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**Title: Reflecting on the tensions faced by a community-based multicultural health navigator service: a case study**

**Abstract**

The 'Community Navigator Model' was developed to assist four culturally and linguistically diverse communities (Sudanese, Burmese, Pacific Islander Group, Afghani) in South East Queensland to negotiate the Australian health system and promote health. Using participatory action research, we developed the model in partnership with community leaders/members, the local health department and two Non- Government Organisations (NGOs) as described in Henderson, Kendall, and See.<sup>6</sup> Following implementation, we evaluated the model, the results of which are published elsewhere.<sup>1</sup> Our evaluation revealed that whilst the model was accepted by the communities and was associated with positive health outcomes, the financial, social and organisational durability of the model was problematic. Ironically, this situation was inadvertently created by critical decisions made during the development process to enhance the durability and acceptability of the model. This paper explores these critical decisions, our rationale for making those decisions and the four hidden tensions that subsequently emerged. Using a reflective case study method to guide our analysis, we provide possible resolutions to these tensions that may promote the longevity and utility of similar models in future. (178words)

**Key words:** Community navigators; health service access, CALD communities, health service, reflective case study.

Revised Manuscript- FEB 2014

**What is known about the topic?** The use of community navigators to assist culturally diverse communities to access health services is not new. Many benefits have been documented for communities, individuals and health service providers following the use of such models. What is not well documented is how to maintain these models in a safe and cost effective way within the Australian health system whilst respecting cultural and community practices and reducing the burden of service delivery on the navigators.

**What does this paper add?** This paper provides a perspective on how the development of community-based service models inherently places them in a position of tension that must be resolved if they are to be long-lasting. Four core tensions experienced during the development and implementation of our model in South East Queensland are explored to develop potential resolutions.

**What are the implications for practice?** Reducing the tensions inherent in culturally appropriate community-based service models will increase the durability of the approach. By addressing these tensions, we can create a more durable pool of community navigators that can facilitate community empowerment, self-governance of health issues and a sense of community ownership of health services.

## Objectives

This case study discusses the tensions that we believe impacted on the financial, social, and organisational durability of the community navigator model following its implementation in South-east Queensland. ~~Aththough Despite~~ the navigators ~~being honoured to hold~~valued their positions<sup>1</sup> it was observed that their work was not easily maintained in the longer term. This situation necessitated reflection on how to retain the cultural integrity and community acceptability of the model, but also ensure its longevity and safety within existing funding constraints.

## Setting

The community navigator model was implemented in a socially disadvantaged part of South East Queensland which is home to a significant number of migrant and refugee communities.<sup>2</sup> Four specific communities participated in the implementation trial, these being the Sudanese, Afghani, Pacific Islander, and Burmese. These four communities were selected by community leaders, the local health department, and the CEOs of the two Nongovernment organisations, all of whom were involved in the model development.

## Participants

Nine bi-lingual community navigators from the four communities were selected by community leaders and members because they were respected and deemed to be trustworthy. They were employed within the Non-Government Organisations (NGO)<sup>1</sup> to implement the model in their respective communities. The use of participatory action research facilitated

Revised Manuscript- FEB 2014

input from all stakeholders in its development and implementation, especially the community leaders who were the gatekeepers of the selected communities.

The role of the community navigators was to work with their communities to support members in attempts to access health and social services; support health and wellbeing promotion initiatives in their community and create opportunities for communities to build relationships with appropriate health professionals and service providers. In return, the community navigators were paid an hourly wage of up to 11 hours per week and were required to keep a record of their activities and outcomes. They also attended weekly learning circles conducted within the university to gain further knowledge about how to navigate the Australian health system.

## Methodology

Our reflection was guided by the work of Donald Schon<sup>3</sup> who championed the use of reflection as a way of improving service delivery. The notions of reflection-in-action and reflection-on-action were central to Donald Schon's approach. The former represented the learning and thinking that had occurred during the implementation of the project, which had been conducted in a thorough, evidence-based and collaborative way over a one year period. The latter represented the post-evaluation reflection that enabled us to reflect on our initial decision-making, identify tensions and challenges that had limited the model and explore how we could resolve these issues in future.<sup>3</sup> We engaged in a 5-step process of reflection (i.e. reporting, responding, relating, reasoning and reconstructing) developed by Bain, Ballantyne, Packer and Mills,<sup>4</sup> that allowed us to examine, by asking a series of questions<sup>5</sup>, what worked in the model, what did not work in the model, what factors enhanced the model, and what factors were barriers to the model. During this process, we consulted with those

Revised Manuscript- FEB 2014

who were involved in the development of the model, such as leaders of local cultural communities, representatives of the two Non-Government organisations and the local health department and others who had been involved or had tried to develop similar models. This exercise helped us to rationalise the way we made sense of the events and experiences of the navigators and the monthly reports they produced.

## Outcomes

Our reflection supported the suggestion that bi-lingual community members, who are respected in their communities, are well placed to form a connection between their communities and local health services.<sup>6,7,8,9</sup> Our reflection confirmed that, due to their understanding of local cultural values and mores<sup>10</sup>, they were trusted and were, therefore, able to more effectively assist community members to gain access to health services and resources, often spending several more hours than the paid allocated 11 hours per week.

Although we did not systematically measure service use, our interviews and focus groups conducted with participants and navigators revealed an increase in the number of community members who accessed health services, particularly in the area of mental health, following the introduction of the intervention.

~~Although we did not use a controlled trial design, we did observe an increase in the number of community members who accessed health services following the introduction of the community navigators, particularly in the area of mental health.~~ Despite the positive

outcomes we also identified, through our discussions and reflections, four core areas of tension that threatened the financial, social, and organisational durability of the model. These areas of tension included 1) using a navigator-centric versus a community-centred approach; 2) training of navigators versus the construction of a broader learning culture; 3) supporting grassroots approaches versus managing risk within a bureaucratic system; 4) maintaining the integrity of the model versus attracting funds.

## The four core areas of tension

Revised Manuscript- FEB 2014

### 1. Using a navigator-centric versus a community-centred approach

Although driven by a community-based philosophy, the model centred on the work of the navigators rather than on the role of the whole community in the model. The decision to focus on navigators as the centre of the model was based on the locally accepted view that community resources were depleted and that members would be well served by paid workers. The decision was also driven by the need to formally and financially acknowledge the work done in cultural communities rather than continuing to expect members to deliver even more than they did already. Ironically, however, this decision meant that some work previously performed by a number of community members was redirected to navigators and the expectations placed on them increased over time. This led to navigator exhaustion and increased the risk of community members becoming dissatisfied.

### 2. Training of navigators versus the construction of a learning culture

To support navigators in their role, we instigated an intense model based on learning circles. This decision was based on the fact that traditional learning models were not accessible to the navigators whose first language was not English. The learning circles were invaluable in that navigators not only gained rich knowledge about how to access health services, but also were encouraged to support each other's practice and develop a professional identity. The unexpected consequence of this approach was the perception that the training conferred opportunities on the navigators who formed an "elite" group that potentially excluded the wider community. The extent to which knowledge gained during this training process was passed onto the broader community was unclear, particularly given that navigators themselves struggled to consolidate such complex information. Thus, the value of the non-traditional learning process did not appear to be translated into tangible benefits.

### 3. Supporting grassroots approaches versus managing risk within a bureaucratic system

Community navigators were selected because they were respected community members who valued cultural traditions and worked well within the grassroots community setting. As such, they were often called upon to give advice about traditional or cultural health practices to health service providers. As well established and embedded members of the community, navigators often had to make difficult decisions about practices and beliefs. In many instances, the cultural or community way of thinking and acting conflicted with the requirements and rules of the bureaucratic setting into which we had placed the navigators. One example was a situation where a Sudanese mother needed to take her toddler to the doctor and had no means of transport. The navigator took the mother and child to the doctor in her own car without a proper baby seat. Many similar examples emerged where the navigator engaged in grassroots community-based thinking that helped the recipient of the service without consciously considering other aspects of service delivery, such as safety, regulations, insurance and liability, privacy and confidentiality. These bureaucratic aspects of service delivery emerge as a result of the funded organisational service context, raising questions about the extent to which a navigator model can be effectively located within an organisation or whether it should remain as a community-driven and owned activity.

Fortunately, nothing untoward occurred as a result of grassroots behaviour, but it posed a risk to the hosting NGO and challenged the durability of the service. The impasse created by this situation is that the very grassroots ways of working that underpinned the success of the navigators endangered the durability of the model by impinging on the accountability of the

Revised Manuscript- FEB 2014

service. By enforcing the regulations precipitated by western health and legal systems, the capacity to act in grassroots ways was limited, thus limiting the durability of the model.

#### 4. Maintaining the integrity of the model versus attracting funds

During the implementation of the model, the navigators and stakeholders all struggled with finding a balance between the integrity of the model and access to funding. In order to maintain the navigator model as a community-based response to health promotion, it was important to find funding that supported this approach. In the initial stages, this type of flexible funding was available. However, in the later years, when funding was not readily available, applications were made to other funding sources that altered the focus of the model. Over time, the hosting NGO integrated navigators into other funded roles, further dissipating the unique focus of the model. This led to the practice demands on the navigators being changed, causing them confusion and frustration. Although these actions were necessary to maintain the model, they ironically jeopardised the integrity of the model. As a result, parts of the model were lost and navigators adopted practices as required by their specific funding bodies.

#### **Discussion/lessons learned/solutions**

In this section, we discuss the four tensions with respect to lessons learned and present possible solutions. The approach we have proposed offers several significant advantages in terms of efficacy of the model as well as durability. With tension 1, in hindsight, a community-centred approach would facilitate the involvement of the whole community in the implementation process. Instead of the navigator taking sole responsibility for providing



Revised Manuscript- FEB 2014

support and health service information to the remainder of the community, a community-centred model would require the work of the navigator to be directed by the community. This would bring the community members together and promote the whole of community involvement in assisting each other to access health services. This concurs with the work of LeFebvre and Franke<sup>9</sup> who explained how non-caucasian cultures engaged in collectivism where decisions are made as a group for the common good and for the successful functioning of the group.

In order to mitigate exhaustion and to build community capacity, navigators might only stay in the role for shorter periods of time after which they would return to their previous roles in the community. If the tenure of navigators was staggered, a new navigator can then be recruited into the paid role to work alongside other experienced navigators. In this model, navigator training would need to be run continuously so each new navigator has access to similar opportunities to learn about the health system and health promotion. Each time the navigator returns to their community role, they bring increased health knowledge into the community, thus building the health literacy of the community over time. By applying the cyclic or apprentice model, navigator exhaustion can be prevented whilst at the same time increasing the number of experienced navigators in the community and enhancing the community ownership of the approach. Indeed, there is ample evidence to support the role of health literacy in facilitating self-governance, empowerment and capacity building of culturally diverse communities.<sup>11</sup>

The building of learning communities as opposed to our learning circles that were designed for just the navigators will also create a more conducive environment for their work. A learning orientated community is one where learning becomes a whole-of-community mandate and members are more likely to be proactive in seeking health information rather than relying solely on the navigators. Thus, the demands of the navigator role could be

Revised Manuscript- FEB 2014

reduced and shared while the success of the role would be enhanced as also supported in LeFebvre et al.<sup>9</sup> with regards to non-Caucasian communities' modus operandi being one of collectivism. A similar cyclical apprentice mentoring model or 'buddy system' has been implemented in Melbourne and is showing evidence of durability.<sup>12</sup>

Investment in the development of a community-based learning culture may have been less costly and more effective in that information would be disseminated more widely. A process akin to the learning circles could have been conducted in community settings, such as local community halls. Navigators were responsible for running educational events that could address the low levels of health literacy associated with poor health outcomes, limited disease preventive measures and inappropriate use of health services.<sup>11</sup> However, the success of these events was limited by the embryonic level of knowledge of the navigators. On the other hand, an approach such as that taken by the New South Wales Department of Health, Multicultural Communication Service,<sup>13</sup> could address this problem. This program is managed by a committee with representation from the multicultural coordinators. Working closely with the culturally diverse communities, the committee identifies the most relevant and acceptable way to translate health information to the broader community. Increasing the health literacy of the broader community is a cost effective and long-term way of improving health outcomes. For community navigators, working with more health literate community members would be less onerous, resulting in greater enthusiasm and enjoyment in their work.

Our reflection revealed a need to work closely with the communities to understand their preferred modus operandi and use this understanding to place structures around the model that will support navigators to carry out their activities both safely and acceptably. For instance, one-on-one advising and supporting may be more suited to some navigators than the

Revised Manuscript- FEB 2014

delivery of a broad-based health promotion mandate. Similarly, some navigators may be less or more able to adapt grassroots practices to suit bureaucratic requirements. We assumed that allowing navigators to operate in ways that best suited their communities would automatically enhance the acceptability of the model. However, the opposite was true. This conundrum, which we have discussed elsewhere in relation to similar programs in rural <sup>14</sup> and Aboriginal<sup>15</sup> health services, needs to be exposed and discussed openly to reach solutions. Navigators need to be mentored through difficult decision points so they can reach the best outcomes for both the community and their employer.

Furthermore, the concept of safety can be understood differently by different cultures and in different contexts. For example, not having a baby seat is considered unsafe practice in Western bureaucratic and legalistic contexts whereas this need may not feature highly in another cultural context. The biggest challenge for health service providers is how best to allow the navigators to perform at the grassroots level in acceptable and flexible ways, but at the same time ensuring safety standards are intact. By responding to this challenge and openly acknowledging the need for navigators to work in creative ways to engage their communities, the success of the model is likely to be enhanced.

It is important to note that the model was relatively inexpensive to run but also had little chance of becoming self-sustaining. Additional financial support was needed, leaving the model vulnerable to the demands of various short-term funding bodies. There is an assumption that communities will be inherently able to maintain the momentum of these models, making them cheaper and more durable. However, our reflections show that these models raise enormous enthusiasm and optimism about the opportunity for the community, but change emerges slowly and with only intense levels of support. The model needs ongoing financial and bureaucratic support to implement its vision and remain viable over time. Paradoxically, however, this type of support comes with significant requirements for formal

Revised Manuscript- FEB 2014

structure or the creation of a mini-bureaucracy. The time and effort required to raise funds and manage structures quickly overwhelmed the community navigators and obscured the purpose of the service. Indeed, there is ample evidence in the non-profit sector that the need to become legitimate to attract funding can force self-help groups into formal structures that ultimately engender an inward focus on organisational processes rather than an outward focus on their community, which was the reason for their formation in the first place<sup>16</sup>. Thus, whilst sufficient structure should be maintained to ensure organisational goals are clear and achieved, many grass-roots organisations adopt a minimalist structure based on strong bonds and accountability to key community stakeholders<sup>17</sup>.

The tensions we identified mean that navigators will be placed in circumstances that will dilute the integrity of the model, suggesting the need to simultaneously build flexibility and structure into the role. Navigators in our model were trained in the essential skills and values of community-based development and health promotion, but were not mentored in how to modify those skills across diverse circumstances or how to maintain those values, but simultaneously meet the demands of other frameworks. Like many community-based initiatives, this one suffered from volunteer fatigue. It depended heavily on a small group of individuals. The core group were the same individuals who engaged in most other community activities, magnifying the fatigue and its impact. Rather than relying heavily on such a small number of individuals, our reflection shows that we should rely lightly on a large number of people for durability. Without this redistribution of load, any service would cease to exist. Thus, a key challenge for the future is to identify innovative ways of engaging a broader set of stakeholders.

## Conclusions

Revised Manuscript- FEB 2014

This reflective case study on the community navigator model highlights tensions that impeded its durability. In this paper, we have proposed an approach that focuses on community-centred implementation with rotating navigators and a strong community-based learning culture. We have also proposed an approach that balances grassroots flexibility with bureaucratic regulations and brings this dilemma into the open for resolution. Finally, we have proposed an approach that balances model integrity with funding opportunities and enables stakeholders to openly discuss ways in which the two can be achieved simultaneously. The solutions we have identified through this reflective case study would dramatically change the way in which we would implement the navigator model in future.

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Revised Manuscript- FEB 2014

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Revised Manuscript- FEB 2014

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