Regions for Health

No. 3

Leading Edge

HEALTH FACILITATORS
An investment in local health work

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and
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REGIONS FOR HEALTH NETWORK
in Europe

EUR/ICP/POLC 05 02 02(3)

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October 1997

TARGET 13

HEALTHY PUBLIC POLICY

By the year 2000, all Member States should have developed, and be implementing, intersectoral policies for the promotion of healthy lifestyles, with systems ensuring public participation in policy-making and implementation.

TARGET 16

HEALTHY LIVING

By the year 2000, there should be continuous efforts in all Member States to actively promote and support healthy patterns of living through balanced nutrition, appropriate physical activity, healthy sexuality, good stress management and other aspects of positive health behaviour.

COMMUNITY HEALTH SERVICES - trends
PRIMARY HEALTH CARE - trends
HEALTH PROMOTION
SOCIOECONOMIC FACTORS
HEALTH STATUS
EUROPE

TARGET 33

HEALTH FOR ALL POLICY DEVELOPMENT

By the year 2000, all Member States should have developed, and be implementing, policies in line with the concepts and principles of the European health for all policy, balancing lifestyle, environment and health service concerns.

TARGET 37

PARTNERS FOR HEALTH

By the year 2000, in all Member States, a wide range of organizations and groups throughout the public, private and voluntary sectors should be actively contributing to the achievement of health for all.

Foreword

The aim of the Regions for Health Network (RHN) is to promote health gain at the regional and local level across Europe. One way of doing this is through a rapid exchange of knowledge between the regions. For this purpose, the RHN has launched the LEADING EDGE series.

These short papers present some of the interesting initiatives being implemented in our member regions, and cover a wide variety of issues. They have been written in an easily readable form, and are intended to stimulate discussion.

We hope however that these short articles will also encourage action. If you are interested to learn more about the initiative presented here, and perhaps to carry out something similar in your region, why not contact your colleagues in Östergötland for further information and advice. You will find the names and telephone/fax numbers of people to contact on the last page of this document. Go ahead, give them a call, the purpose of the Network is to provide such an exchange of information and mutual support between the regions.

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HEALTH FACILITATORS - AN INVESTMENT IN LOCAL HEALTH WORK

Introduction

While basic medical research and new technology certainly have an impact on health and well-being over the long term, the health of the population in a shorter perspective depends only to a minor degree on the current medical research and medical care. In this shorter perspective, lifestyles, cultural patterns, socio-economic conditions, and living conditions in general are much more important determinants of population health. Also the health of each individual depends significantly on their own level of knowledge and on psychosocial factors. The term "cultural poverty" is often used to describe a mixture of relative financial poverty combined with a lack of education and employment. Such cultural poverty is, as a rule, combined with poor health and reduced life expectancy.

Therefore health development depends to a large extent on social development, health policy and its implementation, the conditions in settings such as the workplace and schools, the situation within the family and the informal relations within the social network of friends and neighbours (the community).

It is in this context that we want to distinguish between the concept of *society* and that of *community*. Society performs activities through formal structures such as local authorities (in the case of Sweden, municipalities) and regional authorities (County Councils). These activities are carried out by experts and civil servants with formal skills and education. Within the community, activities are carried out amongst ordinary people, by ordinary people. In the community there is a common

culture and common values. There is a certain degree of social control and established common opinions on health and on what promotes health. The Health for All approach is best achieved when health-promoting activities are established and integrated in the local community or even better, when they are firmly rooted in and emanate from the community itself.

People require certain basic knowledge in order to understand the importance of healthy lifestyles and settings. To enable them to integrate that knowledge into their own individual behaviour or local arenas, they also need a supportive environment. Both factors, the knowledge and the environment, need the backing of the formal structures of society.

In some societies, public services and public health organizations have been established with one core mission - to carry out health promotive activities. The objective of these is to coordinate resources to promote health of the population in general and of vulnerable groups specifically. The cross-sectoral nature of such work calls for a seamless coordination of different authorities and a smooth collaboration between the authorities and the people of the community. These public services may be carried out by people who are called health planners, health nurses or health facilitators. Their basic education may vary: they may be physicians, nurses, sociologists or teachers. Ideally they have supplementary education in public health, health promotion or health education.

Public services are often organized geographically with well defined boundaries. The informal community, however, does not recognize these boundaries. Social relations as well as voluntary collaboration between people combine networks of

very different sizes and structures which cross formal boundaries. A Health Facilitator must be very sensitive to this and must be able to adjust his or her work to the reality of social networks even though employed to work within a geographically well-defined catchment area.

The strategic decision

Östergötland County Council, the regional authority responsible for health care within Östergötland County in Sweden, had already developed a Health for All policy in 1988. A clear need to support local health work was identified during the early years of implementing that policy. In 1993, it was deemed necessary to initiate intensified collaboration between the official society and the informal community to strengthen local health work and to promote the health of the population, and the **"Health Facilitator Project"** was seen as one way of achieving this.

In Sweden primary health care (PHC) is geographically organized with distinct territorial boundaries, each Primary Health Care Centre being responsible for health care within a defined catchment area. The regional authority, the County Council, is the responsible organization for all health care, whereas the local authorities, the municipalities, are responsible for social support. It is important to note that the regional authorities are not placed hierarchically above the local authorities. This means that all collaboration has to be based on mutual interest, free alliances and voluntary agreements. Nevertheless, health care needs and social support need to be tightly interwoven and a seamless interaction between the relevant authorities is highly desirable but not always easy to establish.

The "Health Facilitator Project" had the following overall strategic goal:

To promote health by strengthening local health development, through increasing the collaboration between formal organizations and the local community.

The instruments used to achieve this were:

- the employment of health facilitators to support this development, and the
- the establishment of Local Health Groups.

The operative approach

For a three year period (1994-1996), the "Health Facilitator Project" was implemented in four local areas in Östergötland County. These areas were identical to the four PHC catchment areas where the most socially disadvantaged and unhealthy population live. In these areas there are high unemployment rates and many families live on social support. There are also comparatively high numbers of immigrants, single parents, long-term sick-listed and high rates of drug problems.
Health facilitators were employed by the PHC units of the four participating areas, funded by County Council money. To be eligible for participation in the Health Facilitator Project, the Chief Medical Officers at the PHC Units in question had to accept the following **three requirements:**

1. To initiate a Local Health Group with representatives from the Public Services (the official society) and the NGOs (the informal community) of the area.

This group was to:

- support an analysis of the health conditions in the area,
- decide on health activities to be carried out, and
- participate in such health promotive activities.

In this group the Health Facilitator was to play an important role as a link between people living in the area and those in position of power. It was intended that the group would constitute a stable relationship between the Health Facilitator, the informal community, and local official services (police, social care, church) outside the PHC Unit.

2. To develop a "Health Profile" as a basis for the health activity plan of the area.

This was to be approved by the Local Health Group. The County Council Primary Health Care Research and Development Unit was contracted for methodological support when data for the "Health Profile" was collected and analysed.

3. To assist the Health Facilitator and the Local Health Group in initiating and/or supporting activities, with the aim that people and NGOs of the area (the informal community) would eventually take sole responsibility for these activities.

The intention in doing this was to build on the internal power of the people of the area and ensure the long-term survival of the activities.

The *operative objectives* which were to be reached by the project were:

- *to describe the Health Profile of the four participating areas;*
- *to identify and start activities which might affect population health in a positive way, giving preference to activities which promote health among vulnerable groups such as children and youth.*

Supportive backing

It was recommended that the Chief Medical Officers of the four PHC centres should guarantee supervision and technical and professional support through an appointed senior medical officer at the PHC unit.

Apart from the professional support the County Council asked the Health Facilitators to form a network amongst themselves for mutual support and exchange of ideas and experiences. In

addition, two meetings a year were arranged by the County Council where the Health Facilitators met with responsible politicians and officials and where they were able to raise any questions in relation to the project. They also had an "open line" to the Public Health Executive Officer of the County Council for more informal contacts.

Finally, the County Council Centre for Public Health Sciences in Linköping was contracted to evaluate the project.

Experiences of the project

Often implementation is thought of as being the execution of decisions taken at a higher level. This top-down definition seldom corresponds with reality. In reality, political decisions leading to policy projects are often vague in their wordings. Particularly in a policy project guided by objectives rather than formal structures, there are only few formal requirements. Implementation therefore becomes a learning process. This situation also allows for a free and broad interpretation of the project objectives and increases the freedom of action of the person who is to meet the project intentions, in this case the Health Facilitator.

When policy decisions imply collaboration with other organizations over which the deciding body (County Council) has no authority, results depend on free alliances, mutual interest and benefits and on the persuasive powers and commitment of the Health Facilitator. In this situation, personal skills, confidence, personality and backing become very important.

The Health Facilitator Project was a pilot project with the above characteristics. It has allowed the PHC unit and the

Health Facilitator considerable freedom to act, following local interpretations of the County Council's policy decision. It is essential therefore, that the Health Facilitators have knowledge, experience, a theoretical background in public health and a supportive environment in which to work.

In this rather elastic situation, different Health Facilitators may interpret the policy decision very differently. To the County Council as the initiator of a pilot project, this can be an advantage, since the project evaluation can build on a wider variety of experiences. Consequently decisions about the future of the project can be based on a broader foundation. For the Health Facilitators themselves, however, such a broad degree of latitude could be seen as a disadvantage, creating uncertainty and increasing the need for a supportive and committed surrounding.
This was the reason when the project was formulated that the County Council recommended the opportunities for networking, supervision and political support as mentioned above.

Despite this support, two of the four Health Facilitators did report an undue degree of uncertainty and a feeling that the project success depended entirely on their own ability and understanding of the policy decision.

The PHC Centre supervisor is also in a position to affect and modify the way the project develops, depending on his/her interest and theoretical skills. This was another reason why the project developed very differently in the different areas. Three of the areas reported an impressive list of contacts and activities while the fourth put most of its efforts into investigating the health need of the area. These developments seemed to coincide with the supervisors' interests.

Some of the Health Facilitators were disappointed with what they saw to be low commitment and support from the PHC unit as a whole in the initial project phases. This related both to the project itself and to support for health promotion in general. Indeed, since combining health promotion with medical care was initially considered by the PHC unit staff to be a difficult task, this might explain their initial low interest. Public health work in its broad sense differs a lot from the more narrow secondary prevention that the PHC staff is normally familiar with. The increasing interest and commitment from the PHC unit staff as the project progressed was one important result of this project. Local health work and health promotion got on to the primary health care agenda in a more obvious way when the new Health Facilitators were appointed as part of the PHC unit staff.
An important objective for the project was to establish an external network, the Local Health Group, as a link between formal social structures and the local community, the evaluation of the project verified that forming and developing these networks has been accomplished and that they function well in most cases. The link to the NGOs was firmly established. The relationship with the formal society apart from the County Council, was, however, not so easy. One of the PHC Units complains in a written petition that the municipality is genuinely uninterested in health work.

One important observation from the evaluation was that the Health Facilitators found their background as district nurses, and their established relations to local health care services, to be of help in establishing relations to the local community. But it was also found that this could lead to a medicalization of problems and problem-solving that sometimes did not harmonize well with their mission as public health and health promotion officers. As a result of the evaluation, it was

proposed that complementary education such as a Masters in Public Health would instill facilitators with a broader knowledge of health issues. Another recommendation was to also accept people who do not have a nursing background as health facilitators, for example sociologists, trained social workers, teachers and others.

What made the Health Facilitators project different from previous attempts at health promotion ?

One of the main differences was the physical location of the Health Facilitators. They moved out from the Primary Health Centre where health services are normally located, and established small offices within the local community. In a sense, the facilitators "cohabited" with existing programmes in the local community, for example, with activities targeted at various groups such as the unemployed, immigrant mothers etc. Secondly, the Health Facilitators provided a different type of knowledge and skills for the local community in matters relating to health, knowledge and skills to enable them to both deal more effectively with the formal services, and to cope with their own health problems and promote their own and their families' health. Their manner of working was also different to other primary health care workers. By walking around the locality, talking to people, and participating as far as possible in local community life, they were able to gain important insights on what *people living in that community felt to be the main health concerns.*

What did the project achieve in practical terms?

Perhaps the main contribution of the project was that the Health Facilitators were able to provide qualitative information about the local community, which could only be gathered by

working in the way described above. As well as meeting and talking with people, facilitators wrote to key people within the community, for example asking voluntary organizations, and people in the private and business community such as shopkeepers, to describe what they saw as the main health issues for the community. This type of qualitative information was unique, and later supplemented the official statistics and survey data which until then were the usual basis for health policy analysis.

Because some of the information was quite sensitive, it was agreed that the health analysis report should not be officially published but kept as a "working book" by the local health group. A second reason for not publishing the analysis was that the areas chosen for the Health Facilitators project were comparatively disadvantaged. They were, therefore, often the focus of various sociological and social medicine research projects and past experience showed that when the local newspapers wanted to publish information on issues such as alcohol problems, decreasing social insurance benefits, or increasing violence in schools, they invariably turned to these areas for a story. Although the plight of these disadvantaged areas might be given publicity, their image was naturally affected.

This time, the Health Facilitators in conjunction with the Local Health Group felt that the areas should have no more negative publicity during the project period. The local inhabitants needed to feel good about themselves, and to be proud to live in these areas. It was felt therefore, that if the local health report was made official, once again the newspapers would be able to publish negative information about the communities, which would lower the esteem of people living in those communities. The County Council were requested, therefore, not to make the report official as is the normal custom. Had

the Council insisted on an official report, then all the qualitative information gathered in the area would have had to be removed. The County Council agreed therefore that the report should not be published but remain as a working document.

The political conclusions and the future

Built on the experiences from the Health Facilitator Project and the evaluation made by the Centre for Public Health Sciences in Linköping, the County Council has decided:

- to employ Health Facilitators permanently in the four project areas,
- to assign funding to gradually allow additional PHC units to employ Health Facilitators,
- that only persons with a Masters degree in Public Health should be employed as Health Facilitators,
- that the political body of the County Council shall intensify their dialogue directly or through civil servants with the municipalities in the region, to facilitate the seamless collaboration between the formal society and community in the local area.

The County Council's attempts to reach out to empower the people through improved links between the formal services and the community, and to listen and respond more actively to the feelings and wishes of the people for the improvement of their health, seem to have taken root. It remains to be seen how this will develop in the future. The potential for bringing about change at the local level is already obvious.

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