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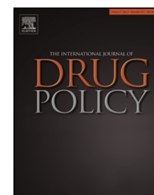

Research paper

Community health workers: A bridge to healthcare for people who inject drugs

Kirsty Morgan*, Jessica Lee, Bernadette Sebar

Population and Social Health Research Program, School of Medicine, Griffith University, Gold Coast, Australia

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ABSTRACT

Background: Although people who inject drugs (PWIDs) have increased healthcare needs, their poor access and utilisation of mainstream primary healthcare services is well documented. To address this situation, community health workers (CHWs) who have personal experience of drug injecting in addition to healthcare training or qualifications are sometimes utilised. However, the role peer workers play as members of clinical primary healthcare teams in Australia and how they manage the healthcare needs of PWID, has been poorly documented.
Methods: A qualitative ethnomethodological approach was used to study the methods used by CHWs. Data was collected using participant observation of CHWs in a PWID-targeted primary healthcare centre. CHW healthcare consultations with PWID were audio-recorded and transcribed verbatim. Transcripts along with field notes were analysed using membership categorisation and conversation analysis techniques to reveal how CHWs' personal and professional experience shapes their healthcare interactions with PWID clients.
Results: CHWs' personal experience of injecting drug use is an asset they utilise along with their knowledge of clinical practice and service systems. It provides them with specialised knowledge and language – resources that they draw upon to build trust with clients and accomplish transparent, non-judgmental interactions that enable PWID clients to be active participants in the management of their healthcare. Existing literature often discusses these principles at a theoretical level. This study demonstrates how CHWs achieve them at a micro-level through the use of indexical language and displays of the membership categories 'PWID' and 'healthcare worker'.
Conclusion: This research explicates how CHWs serve as an interface between PWID clients and conventional healthcare providers. CHWs deployment of IDU-specific language, membership knowledge, values and behaviours, enable them to interact in ways that foster transparent communication and client participation in healthcare consultations. The incorporation of community health workers into clinical healthcare teams working with IDU populations is a possible means for overcoming barriers to healthcare, such as mistrust and fear of stigma and discrimination, because CHWs are able to serve as an interface between PWID and other healthcare providers.

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Background

People who inject drugs (PWID) have significantly higher rates of morbidity and mortality than non-injecting drug users in Australia. Despite PWID's increased healthcare needs, their poor utilisation of mainstream primary healthcare services is well documented (Day, Islam, White, Reid, Hayes, & Haber, 2011; McCoy, Metsch, Chitwood, & Miles, 2001; McDonald, 2002). Contributing factors to this problem include a lack of material resources, complex service systems that are difficult for many PWID to navigate, and poor relationships between PWID and conventional healthcare providers (Ahern, Stuber, & Galea, 2007; Holt, Treloar, McMillan, Schultz, & Bath, 2007; Merill, Rhodes, Deyo, Marlett, & Bradley, 2002; Neale, Tompkins, & Shear, 2008). In response to these concerns, a number of primary healthcare services for PWID were established in a few Australian cities with prevalent street-based drug use. Some of these services employ community health workers (CHWs) who have personal experience of drug injecting as well as occupational training and/or tertiary qualifications. This study

* Corresponding author at: PO Box 223, Southport, QLD 4215, Australia. Tel.: +61 423162850; fax: +61 7 5678 0303.
E-mail address: kirsty.morgan@griffithuni.edu.au (K. Morgan).

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examined how community health workers performed their role and how their personal experience of injecting shaped the delivery of primary healthcare services to PWID.

There is consensus in the literature that primary healthcare is made more accessible and acceptable to PWID if it is delivered within a harm reduction framework, employs peer workers, is non-judgemental, free of cost, confidential and provided by a multidisciplinary team on a non-appointment basis (Day et al., 2011; Holt et al., 2007; Islam, Topp, Day, Dawson, & Conigrave, 2012; van Beek, 2007). It is also suggested that primary healthcare centres augmented to needle and syringe programs (NSPs) are the most effective model (Day et al., 2011; Islam et al., 2012; McDonald, 2002). Furthermore, the literature shows that peer workers extend the reach and effectiveness of conventional public health interventions. Peers have been used to educate and influence injecting behaviours in order to reduce blood-borne virus (BBV) transmission in Australia for more than two decades. A systematic review of drug-related harm reduction literature (Ritter & Cameron, 2005) concluded that there is good evidence to support the effectiveness of peer outreach services (such as provision of injecting equipment and HIV prevention information) in reducing HIV risk behaviours. According to Broadhead et al. (1998) and Power, Jones, Kearns, Ward, and Perera (1995) the use of PWID peer workers improves the reach of health interventions with PWIDs, whose behaviour is illegal and highly stigmatised. Peer workers are described as being able to use the language and terminology of the IDU subcultures and are aware of the social rules, thereby enabling credibility and trust to be established more readily (Australian Drug Foundation, 2006; Trautmann, 1995; Treloar & Abelson, 2005; UNAIDS, 1999). Research findings from Latkin (1998), Treloar and Abelson (2005) and Shen et al. (2011) also suggest that injecting-related information from peers is likely to have greater influence on injecting behaviours than information from other sources. The weight of this evidence is reflected in Australia in the Commonwealth's HIV Strategy and Hepatitis C Strategies 2014–2017, which identify peer-based approaches as integral to blood-borne prevention efforts.

Although the use of peer workers in BBV prevention interventions, such as needle and syringe programs and health education, and the use of peer support workers in drug rehabilitation interventions, is well documented, there is scant reference to the use of IDU peer workers in clinical roles in Australia. The role of a peer educator, peer outreach worker, support worker or NSP worker is distinctly different to that of a peer CHW involved in the delivery of clinical services and the healthcare management of patients. One of the few examples of evidence that could be found on the topic of IDU peer workers in clinical care teams in Australia, was an article reporting the demonstrated feasibility and acceptability of a peer worker role within a liver clinic providing hepatitis C treatment to PWID in Melbourne. The qualitative evaluation found that the inclusion of a peer worker in the clinical care team improved client/doctor communication and increased the clinic's ability to provide broader healthcare that was responsive to psychosocial as well as biomedical needs, thereby improving clients' experience of treatment (Norman et al., 2008). Another relevant study reported on the evaluation of a pilot project using peer-delivered hepatitis C testing and counselling. The evaluation found that hepatitis C screening by a peer worker negated fear of disclosure of illegal heroin use and stigma, thereby enabling PWID to discuss their lives at a level of depth and detail which was unlikely to occur under more traditional clinical conditions; thus the potential for addressing people's health problems was enhanced (Aitken, Kerger, & Crofts, 2002). The findings of these studies are supported by Ti and Kerr (2013), who argue that task shifting of healthcare duties to trained lay workers may serve as means of addressing barriers to HIV testing and treatment among IDUs.

There is also an expanding body of literature discussing the use of CHWs internationally. Literature reviews (e.g. Bhutta, Lassi, Pariyo, & Huicho, 2010) illustrate their effectiveness in addressing the most common causes of morbidity and mortality in South Asian and African countries, such as childhood illness, prevention and treatment of malaria, TB and HIV. In the United States, CHWs are being increasingly used to address the disproportionate burden of disease that exists among vulnerable populations. Their growing recognition is evidenced by the US Department of Labor decision in 2010 to assign a specific designation for CHWs and they have their own professional association supporting a workforce comprising of an estimated 121,200 CHWs (United States Department of Health and Human Services, 2007).

Large variations in roles undertaken by CHWs were found in the literature, with some working with specific ethnic communities and others working to address specific diseases such as diabetes, CVD and HIV/AIDS. To encompass the breadth of the role The American Public Health Association (2012) has developed a broad definition, describing CHWs as front line public health workers who are trusted members of and/or have an unusually close understanding of the community being served. A desktop review by the World Health Organization (Lehmann & Sanders, 2007) to assess the effectiveness of CHW programmes found that there is robust evidence that CHWs' actions lead to improved health outcomes and that CHWs make healthcare more accessible and appropriate to marginalised communities. The review, however, found many CHW programs to be inadequately documented. There is a lack of literature that describes *how* CHWs perform their role and the explicit methods used by CHWs in their healthcare interactions. Previous studies, such as the Community Health Worker National Workforce Study (U.S. Department of Health and Human Services, 2007), the World Health Organization review (Lehmann & Sanders, 2007) and the Centers for Disease Control and Prevention (2011) recommend that research be conducted to further clarify the methods used by CHWs and identify and share common 'best processes' of CHW programs.

Despite CHWs' international recognition as valued members of the healthcare workforce, their use in Australian clinical settings with IDU-populations is not well documented or understood. By increasing our knowledge of the CHW role, their unique skill-set may be better utilised to enhance the healthcare for this population. It is also necessary to establish the practical content of CHWs' work practices in order to define best practice for CHW programs and train future CHWs. This study attempts to address the gap in the literature regarding the role of community health workers working with PWID in Australia and increase knowledge of how they manage the healthcare needs of people who inject drugs. It examines in detail their work practices and seeks to explain how they serve as a bridge between the healthcare system and marginalised PWID. The research aims are facilitated by:

(1) examining how CHWs structure healthcare consultations, make decisions and deliver healthcare.
(2) exploring how CHWs use their personal experience of injecting drug use to communicate with PWID and how it influences clients' healthcare encounters.

The CHWs under study are employed as part of a PWID-targeted primary healthcare service. Community health workers delivering healthcare services to PWID as members of clinical teams constitute a small workforce in Australia. In accordance with HREC conditions and to protect the confidentiality of the CHW study participants, the city in which these CHWs are based cannot be named (ethical approval was granted by the Griffith University Ethics Committee GU Ref: PBH/42/11/HREC). The primary healthcare clinic in which the CHWs work is attached to a needle and syringe program (NSP)

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