"It's a 24-Hour Thing . . . a Living-for-Each-Other Concept": Identity, Networks, and Community in an Urban Village Health Worker Project

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Social networks are webs of relationships between individuals, and they play an important role in the complex social processes through which individuals seek information, obtain social support, and mobilize for collective action to modify social, economic, and environmental conditions associated with health and illness. Studies have described and evaluated lay health advisor (LHA) programs that use social networks to improve individual and community health. The experience and perceptions of community members involved with LHA programs have been explored less often and offer essential information to health educators about the design, implementation, evaluation, and support of such programs. This article examines the perspective of LHAs in Detroit, Michigan. Their understanding and experience of their work, the relationships between their activities and a sense of self and community, and personal and programmatic rewards and challenges are examined. The authors discuss implications for health educators related to LHAs' roles, relationship to supporting organizations, recruitment, training, and ongoing support.

> It takes the people that's out in the community to make the project work. It takes all of us—the arms, the legs, the feet. . . . We need a whole complete body . . . in order to make the Village Health Workers work.
>
> —Adena,* village health worker

INTRODUCTION

Social networks are webs of relationships between individuals. They play an important role in the complex social processes through which individuals seek health-related information and advice, obtain social support, and mobilize collective action to modify social, economic, or environmental conditions associated with health and illness.[1-12] The

*Names of village health workers and other identifying information have been changed to ensure anonymity.

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burgeoning literature on social networks and social support has coincided with the development of interventions that build on existing resources within social networks to improve individual and community health. Many studies have defined, described, and evaluated lay health advisor programs[13-24] and examined implications of different recruitment processes, relationships to formal health care systems, types of training, lay health advisor roles, and the effectiveness of this intervention approach.

Relatively few studies have examined lay helping from the perspective of the community members who participate in these programs. Their definitions of helping, their conceptualizations of their role, the qualities they believe are important to their work, the perceptions of their relationship to the community, and the tensions as well as the rewards encountered in the day-to-day process of living and helping in their communities are relatively invisible in much of this literature.[25] Yet, these factors shape the work of lay health advisors, influencing their interactions with other community members, relationships with community organizations, and the type of collective action they undertake. Understanding the experience and perceptions of the community members involved is essential for health educators who design, implement, and evaluate such lay health advisor programs.

In this article, we begin to examine these questions from the perspective of a small group of lay health advisors working in a large urban community in the Midwest. The Village Health Worker Project is an example of an intervention based on an ecological approach, designed to create change at the individual, organizational, and community levels. Using data from focus groups, in-depth interviews, document review, and participant observations, we explore lay health workers' understanding and experience of their work across these levels, and the interface between lay health work and a sense of self in relation to community. We examine the rewards and challenges lay health advisors describe and discuss implications for health education interventions that build on this model.

HISTORY AND CONTEXT

Detroit, Michigan, is one of the largest cities in the United States, with a population of around 1,000,000. Economic decline that began in the 1960s has contributed to poverty and unemployment rates that are among the highest in the country.[26] In 1992, 32% of all residents and 40% of children under the age of 18 in Detroit were living below the poverty line. Increasing racial and class segregation over the past two decades has contributed to the isolation of inner-city residents as employment, stores, and other community institutions have relocated to suburban areas. Yet, Detroit is also a city with many resources, a long tradition of neighborhood organizing, churches that provide social support and are active in community development efforts, and community members with skills and a commitment to strengthen their neighborhoods.[26]

In 1992, the Village Health Worker Project described in this article was initiated as one component of a consortium of community-based organizations, local health departments, and academic institutions funded by the W. K. Kellogg Foundation for a four-year period to address health problems in Detroit and Genesee County. The Village Health Worker

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Project was developed by a steering committee made up of students and faculty from the Schools of Public Health and Social Work at the University of Michigan and Wayne State University, the Detroit Health Department, and Hartford Agape House, a church-based community agency providing a variety of social and community development services. Formally housed in the Detroit Health Department, the Village Health Worker Project was administered through Hartford Agape House and supported by members of the health department and academic institutions.

The lay health advisor model emphasized working through existing social networks to identify individuals who were active and respected in their communities. Village health workers would work with the Detroit Health Department according to their own perceptions of priorities within their communities, not as paid employees working for the Detroit Health Department according to its objectives. They would live and/or work in the settings in which they provided support and assistance to other community members. In addition to providing a variety of types of social support to members of their social networks—for example, affective support (caring, trust, love), informational support (advice, suggestions, information), and instrumental support (tangible aid and services)[8]—village health workers would help link community members to organizations within their community. The relatively autonomous position of village health workers would enable them to advocate for change within community organizations more effectively than if they relied on those organizations for employment.

The Detroit Health Department hired a community organizer to coordinate the Village Health Worker Project. The first cohort of 25 village health workers completed an eight-session training sequence in 1993; a second group of 25 completed the training sequence in 1994. The training provided information about a variety of health-related topics (e.g., hypertension, AIDS), introduced participants to health and social service providers and other resources within the community, and strengthened community organizing skills. At the time of this writing, the project had been underway for four years; 20 village health workers continued to be very active.

The village health workers were primarily women, ranged in age from their 20s into their 60s, and lived in the communities in which they worked. All were African American, reflecting the ethnic composition of their communities. Following the initial training session, they met on a monthly basis to discuss their work, offer and obtain feedback and support from other village health workers and the project coordinator, and participate in ongoing training sessions. Training sessions were developed in response to needs and interests identified by the village health workers based on their experiences working in the community. These ongoing training sessions included, for example, community assets mapping,[27] promoting policy change to encourage smoking cessation, addressing stores that stock outdated food items, and reporting abandoned vehicles and crimes without threat of retaliation. Between meetings, village health workers provided information and support to community members about health-related concerns and participated in collective actions to create change within their communities.

METHODS

The analysis presented in the following pages draws on multiple sources of data, including a focus group interview and feedback and discussion with the village health workers, supplemented by analysis of monthly activity report forms, the village health worker newsletter and other documents, in-depth interviews, and participant observation

by each of the authors over a four-year period. The focus group was structured around questions that were both descriptive (e.g., What was it about this project that made you want to get involved? What do you do as village health workers?) and reflective (e.g., What have been the most important barriers or challenges to you in doing this work? What is it that keeps you involved?).

The focus group interview was tape-recorded, and field notes were taken to note relevant dynamics that would not be captured by the tape (e.g., body language, eye contact). Field notes were integrated with the transcript when the tape was transcribed. Analyses were conducted according to processes described in the literature on qualitative analysis,[28-32] beginning with readings of the text to familiarize ourselves with the contents. The first author then divided the text into "chunks" that seemed to convey a single idea and that could stand outside the body of the text as meaningful concepts. When necessary, descriptive words or phrases were added (in brackets) to these chunks of text to ensure that meaning derived from the surrounding context was not lost in the analysis process.

Next, data chunks were arranged and rearranged in a process of constant comparison[32] within and between clusters to create groups of data that seemed to convey similar concepts. When several dimensions appeared within one of these clusters, it was subdivided into two or more clusters, and when two clusters appeared to reflect a similar idea, they were collapsed to form a single cluster. For example, clusters of similar village health worker activities were created. One of these, initially labeled *provide support to community members*, was subsequently divided into several clusters that appeared to the authors to represent qualitatively different kinds of support (e.g., emotional, informational, instrumental support).

Throughout this process, descriptive memos were developed that summarized concepts within the categories and that sometimes recorded the authors' ideas about links among categories. Two of the other authors reviewed these clusters independently and then met with the first author to discuss and agree upon changes. These clusters and illustrative excerpts from the focus group were brought back to a village health worker meeting for discussion. Several of the village health workers who participated in the focus group attended this meeting, as well as others who had not been part of the interview. This discussion provided an opportunity to validate initial themes,[33] to pursue unanswered questions, and to further clarify the data. Field notes from that discussion were subsequently incorporated into the themes presented below.

RESULTS

Results are described in five sections: community work and identity, activities, accomplishments and challenges, benefits and rewards, and interpersonal and institutional support. Names have been replaced with pseudonyms to protect the anonymity of the participants and community members.

"We Are Community-Oriented People": Community Work and Identity

During the focus group interview, nearly all of the participants introduced themselves with some variation of the following: "OK, my name is Shanise. I'm a village health worker and I'm very proud of that." As they discussed their entry into the project, it was

apparent that they developed identities as village health workers over time as they became increasingly engaged in the project. For example, Shelia described her entry into the project as follows:

> When it initially first started out, Sue [the project coordinator] asked me if I was going to come to the meeting. I told her OK, and I didn't really come the first couple times. And she just kept on me so I said OK. . . . But then I think we were at 123 Church; she had a meeting. And it was so ironic, they asked us all why did we all become village health workers. And I said because Sue twisted my arm for me to be here. But then after I left the meeting, it was so ironic that I was riding home, and just as I'm talking to you I heard a voice say to me, "Stop taking this lightly. Learn all you can learn, and do all you can do because this is going to open doors for you and put you where you need to be." And from that moment I took the village health workers—I began to see it in a different light. Before, I didn't even see it seriously. . . . But then, I really took it in a different light. I started becoming involved, attending all the training sessions, and trying to learn what I could from it.

Shelia's story illustrates the importance of social networks in identifying community members who might participate in such programs. The project coordinator, a longtime community organizer and resident, initially recruited friends and acquaintances who she knew were active in their communities. Later, village health workers encouraged friends and family members to become involved, and they participated in subsequent training sessions. Shelia's story also illustrates a process of increasing identification with the project. She began by attending a few meetings reluctantly, out of a sense of obligation. As she began to articulate connections between her personal goals and the doors that she believed would open through involvement in the project, she began to identify as a village health worker.

Village health workers described themselves as "people persons" and as "community-oriented people." They believed it was essential for village health workers to genuinely like people, be committed to community work, be readily available, and have a personal or spiritual foundation that supported service and action in the community. As Yvonne noted, these were qualities that they brought to the program:

> It's the strength that we already have, to do; the love that we already have. . . . You don't have to teach us to love. You can't teach us that. They have to already be that, you cannot train them in no classroom.

Village health workers also developed new skills, knowledge, and understandings of their communities through their participation in the project. For example, Adena described her increased awareness of information, problems, and resources in her community, as well as her ability to play a role in creating change:

> During the time that I've been affiliated with the village health workers, it has opened a lot of doors. First, the doors in my mind to see the need in my own community. . . . I just didn't want to be bothered with the Block Club, I just didn't want no part of the Block Club. And now being a village health worker, I've had an enlightenment and knowledge that the Block Club is an important thing. . . . We take back information that we know. We take back things to help to make our area safer and a more decent place to *be*.

Adena, like other village health workers, emphasized the spiritual foundations of her commitment to others in her community:

> It's a 24-hour thing. When you go home, it does not end. If you think just because you leave here—on your way out of the door you will see something you need to say or someone you need to offer something to, it never ends. But if you think about it, it's only a god way of life, and it have nothing to do with whoever your god is; it's a living-for-each-other concept.

"You Can Send Out a Little Prayer, But You Have to Put a Little Leg Work With It Too": Providing Support and Creating Change

Village health workers described providing affective, instrumental, and informational support.[8,34] They brought information about a variety of health-related topics and resources within the community (e.g., regarding breast and cervical cancer screening programs, prescription drug cost coverage programs) to community members through their day-to-day activities—in church, in neighborhood Block Club meetings, and in other informational interactions. For example, Shelia described her work as follows:

> I started going to Block Club meetings, and I started sharing the information that I learned. Because there's a vast of information about being a VHW [village health worker], there's things that you learn out here in the community that you can help other people, and I realize that there are so many people that's in need of the things that we have to offer.

Village health workers also provided emotional support through informal conversations with people who approached them with a health concern or a request for assistance. Some went further, developing small organizations intended to address particular issues in their communities. For example, Shelia's experience with the death of her child and her struggle with her own grief process led her, with the support of the Village Health Worker Project, to establish a small nonprofit organization to provide support for grieving individuals. As she explained, "people need to know that there is a place that they can come for help. YANA [You Are Not Alone] is a grief support program, to help individuals with death and dying and to educate people on the grief process."

Village health workers provided instrumental support to community members by, for example, providing transportation to health clinics, helping locate food, and organizing and implementing health fairs in the community with the Detroit Health Department. Gloria, who organized opportunities for neighborhood children to go to the recreation centers, noted,

> Sometimes you have to even get in your old car to take these kids. If you want that crime to stop, you have to get involved [others in the focus group chimed in so "get involved" became a chorus].* There's no ifs—you can send out a little prayer, but you have to put a little leg work with it too.

In addition to providing social support, village health workers also worked for change in their communities. They created new resources in their communities, including YANA;

*Segment in brackets was added to the text of the village health worker's statement from the field notes.

the Special Institute, which offered clothing, nutrition education, and emergency food supplies; and the *Village Voice* newsletter, which provided information about community resources, events, and activities.

Village health workers organized neighborhood change efforts and participated in those organized by others. They developed a strong alliance with the Community Law Enforcement and Neighborhoods (CLEAN) Team in the community police precinct in their area of the city and worked together on a number of initiatives. In 1995, the village health workers worked with the CLEAN Team, bringing together more than 1,200 community members to participate in pre-Halloween activities to improve safety and reduce the number of fires and other incidents in the community. They also organized a monthly abandoned-vehicle effort to identify and remove abandoned cars in their community, monitored local stores to report violations of food safety (e.g., failure to remove outdated food from shelves), and encouraged authorities to enforce regulations designed to protect the health of community members.

Finally, village health workers worked with state legislators and other decision makers to educate them about the concerns of community members and to influence policies and programs that affect the health of community members. For example, when state funds initially granted to community-based organizations for smoking cessation programs were diverted to smoking research, village health workers participated in a letter-writing campaign that convinced state legislators to reverse the decision and return the funds to the community-based organizations.

"Sometimes You Don't Think You Make a Difference, But It's on the Inward That It Acts": Accomplishments and Challenges of Village Health Work

Focus group participants spoke of both personal and collective accomplishments as village health workers. For many, the knowledge they developed about health concerns and community resources through participation in the project was an important accomplishment, as were the skills that enabled them to convey information more effectively to friends and neighbors. They told success stories in which friends or neighbors quit smoking; learned about diabetes, high blood pressure, or other illnesses; and changed health-related behaviors. For example, Connie described her efforts to convince a young mother to stop smoking. Initially not interested, the young woman later did quit and began to encourage her friends to do the same. Connie noted,

> Sometimes, you don't think you make a difference, but it's on the inward that it acts. You can't take it personally if they don't seem to be listening to you; you don't know if it may be impacting them in ways that you can't see.

Accomplishments were not limited to changes in individual-level behaviors. Village health workers described changes in existing organizations and the development of new organizations, like YANA and the Special Institute. Some of these changes provided mechanisms to continue the project beyond the initial funding period. For example, the Detroit Health Department established formal links with YANA as one means to address violence within the community, committed ongoing funding support for the Village Health Worker Project, and established the project coordinator as a member of the health department's executive committee. Shavonda, the village health worker who established the Special Institute, was appointed to a statewide hunger task force. These structural

changes place village health workers in a position to participate in, and influence, decisions about community services, funding, and other resources that affect the health of their communities.

While achieving these accomplishments, village health workers encountered personal, interpersonal, and structural or administrative challenges in their work. They juggled many roles in addition to that of village health worker—as students, parents and grandparents, paid employees, volunteers, and members of organizations and other community groups. All of these competed for their time. There were also financial challenges. Gloria referred to nonmonetary rewards that village health workers received for their efforts—smiles or a thank you from community members—then went on to note that these rewards, while important, did not help village health workers who had few economic resources themselves:

> Everybody don't look at it "a smile'll do" when their pockets is empty. A smile is all right, but you want something to go with the smile. Then you really can smile, you know. Especially if you don't have an income coming in, then it's kind of difficult to just say you getting a thank you all the time. You want more than a thank you.

Village health workers made it clear that they did not expect or desire financial or other recognition from community members that they helped as they attended church, went to Block Club meetings, or otherwise participated in their day-to-day activities. However, particularly those with fixed or limited incomes indicated that reimbursement for travel costs and other expenses encountered in their work was essential to their ability to continue their efforts.

Village health workers believed that their activities and their reputation in the community increased the visibility and credibility of the institutions with which they were affiliated. They found it particularly frustrating when community organizations received new grants and asked village health workers to implement them, without including funds to support their work (e.g., funds for copying, transportation, honoraria). Shelia expressed her reaction to one such incident by saying,

> And I feel, not only was [my willingness to volunteer] taken advantage of but because I love what I do—and I have worked from zero, I did not have income at all—I would come when I didn't even have gas money. And to sit in a meeting and hear someone say, "You should have been grateful to get the information we gave you!" Suppose I felt like that about the people that I see. [Others in the group say, "Exactly."] I thought . . . that was a hit below the belt.

Village health workers made it clear that they did not hold the project coordinator responsible for these difficulties. The conflicts arose when they were expected to implement programs that others had developed without their participation and without social or material recognition for their commitments and contributions.

Other challenges arose as cuts in state and federal programs left large gaps in the resources available within the community. Increasingly, the village health workers encountered problems that they did not have the resources or the power to address. The optimism with which many village health workers faced these limits is evident in Yvonne's comment: "We know we can't solve every problem in our community—they are too big. But we go out there every day; if we can change 1% every day, we're doing something."

"But When You Put Yourself Out There to Help Life, Life Give You So Much More in Return": Benefits and Rewards of Village Health Work

Village health workers emphasized the importance of opportunities within the program to act on values that were central to their sense of themselves as members of their communities. There was nearly unanimous agreement that participation in the project opened doors for those involved, providing opportunities for personal change and growth, participation in collective activities, greater access to resources, employment, and personal satisfaction. Shelia described using the information that she gained about breast and cervical cancer to address her own health concerns:

> When I went I learned something out of that training that I could take back and use into my own personal everyday life. Even just the breast and cervical cancer. At the time, I needed a mammogram, I needed to have—"well go to the health department then you can get one done." So that was a resource for me; I utilized it first. And I was very pleased with the treatment, and then I recommend it to other people. And now I'm beginning to tell other people the importance of having these things done.

Adena described the satisfaction she felt as she shared information and other resources with friends and neighbors:

> See sometimes, people want to pay, ain't got nothin' to pay me, well I'm not working for that. But it's a joy. And then sometimes we don't get a deluxe breakfast like this, but we had a deluxe menu in our minds of things we can help people with. That's the fine part of it.

Benefits of participation included working with others they liked and respected and the mutual support they experienced. Yvonne described working with other village health workers:

> And I mean I think we are an excellent group of people 'cause we all special. And all of us brought in our expertise. Like she said, nobody better than the other person, nobody snob down—if you did you overcome it when we get through with you anyway. . . . The reason I love it is because we network so beautifully. No one being a village health worker can feel insecure because everyone help everybody else. I can go to anyone and I love being a part of this. I can't get enough of being around people that make me feel like you're somebody. Nobody make you feel like you're less than they are.

Village health workers also spoke of the satisfaction they felt as people in their neighborhoods came together to work toward common goals. Shanise noted how important it had been to her to see community members working together to reduce Halloween-related incidents:

> Like Halloween—I never seen so many people out at the Northwest Activities Center, to come out being concerned again. That's the primary thing—being concerned. And they were serious—I mean it wasn't just young people there. It was old people, about not letting their house get burned down, not letting their community get destroyed. The foundation is solid. I don't think it can get any solider.

Finally, village health workers described their belief that the rewards of their work with the project were not all in the present. They noted that the problems in their communities were large and that they would not be solved in a day. Shanise expressed her belief that there were future and currently unknown benefits: "We don't know what door might open up because we gave of our time."

"It Takes All off Us—the Arms, the Legs, the Feet—to Make It Work": Interpersonal and Institutional Support for Village Health Workers

Village health workers described support from many sources that enabled them to do their work in the community. These included the mutual support that was apparent in the interactions among the village health workers and the project coordinator. As noted earlier, the project coordinator was a resident of the community and had been a community organizer and leader for many years before beginning to work with this project. In addition to recruiting and training the village health workers, she was actively involved with their work, helping them locate resources within the community, providing ongoing education and training, assisting with community-organizing efforts, and developing new initiatives to bring together different groups within the community and local government to work toward community change. Adena described the importance of the coordinator's ongoing support:

> But she give me so much encouragement, she's never too busy to tell you, to give you the information that you need. . . . She makes sure that we keep abreast. And I appreciate that because we got someone double checking and double checking, some of the things you don't often use and you will forget, so I appreciate when someone follows through with trying to see that I'm doing what I'm supposed to do. I think that's just as important as sending a person out; you should see that they're doing what they're supposed to do and they're doing it right. So reviews and all that, and coming together and listening to what they're saying . . . and we come together, she talking about this and say, "Oh, that's right"—it refresh our memory. I think it's very important so, helping the people, you know we have to get help also. And I'm grateful for that.

Village health workers also had suggestions about how their work might be supported more effectively. Although they described rich personal rewards, village health workers also felt that they needed positive and concrete recognition for their work. Some, like Shelia, felt that small monthly stipends or other financial supports would help: "People need some kind of compensation. It doesn't mean that they're looking for a big salary. . . . Give them something, an incentive."

In addition to financial and social recognition, institutional support in many forms and from many sources was essential. The Detroit Health Department provided training and a base for community organizing and development efforts initiated by the village health workers. The project coordinator's position as part of the executive committee in the Detroit Health Department allowed her to communicate on a regular basis with decision makers and to build a strong base of support for the project in the health department. Agape House wrote grants that included the village health workers and helped obtain material goods for the Special Institute. The University of Michigan's School of Public Health helped develop the project initially and provided ongoing training and consultation

in the area of community organizing and organizational change. The 2nd Police Precinct was an ongoing partner providing support for the village health workers.

Village health workers felt that they could do even more if they had a stable space that they could count on as a home base, with some support for basic materials such as gas money. Furthermore, they stressed the importance of recognition and legitimacy in the eyes of organizations and institutions in the community so that, for example, their referrals would be treated with respect. They believed that support and teamwork among all levels of individuals and organizations working with the project were essential to its success. Gloria summarized this belief:

> But, you know what, that's why it's very important that everybody is somebody. You may be the person that sits behind the scene and get the ideas and write the grants, but in order for those grants to work effectively, it takes the people that's out in the community to make them work. It takes all of us—the arms, the legs, the feet—to make it work. We need a whole, complete body. If you don't work it as a whole, it's going to be something missing. You may have the money or whatever, but if you don't get anybody to work it, you're still out of luck. We may have the legs and arms and stuff, but we don't have the other part that goes with it; we're still out of luck. So it takes all of that in order to make the Village Health Workers work.

DISCUSSION AND IMPLICATIONS FOR HEALTH EDUCATORS

These results have implications for health educators working with lay health advisor programs that emphasize the development and enhancement of existing social networks as avenues for social change. These include implications for designing programs that build on lay health advisors' expertise and knowledge of their communities, structuring the relationship of lay health advisor programs to community organizations and institutions, and supporting lay health advisors activities toward change at multiple levels in their communities.

Building on Community Resources

A number of processes have been described for identifying community members to participate in lay health advisor programs.[35-37] In this article, rather than asking how to identify community health workers, we examined the qualities, values, and identities that community members bring to their community health work. The results highlight the role of existing social networks; the project coordinator and, later, village health workers identified members of their social networks who were engaged in community work and encouraged them to participate in the project. They brought with them essential qualities—qualities that "you can't teach in a classroom." Through participation in the project, they gained new skills and found support for individual and collective actions to influence processes and changes related to health within their communities. Our results also illustrate the reciprocal support that developed among lay health advisors, community members, the project coordinator, and the supporting institutions. Basic research has indicated that aspects of social networks and social support are associated with health

status, suggesting that lay health advisor programs also offer health-protective effects by strengthening and expanding existing social networks.[6-8,10,11]

These results highlight three challenges for health educators working with lay health advisor programs. The first challenge is to locate community members who are embedded and active members in their social networks, whose basic philosophy and values are consistent with those of the program, and whose skills and interests match with broad program goals. The second challenge is to build on the skills and knowledge that community members bring and to offer opportunities for individual and collective action that are consistent with the values of the lay health advisors as well as the objectives of the program. The third challenge is to provide opportunities for lay health advisors to shape the program and to develop relationships among participants that provide mutual support for them and for their activities. This means recognizing the qualities, skills, motivations, and interests of lay health advisors, involving them in making decisions about training and other program activities to ensure that the program develops in ways that are consistent with their interests and goals, and developing relationships among participants and supporting organizations and staff that provide mutual support and reinforce the autonomy of the lay health advisors. Issues of control and influence are important. The autonomy of the lay health advisors and their ability to define their roles according to their perceptions and experience in the community are essential in programs that seek to build on those strengths.

Relationship to Supporting Institutions

Village health workers developed diverse relationships with a wide range of organizations, including neighborhood Block Clubs, churches, police precincts, service providers, academic institutions, and community-based organizations, including those that they established themselves. These relationships provided ongoing access to information and expertise, funding, decision makers, and a wide range of community members, and provided a broad base of support for their work. The importance the village health workers placed on these supports is consistent with other work emphasizing that lay health advisor interventions should provide opportunities for ongoing training, consultation, communication, and support for the activities of involved community members.[9,23,37]

Our results show that it is not simply the quantity of these relationships that is important but the quality. Although village health workers had different experiences and expectations, the importance of recognition and respect for their contributions was evident. For most, this meant social and material support; affirmation and acknowledgment of their skills and contributions; reimbursement for expenses incurred in the course of their work; for some, opportunities for paid employment with the supporting institutions; and, perhaps most important, being treated with honesty, integrity, respect and consideration in their interactions with service providers and other community organizations. Reimbursement or financial recognition became salient when lay health advisors felt these elements were absent or when they felt their contributions were taken for granted.

These results are consistent with the results of others who have examined reasons given by community members for discontinuing involvement with similar programs[38] and lay health advisors' expectations for autonomy and respect.[39,40] They highlight some of the fundamental distinctions between lay health advisors and outreach and peer education

programs.[38] Lay health advisor models build on existing social networks, recognizing that the credibility of lay health advisors is grounded in their history, autonomy, and availability to community members; they are people to whom others already go for help and advice. In contrast to outreach workers or peer educators, they are not paid employees and do not work for an organization performing defined tasks. As employees and representatives of an organization, outreach workers may or may not live in the community that they work within. They provide valuable services for the organization that they work for but may be less willing to advocate for organizational change than lay health workers who do not rely on the organization for employment. Our intent is not to suggest that one model is better than the others but to emphasize distinctions among them and encourage health educators to plan and implement programs that are appropriate to the desired goals and community context.

Health educators can support lay health advisors by recognizing their diverse interests and priorities, listening and being attentive to their particular motivations, and providing ongoing informational, emotional, and material support (e.g., providing stipends for training and ongoing participation and reimbursement for transportation, photocopying, and other expenses) for those who contribute their time, energy, and skills to their communities. Furthermore, they can reinforce the autonomy of lay health advisors, supporting their ability to act as advocates and agents for change in their communities.

Individual, Organizational, and Community Change

Village health workers described activities at multiple levels of practice. At the individual level, they provided informational, emotional, and instrumental support to community members, consistent with the literature describing dimensions of social support.[8,35] At the organizational level, they worked to change existing organizations, develop new resources and services, institutionalize mechanisms for community voices to be heard by local and state decision makers, and create new pathways to bring information and services to community members. At the community level, they worked with other groups to mobilize for community change to address health-related concerns. These findings are consistent with those of others who note that social network interventions can contribute to change at the individual, organizational, and community levels.[13,38,41] They are consistent with an ecological intervention approach that emphasizes that individuals are embedded within a social context and that suggests that interventions are most effective when they address change at multiple levels within the social system, not simply at the individual level.[42]

The three levels of change—individual, organizational, and community—together reflect dimensions of community empowerment. Empowered communities have been described as communities in which individuals work within groups or organizations to increase control and access to resources and to ensure that the needs of members of the community are met, which is, in turn, associated with enhanced health and quality of life.[43-47] By creating programs that facilitate ongoing skill development at multiple units of practice, that support the participation and influence of lay health advisors, and that foster collective action for community control and change, health educators can assist in strengthening the ability of community members to work through existing social networks to influence political, social, and economic processes related to health.

LIMITATIONS OF THE STUDY

The results presented here are grounded in the experience and reflections of individuals who have been involved with a lay health advisor project in Detroit over several years. The particular historical, social, and economic context within which this program developed has shaped the experience of the participants in their communities and in the program. Furthermore, these results draw on one focus group discussion with the village health workers, supplemented by participant observation, in-depth interviews, and document review. They reflect the personal experiences of the village health workers and do not examine the effects of their work in the community from the perspective of the community members or other potential indicators of individual or community change. Therefore, while the findings discussed above have important implications for health educators, these limitations should be considered when translating these results to other programs and settings.

CONCLUDING COMMENTS

Lay health advisor interventions draw on theoretical and empirical evidence that suggests that existing social networks can provide information and social support and mobilize collective action to address health-related issues within communities. This article highlights the perspectives of lay health advisors to emphasize the resources, experience, and expertise that they bring to health education interventions. The results presented here highlight some of the limits and challenges as well as the strengths of lay health advisor approaches to address social processes that contribute to inequalities in health.

An appropriate and comprehensive training program is necessary but not sufficient to ensure a successful lay health advisor intervention. Recruitment strategies and selection criteria that identify individuals with existing skills in helping people, an interest in community change, and values that match those of a lay health advisor approach are important. Ongoing support and technical assistance that is grounded in the interests of both the lay health advisors and the health educators and that is responsive to challenges faced by lay health advisors as they carry out their role in the community are also essential. Finally, ongoing evaluation and feedback in which the village health workers are active participants can further enhance the relevance and effectiveness of the program.

Community members bring different expectations, motivations, and skills to lay health advisor programs, and they will find their rewards in different ways. To create programs that build on, but do not interfere with, existing resources within the community, health educators must find ways to support lay health advisors without interfering with their autonomy. Interventions that encourage the participation and influence of lay health advisors in program implementation and evaluation, that build on the strengths of participants, and that provide ongoing technical, social, and material support to help them work toward their goals can enhance the capacity of the community to effect health-related changes at multiple levels.

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