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Engaging with marginalized communities: The experiences of London health trainers

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Key words

health trainers; health promotion; community engagement; public health workforce; lay health workers; behaviour change

Abstract

Aims: Health trainers represent a new occupational role within the NHS which has been developing since 2006, when the first 'early adopter' sites were funded by the Department of Health. Health trainers are 'lay' people recruited to engage 'harder-to-reach' people from their communities, offering one-to-one support to enable them to make the healthy lifestyle changes of their choice. The aim of this study was to explore the experiences and approaches adopted by health trainers in engaging with marginalized communities.

Methods: This paper describes an exploratory study using in-depth semi-structured interviews with 10 currently employed health trainers with diverse backgrounds, forms of employment and interpretation of role, drawn from seven London primary care trusts (PCTs) or boroughs.

Results: The study found tensions between the lay identity of health trainers and their adoption of a formalized role. Health trainers emphasized their similarities but underestimated their often significant differences to their communities. Health trainers based in community or voluntary groups found engagement easier than those based in PCTs, and saw engagement as an end in itself, through its creation of opportunities for health.

Conclusions: There remains a lack of clarity about the role of the health trainer. Lay workers are not necessarily part of the marginalized communities they are expected to engage, while their ability to do so is compromised by the professional culture of the NHS and its approach to community engagement. Health trainers based in the community or voluntary sector appear to offer greater potential for engaging communities and providing those communities with practical opportunities for health gain.

INTRODUCTION

In 2004 the Department of Health[1] launched a new public health role to reduce inequalities, called health trainers. By March 2009, 76% of UK primary care trusts (PCTs) had a service named 'health trainer' in place, with more than 2,076 health trainers, or health trainer champions who support them, recorded.[2] National job descriptions, competencies[3,4] and a system of accreditation to level 3 City and Guilds for Health Trainers and RSPH level 2 for Health Trainer Champions[2] have been developed.

The Data Collection Recording System (DCRS) is used to monitor the impact of the services nationally but it is still at an early stage. In addition, case stories are collected using a common template (see, for example, those from Bexley[5]); some services have commissioned evaluations[6–10] examining recruitment, training and practice; and a value-for-money tool has been developed nationally. Several papers from studies of PCTs in northern and central England, undertaken in 2007–2009 comprising in-depth consultations with key primary care stakeholders, health trainers and their clients have also been published[11–13] but there is little critical literature exploring the nature and impact of the scheme.

Health trainers were established specifically to work with the most disadvantaged groups to improve health and are generally intended to be 'non-professionals' whose personal qualities are more important than formal training.[3] They will 'often come from local communities'[1] (p. 106) and work within them to promote health among

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marginalized groups, although once in post they will be 'professionally trained and accredited by the NHS'[1] (p. 105).

The non-professional or lay aspect of the role was expected to bring new approaches and increase effectiveness in 'making relationships'[4] (p. 3) with marginalized communities. *Choosing Health*[1] stated that health trainers will:

> '…be in touch with the realities of the lives of the people with whom they work and connected through a shared stake in improving the health of the communities that they live in.' (p. 106)

Lay health workers are widely used internationally and across different settings, acting as a bridge between healthcare systems and disadvantaged populations. Typically, they are unpaid, without professional qualifications and trained for a specific role. A systematic review found high-quality evidence that lay health workers may be effective in improving specific health outcomes, such as vaccination and breast cancer screening uptake, with the potential to reduce costs.[14] A UK literature review[15] found evidence of other possible outcomes, including engagement of hard-to-reach groups, flexibility and sensitivity to need, improved communications with services, and contribution to social capital, but the quality of the evidence is variable and unclear. Early health trainer programme stakeholders saw the recruitment of health trainers from within local communities as a positive move,[12,13] but in 2009 still had some concerns about how they 'fit into current service provision'[11] (p. 7). Interviews with health trainers' clients in West Sussex concluded that the programme had not successfully engaged more marginalized groups and noted tensions between the lay and professional aspect of the role,[8] while another reported that health trainers would have welcomed training on how to successfully engage with communities.[9] South et al.[12] recommended that the lay concept and 'the complexity of the relationship between such workers and their constituent communities' (p. 229) be further explored.

It has long been thought that social networks, which already have 'natural helping' or informal systems of support, could also act as agents of health promotion change.[16,17] Being lay is seen as central to effectiveness and particularly the ability to engage communities.[18–20] Shared language, beliefs and social or ethnic characteristics are claimed to enable lay workers to act as 'cultural brokers' for marginalized groups, according to Brownstein et al. and cited by Earl et al.[20] Lay workers are believed to belong to local community networks, giving them a unique and necessary advantage in accessing hard-to-reach groups.[19,20] As such they are seen to make 'a unique contribution to multi-disciplinary public health'[21] (p. 99) and able to overcome barriers created by professional culture and background.[20] Other research indicates that the reality is more complex[18] and potentially related to the variable characteristics of the worker, community, employing organization and training.[15,18,22–27] There has been little or no research that demonstrates the extent to which lay workers have successfully engaged the most marginalized groups.[15]

Health trainers are distinct from other community-based lay health roles because they are intended to facilitate behaviour change in individuals from a range of communities, addressing a range of health issues, which is described as a 'generic' approach;[4] others tend to target individuals from particular communities or with specific health issues, or they work at the community level.[15] However, health trainer policy implementation has been locally determined and diverse.[13,28] Although led by PCTs, health trainers are based in a range of health and non-health settings, and are also employed by other statutory bodies and community or voluntary groups;[1,5] not all have followed the generic individual behaviour model.[29]

'Make relationships with communities' (HT1) is one of four national competencies required for the health trainer role, and can include building trust and engaging with, or possibly running, community groups.[4] This aspect of the role fits within the concept of community engagement, used to describe a wide spectrum of approaches to, and purposes of, working with communities recently enshrined in National Institute for Health and Clinical Excellence (NICE) guidance:[30]

> '…an umbrella term that encompasses a range of different approaches to involving communities of place and/or interest in activities aiming to improve health and/or reduce health inequalities. It therefore refers to an eclectic arena of activity with no single defining value base.'[31] (p. 2)

This spectrum, like other typologies of participation, reflects differing degrees of engagement: from simple provision of information at one end, to community development at the other, where higher levels of empowerment are assumed.[31]

Early research identified a lack of clarity about the nature and approaches of health trainers to community engagement.[12,13,15,28] Visram et al.,[13] for example, found that some early implementation sites were putting greater emphasis on community engagement than work with individuals, seeing this as essential to finding clients: '…people are not just sitting waiting for a health trainer' (participant cited p. 22). According to an earlier national activity report, 16% of health trainer service providers saw themselves as taking a predominantly 'community approach'[30] but the meaning of this is not explicit. For example, some participants who planned a community development approach were referring to working in a community setting, but using something 'similar to a medical referral model'[28] (p. 34). Another of the health trainer activity reports[2] found most health trainer services were shifting away from 'community work' to individual behaviour change.

In this context, the study aimed to explore health trainers' understanding of engagement with marginalized communities, and in particular:

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- the extent to which they perceive themselves as from their communities
- the extent to which they perceive themselves as professional or lay
- what they see as the purpose of, and their approach to, community engagement activity.

METHOD

At the time of the study 14 of the 32 London boroughs had an active health trainer programme, but three were excluded from this study because they were insufficiently established, and one declined to participate. Coordinators in the remaining 10 forwarded written invitations to all health trainers in their borough to take part. Responses were received from health trainers in seven PCTs or boroughs located in both inner and outer London, and at least one health trainer was interviewed from each. Their health trainer services varied widely, employing between 5 and 20 health trainers, voluntary and paid, and using diverse approaches and employing organizations.[7] Six of the borough programmes were led by PCTs, and the seventh by a local authority, reflecting the largely PCT-led programme nationally.[2]

All 10 study participants worked with adults, were currently employed in a role they and their coordinators described as health trainer, and had been in post from six months to over five years (Table 1). All participants but one were female and ethnic backgrounds were very diverse. Table 1 illustrates the wide interpretation of the health trainer role: five participants were employed by the NHS and worked solely as health trainers, mostly with individual clients in a generic way; four worked in the third sector, in existing roles to which health training was an 'enhancement', although none used the term 'enhanced role'. These enhanced-role health trainers described working mostly at a group or population level, with all those in the third sector targeting either specific health conditions or population groups (such as diabetes or women). Four of the five NHS health trainers were paid and had written job descriptions; the rest of the participants were volunteers in their health trainer role. Four had a degree or professional qualification, split equally between NHS and third-sector health trainers. The type of training received varied: while none used the term health trainer champion, half of the participants had already gained or were working towards a level 2, rather than full health trainer, qualification; four of these participants were in the third sector.

Participation in the study was voluntary and the role of coordinator was limited to forwarding invitations to participate. These included detailed information and written consent was obtained from all participants. Ethical approval was obtained from Bromley Research Ethics Committee in February 2009, and research governance approval was obtained from all participating PCTs. The health trainers took part in in-depth semi-structured interviews of up to 90 minutes, focusing on:

- their communities, including harder-to-reach and disadvantaged groups
- views on their membership of their communities
- views on the lay and professional aspect of the role
- their approaches to community engagement, its intended outcomes and their actual experiences
- the nature of their employment, training and employing organization
- barriers and facilitators to community engagement.

This approach was chosen to give health trainers a voice and explore the range of individual experience in depth: it produced a rich and insightful understanding of the role and of their relationship with the communities with which they worked. Interviews were digitally recorded, transcribed verbatim and the data were grouped into categories and themes, in consultation with the principal researcher. Analysis was led by the data but with reference to field notes, participant characteristics and underpinning theoretical concepts.[32] Deviant cases were sought out. The data reported are anonymized and quotes are not attributed to individual participants to protect the anonymity of a small sample.

RESULTS

Three overarching themes emerged from the findings, revealing an ambiguity about the role:

- Health trainers emphasized their similarities with their communities and underestimated their differences.
- Most health trainers did not consider themselves to be professionals but aspired to be, or on some level already were, professionals.
- Approaches to, and experiences of, community engagement varied according to their employing organization.

Similarities and differences to communities

> 'We are the community aren't we? I'm not just any Tom, Dick or Harry off the street.'

All the health trainers saw being similar to the community as what is unique or important about their role, yet the role itself, or certain aspects of their own background, established a difference and created a sense of contradiction. All described themselves as very much members of, or similar to, their target communities and saw this as a key facilitator to community engagement, irrespective of employer.

> 'And and that's what's good about the health trainers,…I am what I am from the community myself…and I can connect with them people you know.'

All regarded local knowledge was seen as key to the work, whether this derived from living locally for a long period of time or from having some form of shared experience, such as being an immigrant, having a health condition or experiencing marginalization:

> 'Erm well first of all I am an immigrant, right, and er so I share something with a large proportion of the people who live in [X] borough, right?'

While displaying considerable empathy towards their communities, many of the

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Table 1

Study participants' characteristics

Employer type	Primary/ Enhanced role	Paid/ Unpaid	Main approach*	Period in post (years)	Health trainer training	Previous training (non-health trainer)	Job description
NHS	Primary	Paid	Generic individual	5.7	Non accredited	Not sure, below degree level	Yes
NHS	Primary	Paid	Generic individual	0.6	Level 3 City & Guilds	Degree	Yes
NHS	Primary	Paid	Generic individual	0.7	NVQ in progress – did not know level	Certificate	Yes
Third sector	Enhanced	Unpaid	Targeted community	0.5	Level 2 City & Guilds	Qualified professional/ degree	No
Third sector	Enhanced	Unpaid	Targeted group	0.6	Level 2 City & Guilds	Vocational qualification	Yes
Third sector	Enhanced	Unpaid	Targeted group	1.0	RSPH level 2	Qualified professional	Not sure
NHS	Primary	Paid	Generic individual	0.9	RSPH level 2	Degree	Yes
Third sector	Enhanced	Unpaid	Targeted population	0.75	Working towards NVQ level 3 City & Guilds	NVQ level 2	No
Third sector	Enhanced	Unpaid	Generic group	3.0	Working towards NVQ level 2 City & Guilds	NVQ – level not reported	Yes
NHS	Enhanced	Unpaid	Generic group	3.0	NVQ level 3 planned	Level 2 City & Guilds in progress	No

* Visram et al. evaluation of early health trainer schemes uses this distinction between individual/group and generic/targeted approaches[13]

participants also dissociated themselves, particularly from the most marginalized. While understanding the difficulties their clients faced, most were frustrated by the lack of health knowledge or the attitudes they often encountered:

> 'You want to sit down with them and talk, you know, they look like they don't live in this world, they don't understand, they are not watching the news, they don't know, they are surprised when you tell them something, you know, and they keep asking silly questions.'

These attitudes included resistance, apathy, self-pity and denial, which alongside lack of knowledge, were seen as some of the main problems, and sometimes a cause of the marginalization experienced by some of their target groups.

Lay versus professional role

> 'I'm not a nurse, so who am I?'

None of the health trainers saw themselves as health professionals and perceived this as an advantage in their work. They considered themselves more accessible because they were from the community, had more time, were more people orientated, flexible and understanding, or did not behave in a superior way:

> '…we are not seen as a health professional as such, it's not judgemental is it? It's sort of not intimidating…we don't have a set time with anyone, it's more laid back and relaxed. And you know we are just generally helpful people where we go out of our way…'

At the same time, all either saw themselves as a kind of professional or aspired consciously or subconsciously to being more professional at some level, principally because it would give them greater status and influence, not only in the workplace, but also in the communities they saw themselves as part of. While work experience or qualifications were not emphasized, these were seen as differentiating the health trainer from the community:

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> 'I don't want to downplay the whole training role but I don't see myself as being, erm, any better than them in any which way because I am exactly the same as them, but I have had a bit more training and so I have a bit more knowledge.'

Four of the participants had obtained an earlier degree or higher-level qualification, and all put strong emphasis and value on their training and knowledge as their main contribution to the community. This contradiction between being 'of' a community and 'for' a community created some degree of internal conflict or confusion for most of the participants.

Although some of the NHS health trainers had close working relationships with health professionals, almost all encountered health professionals, in particular GPs, who were unsupportive, or saw the role as inferior. Many health trainers noted their lower status as non-clinicians:

> '…then you know there's this thing about ooh you know *I'm* medical.'

The health trainers were all generally unsure whether communities saw them as professionals or not, particularly because the role was new, and the majority felt this affected their credibility in some ways:

> 'I suppose really simplifying it if the doctor said you have to take these tablets, they'd take them because the doctor tells them, but if the health trainer says right you really need to er be eating more fruit and veg,…then they might not do it so willingly I suppose, yeah.'

They suggested ways of being, or appearing, more professional to the community and health professionals, such as 'professional' behaviour, greater knowledge and skills, stronger association with the NHS, access to clinicians, uniforms or badges, and greater promotion of the role at strategic level.

Approaches to community engagement

> 'We have to go and get people.' (PCT participant)
> 'They invite all of their friends to come.' (third-sector participant)

Engagement with communities ranged from simply promoting services, to advocacy or to creating social networks and group activities. For the four paid health trainers employed by the NHS and for whom health training was their primary role, community engagement was principally a way to publicize and recruit people to their service, in order to promote individual behaviour change:

> 'Because we started off it was a case of go, go, go to…your people and that's what we do a lot of, we have to go and get people and make them aware of the service.'

Substantial time was spent promoting the service to the public, and while all NHS health trainers were popular with their individual clients and found this work satisfying, some found initial recruitment a challenge, or preferred direct referrals from health workers, questioning whether general promotional activities were effective:

> '…some of them you can't, as soon as they see you, it's like those people standing in the street giving these leaflets. That's how they will see you.'

Most of the NHS health trainers took directions from senior members of staff, with work linked to clinically focused topics. They described limited autonomy and extensive performance management, with the implication that the PCTs were interested primarily in targets and data:

> 'We're kind of like you know this is your slot, you're there, and at the end of the month we're getting data from you, how many people did you see, how many interventions, and that's it.'

Among the five non-PCT health trainers, the aim of community engagement, which was part of their existing role, was mostly to raise awareness of particular health conditions amongst at-risk groups, or to provide practical opportunities for the community to lead healthy lifestyles, such as running exercise classes. Only one of these health trainers reported difficulties in engagement and this was ascribed to stigma associated with their focus on sexually transmitted disease. The rest found their services in strong demand, with clients coming mainly through word of mouth:

> '…because the women when they are happy because they tell everybody and they invite all of their friends to come because they are happy with the activity…'

Benefits of group work for supporting behaviour change and socio-emotional well-being were emphasized by all those running groups, whether NHS or non-statutory:

> 'People are very conscious about health and things. They need an opportunity to er come go somewhere and *do* it.'
> '…some of them at the [cookery] programme that I was running, we are like family.'

Three of the non-PCT health trainers were leading members of their organization, and all described higher levels of autonomy and little or no performance management. At the same time all but one expressed a desire for greater statutory support in some form, such as guidance, recognition or funding:

> 'Till now I haven't had any funding yet, I am still applying for it but I didn't get anything yet and I have been paying for my own pocket, you know, all this time with the help of women…'

DISCUSSION

This study illustrates some of the tensions and contradictions in the health trainer role. There is a tension between assumed lay identity versus the adoption of a formalized role and move to

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paraprofessional status.[19] There is also a tension between a statutory objective of individual behaviour change versus the health benefits of greater community control and empowerment.

In contrast to health professionals, the health trainers had many attributes assumed to characterize lay workers, namely, local knowledge, approachability and accessibility, and described how this facilitated engagement. However, lay worker attributes were not consistent, as found by Chui and West:[18] not all came from the local community and educational background varied. An evaluation in Manchester also found that a third of health trainers were educated to degree level.[10] While seeing themselves as 'credible' members of the community,[11] and very committed to it, most participants in this study described target communities, and particularly marginalized communities, as lacking the health knowledge and attitudes they themselves possessed and aimed to provide. In Ball and Nasr's study in northern England those without earlier qualifications sought to remain deep rooted in their communities,[11] while in the present study most health trainers had continued, embarked on, or aspired to some process of professionalization.

This study shows clear differences between health trainers in PCTs and health trainer enhanced roles in the third sector. Despite their generic occupational title, their actions are very different. The PCT health trainers are more akin to a paraprofessional[19] with a greater degree of formality in the role, lower levels of autonomy, considerable performance management in relation to outcomes, and adoption of more individualistic approaches. Although they do not necessarily see themselves as organizationally assimilated, and often described being outsiders and having a low status within the NHS, accountability is to their employer. Community engagement was seen as a process of service promotion and outreach, to identify at-risk individuals within a medical referral model, as previously observed by Visram et al.[13]

The enhanced-role health trainers, while still aspiring to professionalism, can be described as more like 'natural helpers'[19] because of the greater informality, autonomy and higher levels of community engagement enabled by their pre-existing role. While behaviour change is their objective, they also see, through their wider role, community engagement as a purpose in its own right, the outcome being supportive environments that facilitate healthy lifestyles and have wider social benefits. Community engagement was seen more in terms of a community development approach that aims to build social capital.[33]

It seems therefore that community engagement for better health is likely to be more successful using community development approaches but that this is more difficult within a PCT, as also suggested by an evaluation in the East Midlands.[7] Statutory organizations, which are less embedded in communities, find it harder to build community capacity and prefer more easily evaluated outcomes.[34] This study suggests that the key competence for health trainers of 'making relationships'[4] is conceived simply as a means of finding people for the purpose of 'health persuasion'.[35]

The new coalition government in the UK has shown a great deal of interest in the role of lay people in the delivery of care – both as volunteers and in non-professional paid roles – linked to their ideal of the Big Society.[36] Internationally, community health workers drawn from local communities have a long history, although evidence of their effectiveness is equivocal.[14,37] There is also a growing body of evidence about ways in which lay people can be involved,[38] but the assumption that simply being 'the person next door', or of having less education, would enable engagement with disadvantaged groups is shown here to be simplistic. The health trainers felt they understood 'the realities'[1] of the communities with which they worked, but their differences, in terms of knowledge and attitudes to health, and professional backgrounds or aspirations must question whether they are truly 'connected through a shared stake in improving the health of the communities that they live in'[1] (p. 106).

CONCLUSION

While this is a small-scale, exploratory study, it shows that lack of clarity about the health trainer role[12,13,28] persists at an operational level, including confusion about its various forms. It raises questions about the different types of lay workers, assumptions about their community membership, and their best use within the public health workforce. They suggest they may be more effective at community engagement when they are based in organizations more embedded in the community, where they can operate on a more informal level, have more autonomy and use community development approaches. Within the NHS, health trainers are seen as an entry level at band 3 (Public Health Online Resource for Careers, Skills and Training; PHORCaST), providing a ladder to further employment. Yet this ladder may compromise their 'natural helping' role and ability to work in the informal, more community-led way that makes the lay contribution unique.

Recommendations

1. Higher priority should be given to supporting and evaluating community development approaches to health improvement that go beyond individual behaviour change, particularly through the voluntary and community sector.
2. The inherent tension within the lay health role should be acknowledged, while lay workers' understanding of and ability to engage marginalized communities should not be assumed but explicitly addressed and supported.
3. Care needs to be taken not to undermine the potential contribution of lay workers, particularly their informality and autonomy to respond to need, by overemphasis on performance management and 'professional' conduct and expertise.

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PAPER

Engaging with marginalized communities: The experiences of London health trainers

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Abstract

Aims: Health trainers represent a new occupational role within the NHS which has been developing since 2005, when the first 'early adopter' sites were funded by the Department of Health. Health trainers are 'lay' people recruited to engage 'harder-to-reach' people from their communities, offering one-to-one support to enable them to make the healthy lifestyle changes of their choice. The aim of this study was to explore the experiences and approaches adopted by health trainers in engaging with marginalized communities.

Methods: This paper describes an exploratory study using in-depth semi-structured interviews with 10 currently employed health trainers with diverse backgrounds, forms of employment and interpretation of role, drawn from seven London primary care trusts (PCTs) or boroughs.

Results: The study found tensions between the lay identity of health trainers and their adoption of a formalized role. Health trainers emphasized their similarities but underestimated their often significant differences to their communities. Health trainers based in community or voluntary groups found engagement easier than those based in PCTs, and saw engagement as an end in itself, through its creation of opportunities for health.

Conclusions: There remains a lack of clarity about the role of the health trainer. Lay workers are not necessarily part of the marginalized communities they are expected to engage, while their ability to do so is compromised by the professional culture of the NHS and its approach to community engagement. Health trainers based in the community or voluntary sector appear to offer greater potential for engaging communities and providing those communities with practical opportunities for health gain.

INTRODUCTION

In 2004 the Department of Health[1] launched a new public health role to reduce inequalities, called health trainers. By March 2009, 76% of UK primary care trusts (PCTs) had a service named 'health trainer' in place, with more than 2,076 health trainers, or health trainer champions who support them, recorded.[2] National job descriptions, competencies[3,4] and a system of accreditation to level 3 City and Guilds for Health Trainers and RSPH level 2 for Health Trainer Champions[5] have been developed.

The Data Collection Recording System (DCRS) is used to monitor the impact of the services nationally but it is still at an early stage. In addition, case stories are collected using a common template (see, for example, those from Bexley[6]); some services have commissioned evaluations[7–10] examining recruitment, training and practice; and a value-for-money tool has been developed nationally. Several papers from studies of PCTs in northern and central England, undertaken in 2007–2009 comprising in-depth consultations with key primary care stakeholders, health trainers and their clients have also been published[11–13] but there is little critical literature exploring the nature and impact of the scheme.

Health trainers were established specifically to work with the most disadvantaged groups to improve health and are generally intended to be 'non-professionals' whose personal qualities are more important than formal training.[3] They will 'often come from local communities'[1] (p. 100) and work within them to promote health among

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