHE service does not operate mechanistically but is a living entity with the power to respond to change.

Which perspective and what does it mean?

Taking on board the different dimensions of sustainability means that you will need to look at the effectiveness of your practice so as to maintain the service with different means. However, no matter which perspective you take, the way in which you measure your effectiveness needs to be appropriate. For example:

The Public Health perspective - the population's health benefits and outcomes are stressed

Measurements: Your need to continue to measure the effects of your health intervention, e.g. uptake of screening, lifestyle changes such as smoking, diet etc. The most appropriate performance measures for your funders would be behavioural changes in the targeted community.

Organisational Development perspective- the integration of the CHE service into mainstream services

Measurements: You need to instigate internal changes to accommodate the CHE service and ensure programme integration with the organisation. The health improvement programme of the Primary Care Trusts will be a useful peg on which to hang the CHE service. The sustainability of the CHE service relies on the breadth and depth of the programme it covers. Here, the CHE service does not only have to support the health intervention programme, but must also tackle the access issue as one of its diversified functions.

The Case example 1 in **Workbook 7** describes a CHE service established in primary care. The service has now diversified into promoting access other than cervical screening. The CHE works very closely with the practice nurse in the surgery to improve ante-natal uptakes of minority women.

Community Development perspective - the building of capacity of the community

Measurements: The competence of the CHEs and the performance of the service in tackling inequality issues will be the foci in this perspective. CHEs will be trained to act as a source of information and expertise for the community, so that they can set their own agenda for health, and can participate in the planning and delivery of health services.

The Case example 2 in **Workbook 7** demonstrates the success of the CHE model in building the capacity of the community through well-accredited training programmes.

The capacity-building objectives for sustainability

To build capacity we have to help the CHEs to

- Achieve self-sufficiency for a research-based programme, so that the CHE service itself can generate evidence to support its claims to have delivered change.
- Become a source of support for both the community and health professionals, and play a vital role in building partnerships between them.
- Increase their knowledge and skills in collaborating in new projects with different organisations and agencies.

With the development of the above three capabilities, the CHE service will be able to respond flexibly to the needs of the communities and to align these needs with the objectives of health and social care organisations. In other words, the service will have the capacity to evaluate, to negotiate and to create.

Tracking changes - Monitoring

The CHEs should be able to measure the sense of control and ownership of initiatives and health programmes among communities and stakeholders.

The CHEs can also measure the knowledge and competence of the community in a particular health issue, and capacity for self-organisation. They can also observe the increased ability of the community to articulate its needs and to participate in decision-making.

The CHEs would be able to involve community members in generating appropriate instruments for measuring successes with the support of an action researcher from an academic institution.

Monitor for quality or 'nurture' for quality?

Examination of the processes of formulation, implementation and evaluation of the CHE training programme is one way to monitor the quality of capacity building.

However, whether or not we can detect transformation will depend on the ability of CHEs to become critically aware of the inequalities that disadvantaged people face, and to develop the understanding and appreciation of how to collect quality information to support change. You can also observe their increased confidence in tackling wider issues, and their overall improvement in organisational and communication skills.

The other way of improving the quality of the CHE service is to look at the process of monitoring in a different manner. Rather than focusing on external changes, you should nurture and support changes from within the CHEs' personal development. A well-formed personal development programme will help them to set goals and achieve their objectives. They will need you to give them regular space (time) to air their concerns, and to help them to take a problem-solving approach to these concerns. To put it simply, they need your nurture and support.

It is important to remember that the need to respond flexibly to the changing environment will mean that no single perspective provides the sole key to sustainability. Different perspectives will be appropriate and will work under different conditions and at different times. As a practitioner, you should strive to think broadly, strategically and, above all, creatively about how sustainability can be achieved. And then, go for it!

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