Caring for the neighborhood: a primary health perspective on the collaboration with community health workers in Brussels.

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ABSTRACT (Nederlands)

Achtergrond
Community health workers (CHW's) zijn vertrouwde eerstelijnsactoren die de brug slaan tussen kwetsbare bevolkingsgroepen en de formele gezondheids- en welzijnszorg. Internationale literatuur benadrukt hun rol in het verbeteren van de toegang tot zorg, het aanpakken van sociale gezondheidsdeterminanten en het ondersteunen van overbelaste zorgsystemen, met name tijdens de COVID-19-crisis. In België, en specifiek in Brussel, werden CHW's via federale en lokale initiatieven ingezet om gezondheidsongelijkheden te verkleinen. De Brusselse context, gekenmerkt door een hoge sociaaleconomische kwetsbaarheid en een versnipperd institutioneel landschap, stelt echter specifieke uitdagingen aan geïntegreerde en toegankelijke zorg. Hoewel eerdere evaluaties aantonen dat CHW's inspelen op sociale en gezondheidsnoden, is er weinig bekend over hun samenwerking met eerstelijnszorgverleners zoals huisartsen. Deze studie onderzoekt hoe CHW's en huisartsen in de praktijk met elkaar interageren en welke kansen er bestaan voor een nauwere samenwerking.

Methode
Kwalitatieve cross-sectionele studie. Er werden semigestructureerde interviews afgenomen met 12 respondenten. De interviews werden getranscribeerd en gecodeerd met behulp van NVIVO.

Resultaten
De resultaten tonen aan dat de interacties tussen CHW's en zorgverleners momenteel eerder oppervlakkig en sporadisch blijven. Hoewel CHW's potentieel hebben om nauwer samen te werken met de eerstelijnszorg, verhinderen diverse structurele en relationele drempels een diepere integratie. Duidelijke rolafbakening, het opbouwen van vertrouwen en regelmatige communicatie blijken cruciale voorwaarden voor effectieve samenwerking. Samenwerking verloopt vlotter wanneer CHW's zichtbaar zijn, ingebed zijn in lokale gezondheidscentra en erkend worden door huisartsen en andere zorgprofessionals.

Conclusie
Deze studie wijst uit dat de samenwerking tussen CHW's en huisartsen in Brussel momenteel beperkt blijft door structurele fragmentatie, onduidelijke rolverdelingen en een lage zichtbaarheid van CHW's. De bevindingen sluiten aan bij bestaande literatuur over de uitdagingen van interdisciplinaire en geïntegreerde zorg, zoals omschreven in het Rainbow Model. Wanneer CHW's actief deel uitmaken van lokale zorgteams en erkend worden door eerstelijnsactoren, verbetert de samenwerking merkbaar. Het versterken van hun statuut, zichtbaarheid en interprofessionele opleiding is essentieel. Dergelijke inspanningen dragen niet alleen bij aan een betere operationele integratie, maar ondersteunen ook doelstellingen rond rechtvaardigheid en toegankelijkheid, in lijn met het Quintuple Aim-kader. Ondanks enkele beperkingen vormt deze studie de eerste Brusselse analyse van dit onderwerp en onderstreept ze het potentieel van CHW's om de toegankelijkheid en gelijkheid binnen de eerstelijnszorg te verbeteren.

ABSTRACT

Background
Community health workers (CHWs) are trusted frontline actors who help bridge gaps between vulnerable communities and formal health and social care systems. International evidence highlights their role in improving access to care, addressing social determinants of health, and supporting overburdened systems—particularly during the COVID-19 crisis. In Belgium, and more specifically in Brussels, CHWs were introduced through both federal and local initiatives to reduce health disparities. The Brussels context, marked by high socioeconomic vulnerability and institutional fragmentation, presents specific challenges for integrated and equitable care. While early evaluations show CHWs help address social and health needs, little is known about their collaboration with primary care providers such as general practitioners (GPs). This study explores how CHWs and GPs interact in practice, and what potential exists for closer collaboration.

Methods
Qualitative cross-sectional study. Semi-structured interviews were conducted with 12 individuals from Brussels - Belgium, transcribed and coded using NVIVO.

Results
Findings reveal that interactions between CHWs and healthcare providers remain superficial and infrequent. This analysis shows that while CHWs have significant potential to collaborate with primary care providers, various structural and relational barriers still limit this integration. Clear role definitions, trust-building, and consistent communication remain critical conditions for effective cooperation. The findings suggest that collaboration improves when CHWs are visible, embedded in local health centres, and recognised by general practitioners and other healthcare staff.

Conclusions
This study highlights that collaboration between CHWs and GPs in Brussels remains limited due to fragmented structures, unclear roles, and low visibility. These findings align with existing literature and broader challenges in interdisciplinary and integrated care, as described in the Rainbow Model. When CHWs are embedded in local health teams and recognised by primary care providers, collaboration improves. Strengthening their legal status, visibility, and interprofessional training is essential. These efforts support not only operational integration, but also equity and access—key goals of the Quintuple Aim. Despite limitations, this study provides the first Brussels-based analysis and underlines the potential of CHWs to improve equity and accessibility in primary care.

KEYWORDS

Community Health Workers
Community health
Belgium, Brussels
Primary care
Interprofessional collaboration
Integrated care
Health promotion
Healthcare policy
Access to care

BACKGROUND

Community health workers

Community health workers (CHWs) are broadly defined as frontline health providers who come from or have a close understanding of the communities they serve. According to the World Health Organization, CHWs typically have less formal education and training than professional healthcare workers like nurses and doctors, yet they have significant potential to extend health services to underserved populations—particularly in remote or marginalized areas—by improving access, addressing health inequities, and enhancing health system performance (1). Similarly, the American Public Health Association (APHA) describes CHWs as trusted members of the community who act as liaisons between health and social services and the populations they serve, helping to improve both access and the cultural relevance of care (2).

Historically in many parts of the world, particularly low- to middle-income countries, community health workers have been deployed to address persistent health inequities in resource poor contexts (3,4). Their functions include care coordination, health coaching, providing social support, conducting health assessments, linking individuals to resources, case and medication management, remote primary care delivery, follow-up, administrative tasks, targeted health education, and supporting health literacy. As pressure on the healthcare system continues to increase, CHWs can serve as a valuable complement within the broader healthcare landscape (5). It is believed that CHWs can help alleviate the increasing pressure on health systems by expanding access to basic health services, supporting prevention and early detection, and reducing unnecessary hospital admissions (3, 6).
Although the programs are often expensive (6), they tend to be cost-effective. Kangovi S. et al. showed that for every dollar invested in the CHW program it yielded a $2.47 return (7).
While substantial research has been conducted on the current situation in the US, Canada, and low- to middle-income countries (4), research on the European context remains scarce (1).
During the COVID-19 response, CHWs assumed multiple functions, including community mobilisation, behaviour change promotion, essential service provision, and surveillance activities. Their embeddedness and social trust within communities enabled them to address misinformation, facilitate effective referrals, and extend the reach of formal health systems (4, 8). To accommodate for the increased health needs during this period, two projects with CHWs were set up in Brussels.

Context in Brussels

In Belgium, despite most people having universal health coverage, the health disparities between poor and rich people are substantial. In 2020, 1.1% of households were impoverished or further impoverished after out-of-pocket payments and 5.2% of households experienced catastrophic health spending. Belgium has one of the highest rates of catastrophic spending among EU14 countries[1] with health spending being heavily concentrated among poor households and among the unemployed, inactive and undereducated populations (9).
A significant share of these disadvantaged populations resides in Brussels, which has evolved into a densely populated and multicultural urban centre after successive waves of migration since the 1960s. These waves include labour migration, family reunification, asylum seeking, and more recent arrivals from both EU and non-EU countries (10). As a result, the city is home to a highly diverse population, including many newcomers in vulnerable socio-economic situations. This is illustrated by

[1] Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, and Sweden

the yearly EU-SILC survey carried out by StatBel, which reports that 38.8% of the population in Brussels is at risk of poverty or social exclusion, compared to 18.2% for Belgium as a whole. The situation is especially serious in the more densely populated neighbourhoods of the so-called 'poor crescent', namely the communes of Molenbeek, Koekelberg, Anderlecht, Sint-Josse, Schaerbeek, Ixelles and Saint-Gilles (11).
Its complex governance structure, characterised by overlapping regional and community institutions within the Belgian federal system, also extends into the organisation of healthcare services (12). This institutional fragmentation frequently poses coordination challenges and may reduce the efficiency of policy implementation (13). Combined with the city's diverse and multilingual population, this complexity creates additional barriers to delivering accessible and equitable healthcare for all residents (14).

Community health worker programs

Federal level initiatives
As a reaction to the increase in health disparities after the onset of the corona crisis, the Federal Council of Ministers approved the project "Community health workers (CHWs) in Belgium (CHW-Intermut)" at the end of 2020. This federal initiative, coordinated by the National Institute for Health and Disability Insurance (RIZIV/INAMI) and the National Intermutualistic College (NIC/CIN), deployed 50 Community Health Workers across ten Belgian urban areas, including the Brussels Capital Region. The main goal was to improve the accessibility to primary and COVID-19-related care for persons living in socially vulnerable situations (15).
The core tasks of the CHWs in the Intermut project were described as follows:

- Actively approaching families in socially vulnerable situations in the neighbourhood
- Conducting home visits (if possible, in the framework of the COVID-19 measures)
- Being present in (care) institutions
- Having contacts in the neighbourhood
- Detecting questions and needs among the vulnerable families in the neighbourhood
- Structural problems or deficiencies in access to health care signalling to the coach
- Informing, advising, and directing families to professional care using the tools made available to the CHWs registering data (15, 16, 17)

Local initiatives

Around the same period, the Fédération des Services Sociaux (FdSS) launched a similar project called Relais d'Action de Quartier (RAQ) . It consists of 21 social workers operating exclusively in 19 neighbourhoods of the Brussels-Capital Region, in close collaboration with host partner organizations. The initiative aims to address social determinants of health and improve access to social rights by strengthening connections between local social- and health actors such as NGOs, community health centres, public services, neighbourhood associations, social welfare offices, food aid services, etc. RAQ workers guide individuals toward appropriate services that can respond to their social needs. In addition, RAQ staff facilitate the organization of group information sessions and actively support community-based initiatives within neighbourhoods (18).

The RAQ projects' objectives and missions are listed below:

3 Objectives:

- Combat non-take-up of fundamental rights by facilitating access to social support and self-help services.

- Strengthen access to social and healthcare services.
- Act positively on the social determinants of health.

4 Missions

- Build a local network of supportive neighbourhood actors (associations, social aid services, health and cultural actors, etc.).
- Provide individual guidance toward the appropriate services.
- Develop collective actions focused on health information and promotion.
- Develop and support community-based actions and projects within the neighborhood (19).

At the time the research was conducted, twelve community health workers (CHWs) were deployed across six Brussels communes, while nineteen Relais d'Action de Quartier (RAQs) operated in twelve different communes—altogether covering 17 distinct neighbourhood zones (15, 16, 20, 21).

Various research teams have been assessing these Belgian community health programs, mostly in the form of yearly activity reports. (15, 16, 20, 21) Through examples from interviews, they demonstrate that many people have already been successfully assisted, primarily with COVID-related issues, followed by concerns related to physical and mental health, administration, and housing. Despite these promising initial findings, not a lot has been said on the collaboration or interaction of CHWs with care providers (22).

METHODS

Aim

The present study aims to respond to the following two central questions:

- In which situations have GPs and CHWs collaborated, and how has this collaboration influenced the accessibility and quality of primary care for vulnerable populations in Brussels?
- What are the perspectives and expectations of GPs and CHWs regarding potential future collaborations, particularly in cases where they have not yet worked together?

Study design and setting

This study uses a qualitative, cross-sectional design and was approved by the Ethical committee of UZ Gent on the 2nd of April 2024.
The researchers conducted a total of 12 semi structured interviews with the following disciplines: 5 CHWs (of which 3 of the Intermut project and 2 RAQs), 5 family physicians (of which 2 had had contact with a CHW), 1 social worker and 1 community health project coordinator of a medical house.
The interviews are based on an interview guide to examine how CHWs and GPs perceive their collaboration in the Brussels healthcare context. (See Appendix A)
Demographic information (age, gender, educational level) was not collected since considered not important in the light of our aims.

Characteristics of participants

- General practitioner
    - Inclusion: certified Belgian GPs working in Brussels, with or without regular contact with CHWs, willing to share their collaboration experiences and suggestions.

- Other PHWs, such as nurses, social assistants, physiotherapists or medical house coordinators in Brussels:
    - Inclusion criteria: having had experience in working together with a CHW
- Community health workers (CHWs):
    - Inclusion: part of the CHW Intermut of RAQ project in Brussels

Procedures

Subjects were contacted mostly via email and invited to participate with the study. To maximise participation, detailed information was given about the purpose and social relevance of the study. The respondents were given the option to conduct the interview in person at their residence, in a neutral public place (e.g., coffee bar) or via an online meeting platform (options include MS Teams, ZOOM, Skype). All interviews were held online, apart from one which was conducted in person. Prior to each interview, participants were provided with an informed consent form (see appendix B). Once informed consent was obtained, the interview was conducted and recorded. After the interviews, the recordings were transcribed verbatim manually or by a certified transcription service. An AI tool was employed to assist with transcription, all outputs were subsequently verified and improved by the researchers to guarantee reliability and validity.
The data were coded with NVIVO by the two researchers independently. Initially, they conducted open coding to identify emerging concepts directly from the data, followed by axial coding to organize these codes into broader categories and relationships. The researchers discussed any discrepancies to enhance the reliability of the analysis and ultimately reached consensus on a single coding framework. The data was analysed using an inductive approach. AI tools were used to support transcription of the data, translation, summarization and phrasing of text.
All data was anonymised and saved in accordance with GDPR-guidelines.

RESULTS

It proved challenging to include GPs who had frequent and sustained interactions with CHWs. Despite repeated efforts to reach the GPs most often mentioned by CHWs as key collaborators, these practitioners could not be recruited for this study. As a result, most of the GPs who ultimately agreed to participate reported limited or no direct experience working with CHWs. Several had never heard of the role in practice yet expressed notable interest in the concept and its potential value for primary care, especially in reaching vulnerable patient groups.

The results revealed a layered picture of how CHWs operate in Brussels and how their collaboration with GPs and other primary care professionals is shaped in practice.

Pathways into the Role and Preparation

Participants described diverse pathways into their roles, bringing experience from fields such as social work, community health, or grassroots NGOs. Many were drawn to the role during the COVID-19 crisis, motivated by a strong desire to reach underserved groups and bridge gaps in access to care. While the initial training covered practical aspects such as administrative tasks, local support structures, and working with vulnerable populations, several respondents felt that it did not always equip them sufficiently for day-to-day collaboration with GPs or for clearly positioning their role within the wider primary care landscape.

CHW 1 : *" When we started, we received training in ethics, health literacy, how to work with vulnerable populations, etc. But honestly, I found the training to be rather short. I think it was still unclear to everyone what was expected of us, so the trainings were somewhat general. "* (See Appendix C for original quotes)

Functions and Bridging Tasks

Across interviews, the bridging role of CHWs emerged strongly. Participants explained how they help clients overcome language and cultural barriers that might otherwise prevent them from accessing care. They described providing practical support, such as helping people complete paperwork, attend medical appointments, or navigate complex systems. Many also played an active role in prevention and outreach — organising local campaigns, information sessions, or street-level initiatives to reach communities that would otherwise remain hard to access.

CHW 2 : *" I feel that we act as a bridge between health mediation services, the beneficiaries, and healthcare professionals. We're in the middle, I would say, and that's a tool. (...) We can make things easier between them and the beneficiaries — in terms of communication, and both linguistic and cultural interpretation. "*

Enablers of Collaboration

Several enabling factors were identified that help CHWs build connections with GPs and other care providers. Being physically present in local health centres or trusted community organisations made it easier to exchange information and coordinate support. Informal daily interactions — quick conversations in hallways or between appointments — were often described as crucial for building trust and clarifying cases. Where interdisciplinary meetings were organised, they provided valuable spaces for joint case discussions and follow-up. Over time, many participants observed that trust and mutual understanding increased as professionals became more familiar with the CHW role, although this awareness was still sometimes lacking among general practitioners.

RAQ 1 : "*The fact that everyone is in the same building makes communication much easier. (...) Often, it's during informal exchanges that we're more creative and ideas flow, whereas formal meetings can feel more rigid and less comfortable.*"

Barriers of Collaboration

Despite these positive elements, participants described persistent barriers that limit full integration. A common theme was the lack of a clear and widely communicated role description. Some GPs remained unsure about the exact tasks or added value of CHWs, which sometimes reduced referrals. Concerns about confidentiality also constrained information sharing, especially in the absence of clear legal frameworks. In many cases, direct contact with GPs was limited, with communication often routed through intermediaries such as secretaries. Several general practitioners noted that they missed a more proactive approach from CHWs in introducing themselves. Conversely, CHWs also reported that they often missed regular opportunities for contact and feedback from GPs. Structural constraints such as limited time, high workloads in general practice, and a lack of dedicated funding for collaborative work were also seen as practical obstacles.

GP 2 : *"Yes, I think it's mostly about getting to know each other. That's the first step — introducing yourselves: 'What do we do? What do we focus on? Where can we collaborate? Where can we complement each other?' But I think the main issue is that we don't know each other well enough, and that's the biggest weakness — it's something that can definitely be improved. Because if you don't know something exists, then you just live alongside it, so to speak (laughs). So yes, they should make themselves more visible."*

Structural and Systemic Conditions

Broader structural factors shaped how effectively CHWs could operate. The lack of a formal legal status was viewed as a major barrier to trust and long-term continuity. Many participants expressed concerns about the uncertainty created by short-term, project-based funding and the uneven distribution of CHW roles across neighbourhoods, which meant that not all communities benefited equally from their support.

GP 5 : "*But to be honest, I sometimes wonder whether this will be sustainable in the long term. I'm not sure the funding will continue. These professionals don't have the same legal protection as doctors, nurses, or midwives. So in times of budget cuts, they risk being the first to be let go.*"

Recommendations and Future Perspectives

Building on these findings, participants offered clear recommendations to strengthen the CHW role and its integration within primary care. They called for clear role descriptions, shared with GPs and other stakeholders, alongside more practical and continuous training adapted to the day-to-day challenges of collaboration. A stronger legal framework — including formal recognition and clear confidentiality agreements — was seen as crucial to build trust and protect professional boundaries. Many respondents emphasised the need for more proactive outreach, encouraging CHWs to present themselves regularly to local GPs and maintain visible points of contact. Securing stable, long-term funding and creating more opportunities for shared spaces or joint meetings were seen as essential steps to support integrated practice and ensure the sustainability of this valuable bridging function.

CHW 2 : *"I believe that if they had a better understanding of our role, our tasks — what we do and don't do — they would reach out to us more often. To me, we act somewhat as health mediators between beneficiaries and healthcare professionals. We are in the middle, and if care providers realised that we can facilitate communication — including linguistic and cultural aspects — they would make more use of our support."*

Table 1: Results [2]

Theme	Subtheme	Description	Quotes
Pathways into the Role of CHW and Preparation	Diverse professional background	CHWS come from varied fields, including social work, community health, NGOs, …	CHW 3: *"I've always worked a bit in public health, community health and all that. Before, I also worked with Médecins Sans Frontières on community health issues related to gender-based violence, intimate partner violence. I also worked with other organizations, especially for awareness around cancer screening and all that."*
	Initial training content	Covered administrative tasks, local context, and working with vulnerable groups.	CHW 3: *"When the project started, we had a week of training (…) We also had training on how to behave toward people in vulnerable situations and on breaking down prejudices about poverty: definitions, numbers, percentages. We were also taught to communicate better, to stay understandable and objective, and not to impose our own views."*
	Motivation to join	Many were motivated by Covid-19 and a desire to reach underserved groups.	CHW 1*: "And why? Because for me, this project made sense. I liked being in contact with people, helping them with administrative procedures, and especially offering possible paths for change."*
Functions and Bridging Tasks	Bridging role	Helping clients overcome language and cultural barriers.	CHW 1: *"(…) For me, we are like a bridge between health mediation services, the beneficiaries and healthcare professionals. We are in the middle, I'd say, and we're a tool.."*
	Practical support	Assistance with paperwork, appointments, and basic follow-up.	CHW 2: *"Most frequent cases are things like bills, applications for disability recognition, housing issues for vulnerable people, etc. We also accompany them to doctors because the communication isn't always good."*

[2] for original quotes see appendix C

	Prevention and outreach	Organising local campaigns, info sessions, or street actions.	Social worker: *"What worked well for the RAQs in Molenbeek was that they rented a stand at the Thursday market. They reached so many people. That's where they made lots of contacts—really a lot."*
Enablers of Collaboration	Physical presence	Being co-located or based in trusted local organisations supports contact.	RAQ 1: *"(...) Having everyone in the same building really helps communication. It's a circular building on the ground floor, which makes exchanges easy. (...)"*
	Informal contacts	Everyday informal talks help build trust and enable coordination.	RAQ 1: *"Besides formal meetings, there's a lot of informal interaction. For example, the social worker works right next to my office, so we exchange information regularly by email or in person. (...)"*
	Interdisciplinary meetings	Shared meetings enable joint case planning and follow-up.	CHW 1: *"(...) It's really through these teammeetings that we begin to collaborate better."*
	Growing trust over time	Trust increases as CHWs, and GPs get to know each other.	CHW 1: *"I've noticed, personally at least, that visibility has improved: service providers and actors know us better, beneficiaries trust us more. Now that we've been here three years, we've been able to fix some situations, support people. These positive outcomes have strengthened the project and our mission, and we're trusted more."*
Barriers of Collaboration	Unclear role definition	GPs sometimes do not fully understand CHW tasks or scope.	CHW 2: *"But they don't know we exist, except when we accompany someone."* GP 1 : *"If I'd known about it in the performance-based practice? Yes, I would have found that fantastic."*
	Confidentiality concerns	Lack of clear legal framework limits information exchange.	CHW 3: *"(...) I also understand that for the doctor, our confidentiality contract isn't enough: we're not doctors and that contract wasn't signed with them, so they might still be hesitant. Still, we try to have an unspoken agreement: what is said there stays confidential. I think the real challenge is this: respecting*

			privacy, GDPR, medical records, and personal data."
	Limited direct contact	Communication often depends on intermediaries.	CHW 2: *"Yes, it's when we are there during the consultation. But calling the doctor directly or speaking directly with them—no, that never happened to me."*
	Lack of proactive visibility	Some CHWs do not consistently introduce themselves to GPs or promote their role, which limits awareness and referrals.	GP 4: "*I miss proactivity. CHWs should be bridge-builders and actively go look for people in the neighbourhood. We had to approach them ourselves, whereas they could have come to us."*
	Time, money and capacity constraints	Busy GP schedules and lack of remuneration reduce room for collaboration.	CHW 1: *"Honestly, general practitioners are not very accessible, unfortunately—but it's not their fault. There's a real shortage of doctors, especially in this area."*
Structural and Systemic Conditions	Lack of formal status	Absence of legal recognition undermines trust and continuity.	CHW 2: *"For me, the main issue is that CHWs don't have professional recognition... I also think that makes communication and accessibility harder."*
	Funding and sustainability	Short-term projects create uncertainty for planning.	GP 5: *"(...) But honestly, I sometimes wonder if this is sustainable long-term. I doubt it will keep being funded. These people don't have the same legal protection as doctors, nurses, or midwives. They're the first to be cut when there are budget cuts."* CHW 1: *" At first, the project was only for six or seven months, up to December. So no one wanted to collaborate with a project that might end in six months."*
	Fragmented coverage	Not all neighbourhoods benefit equally from CHW presence.	CHW 3: *"There are still municipalities where needs remain. (...) Even with both projects running, we can't cover every municipality or every district. We just can't manage that."*
Recommendations and future perspectives	Improve role clarity	Develop clear role descriptions and communicate these to GPs and stakeholders	GP 5: *"(...) I think there really needs to be clarity in their core activities at the policy level, and they need to be able to*

			communicate that to medical teams."
	Reinforce training for interprofessional collaboration	Ensure adequate training for CHWs and GPs before and during professional activities	GP 5: *"On one hand, through university training programs, by giving them a place during an interdisciplinary week. So they can introduce themselves, think together, and possibly run exercises with students."*
	Strengthen legal framework	Advocate for formal recognition and confidentiality agreements.	CHW 3: *"For example, regarding confidentiality, there should maybe be a clear structural framework—an official status that binds CHWs to medical confidentiality. Among ourselves, we know we mustn't share things, but unlike doctors, nothing official legally requires us. So it's not up to us or the doctors to fix that—it's up to the project designers."*
	Encourage proactive outreach	Support CHWs to actively introduce themselves and maintain visible contact with primary care.	GP 2: *"And yes, we don't know them either. I really think they should introduce themselves and do that in a meeting."*
	Secure sustainable funding	Ensure structural funding to enable long-term planning and integration.	RAQ 2: *"And then, of course, subsidize both healthcare services and social services."*
	Foster integrated practice	Facilitate regular joint meetings and shared workspaces to strengthen cooperation.	GP 4: *"What could improve is their integration into the team. Not through medical meetings, but maybe through a separate meeting focused on social and preventive needs."*

DISCUSSION

Findings reveal that interactions between CHWs and healthcare providers remain superficial and infrequent. This analysis shows that while CHWs have significant potential to collaborate with primary care providers, various structural and relational barriers still limit this integration. Clear role definitions, trust-building, and consistent communication remain critical conditions for effective cooperation. The findings suggest that collaboration improves when CHWs are visible, embedded in local health centres, and recognised by general practitioners and other healthcare staff.
Our findings are in line with previous studies on collaboration between CHWs and general practitioners or other care providers. For instance, Leban et al. highlighted the lack of role clarity and mutual understanding as major barriers to integration (23), while other research demonstrated how CHWs embedded within primary care practices help build long-term trust with patients (24, 25).
They also reflect broader issues commonly seen in interdisciplinary practice and integrated care, as described in the Rainbow Model. Examples of the enablers of interdisciplinary collaboration Grant et al. mentions are knowledge of interprofessional competencies and adequate funding (26). According to the Rainbow Model of Integrated Care (27), successful integration depends not only on structural and functional alignment but also on normative integration — shared values, mutual trust, and a clear understanding of complementary roles. The limited recognition of CHWs by general practitioners and the lack of a legal framework hinder the development of such shared norms.

However, the current fragmentation in Brussels, combined with short-term funding and limited accountability structures, weakens the potential for CHWs to be fully integrated into care teams. Ensuring visibility, legal recognition, and structural support for CHWs is therefore not only a matter of operational efficiency, but also a necessary step toward achieving the goals of the Quintuple Aim: improving population health, enhancing the experience of care, ensuring more efficient use of healthcare resources, improving healthcare professional well-being and advancing health equity (28).

Strengths

A key strength of this study lies in its inclusion of multiple primary care disciplines, which gives a richer and more nuanced understanding of collaboration with CHWs. By interviewing professionals from diverse first-line settings, the research presents a broader range of perspectives and experiences. Additionally, the use of individual interviews allowed for in-depth exploration of specific topics, while also creating space for participants to introduce issues that may not have been anticipated by the researchers. This was done via follow-up questions and by responding to communicative cues, enabling clarification and uncovering of context-specific insights that would have been difficult to obtain through more structured or quantitative methods.
While recent research has shown that collaboration has been successful on the national level (29), this is the first study to focus specifically on the situation in Brussels.

Limitations

Despite efforts to ensure rigour, the coding and interpretation inevitably reflect the researchers' positionality. As both researchers are family medicine trainees in Brussels, their professional perspective may have influenced the analysis. Reflexivity and peer reviewing were used to reduce potential bias.
Data from CHWs engaged in two distinct projects in Brussels were combined. It should be acknowledged, however, that despite their many similarities the projects differ in their respective training programmes and their objectives. This may have implications for the reliability and broader applicability of the results.

Another limitation is that fewer physicians with long-term CHW experience were interviewed than expected. Furthermore, only Dutch-speaking GPs participated, which meant valuable input from the French-speaking healthcare community was missed.

Recommendations

Directions for further research

Having access to a larger number of participants would have been valuable, as this provides deeper insights into how sustained interprofessional relationships develop over time, what facilitates or hinders their continuity, and how the integration of CHWs can evolve within primary care practices. Their perspectives might have further enriched our understanding of the structural and relational factors that contribute to effective, long-term collaboration. Given the programmes' relatively recent launch, it is expected that in the future more collaborations will take place. Further research should therefore prioritise the inclusion of physicians with established experience working alongside CHWs to capture the dynamics and impact of these relationships more comprehensively. To investigate the effect of their collaboration on patient health outcomes, beneficiaries should be included to future research.

Implications for practice

None of the participants reported having received explicit and individual guidance during their professional training on how to engage in interprofessional collaboration with health care professionals, including how to present themselves, articulate their added value, or coordinate tasks efficiently. This indicates a potential gap in their educational curriculum concerning interprofessional competencies. While they did acquire skills for engaging with other social organizations and actors, specific training for structured collaboration with health care providers appeared to be lacking. Several participants indicated that unfamiliarity with the CHW role remains a barrier for effective referrals and collaboration. Increased visibility and approachableness for both healthcare providers and residents, may lead to more frequent interactions and more continuous support. CHWs could benefit from clearer strategies to increase their visibility among both primary care professionals and community members. Inversely, primary care professionals could also benefit from interprofessional training programs. Practical measures, such as proactively introducing themselves to local general practitioners, distributing information leaflets or contact cards in neighbourhood facilities, and maintaining an updated presence on community websites or social media. Regular participation in local health centre meetings or community events could further support recognition and build trust with other frontline workers.

Policy recommendations

To maximise the potential of CHWs, policy measures should provide sustainable funding and prioritise the formal recognition of CHWs within the healthcare system, provide a clear legal and organisational framework for their roles, and ensure adequate training and support for interprofessional collaboration. Regular joint meetings and explicit agreements on confidentiality and information-sharing could further reinforce trust and integration between CHWs and other primary care actors.

CONCLUSIONS

This analysis shows that while CHWs hold significant potential to collaborate with primary care providers, various structural and relational barriers continue to limit this integration. The findings show that building trust and mutual recognition is a gradual process. Respondents suggested that increased visibility within health centres, clear role descriptions, and sustained opportunities for joint activities or case discussions can help foster stronger working relationships with GPs and other frontline staff. The findings suggest that when CHWs are visible, well-positioned within local health centres, and recognised by general practitioners and other healthcare staff, collaboration improves, and care pathways become more accessible for vulnerable groups.
However, persistent challenges such as limited feedback, unclear task boundaries, and fragmented frameworks highlight the need for clearer agreements and sustained investment in interprofessional teamwork to ensure that collaboration does not depend solely on individual goodwill or informal contacts.

LIST OF ABBREVIATIONS

APHA	American Public Health Association
CHW	Community Health Worker
EU	European Union
FDSS	Federation of Social Services
GDPR	General Data Protection Regulation
GP	General Practicioner
NGO	Non-Governmental Organization
NIC/CIN	National Intermutualistic College
RAQ	Relais d'Action de Quartier
RIZIV/INAMI	National Institute for Health and Disability Insurance
US	United States

DECLARATIONS

Ethics approval and consent to participate

This study was approved by the Ethical committee of UZ Gent on the 2nd of April 2024.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interest.

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Authors' contributions

Both authors were involved in the literature study and recruitment of the participants. Some interviews were conducted by both researchers and others separately. The transcription of the data was divided. Coding of the data was done separately and later discussed. Both researchers were involved in the interpretation and reporting of the results. All authors read and approved the final manuscript.

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APPENDIX A: the interview guide

Primary Health Worker

First Contact

- How did you first come into contact with CHWs?
- What made you interested in working with CHWs?
- How long have you been working with CHWs?

Current Progress

- How often do you work with CHWs?
- What have been your experiences so far working with CHWs?
- In what situations have you deployed them?
- What makes you decide whether or not to use a CHW?
- How do you reach the CHWs?
- How does this process usually go? (or is it always different? Example?)
- What subtypes of patients are mostly helped by CHWs?

Evaluation

- What changes in health behavior have you noticed in your patients after CHW intervention?
- Have you noticed changes since the beginning of the collaboration? (e.g., CHW competencies)
- What are the experienced barriers in the collaboration with CHWs?
- What are the benefits you experience from working with CHWs?
- What are the positive and/or negative experiences?
- Was there any feedback afterwards? How did that go?
- What would you like to change about the collaboration with CHWs? What can be improved?
- Do you feel that this project can contribute to increasing access to healthcare?
- Do you feel it facilitates your work as a primary care provider? In what way?

End

- Are there any other matters you would like to add?

Community health workers

General

- When did you become a CHW and why? What training have you already received?
- What have been your experiences with the training? What went well, what can be improved?
- What are your tasks as a CHW?
- How do you meet patients?
- What help requests are most common?
- With which care providers do you work the most?

First Contact

- When did you first encounter a primary care provider in your role as a CHW?
- How did this go?

Current Progress

- How often do you work with primary care providers?
- What have been your experiences so far with primary care providers/doctors? Have you noticed any changes?
- How are you received by primary care providers/doctors?
- How do you reach primary care providers? Is there smooth contact? Are they accessible enough? Why?

Evaluation

- What are the experienced barriers to working with primary care providers/doctors?
- What are the biggest challenges in working with primary care providers/doctors?
- What changes have you noticed since the beginning of the collaboration?
- What are the benefits for you of working with primary care providers?
- What are the disadvantages?
- Was there any feedback afterwards? How did that go? What are the positive and/or negative experiences?
- What would you like to change about the collaboration with primary care providers? What can be improved?
- Do you feel that this project can contribute to increasing access to healthcare?

End

- Are there any other matters you would like to add?

APPENDIX B: informed consent forms (Dutch and French)

TOESTEMMINGSFORMULIER VOOR DEELNEMERS AAN EEN EXPERIMENT

Referentienummer van de deelnemer voor deze studie	

Ik heb het document "Informatiebrief voor deelnemers aan een experiment" pagina 1 tem 6 gelezen en begrepen en ik heb er een kopij van gekregen. Ik heb uitleg gekregen over de aard, het doel, de duur, de te voorziene effecten van de studie en over wat men van mij verwacht. Ik heb uitleg gekregen over de mogelijke risico's en voordelen van de studie. Men heeft me de gelegenheid en voldoende tijd gegeven om vragen te stellen over de studie en ik heb op al mijn vragen een bevredigend antwoord gekregen, ook op medische vragen.
Ik begrijp dat deelname aan de studie vrijwillig is en dat ik mij op elk ogenblik uit de studie mag terugtrekken zonder een reden voor deze beslissing op te geven en zonder dat dit op enigerlei wijze een invloed zal hebben op mijn verdere behandeling.
Ik begrijp dat auditors, vertegenwoordigers van de opdrachtgever, de Commissie voor Medische Ethiek of bevoegde overheden, mijn gegevens mogelijks willen inspecteren om de verzamelde informatie te controleren. Te allen tijde zal mijn privacy gerespecteerd worden.
Ik ben me ervan bewust dat deze studie werd goedgekeurd door een onafhankelijke Commissie voor Medische Ethiek verbonden aan het UZ Gent en de Universiteit Gent en dat deze studie zal uitgevoerd worden volgens de richtlijnen voor de goede klinische praktijk (ICH/GCP) en de verklaring van Helsinki, opgesteld ter bescherming van mensen deelnemend aan experimenten. Deze goedkeuring was in geen geval de aanzet om te beslissen om deel te nemen aan deze studie.
Men heeft mij ingelicht dat zowel persoonlijke gegevens als gegevens aangaande mijn gezondheid worden verwerkt en bewaard gedurende minstens 10 jaar na het einde van de studie. Ik ben op de hoogte dat ik recht heb op toegang en op verbetering van deze gegevens. Aangezien deze gegevens verwerkt worden in het kader van medisch-wetenschappelijke doeleinden, begrijp ik dat de toegang tot mijn gegevens kan uitgesteld worden tot na beëindiging van het onderzoek. Indien ik toegang wil tot mijn gegevens, zal ik mij richten tot de arts-onderzoeker die verantwoordelijk is voor de verwerking ervan.
Ik ben ervan op de hoogte dat mijn geanonimiseerde gegevens gebruikt worden voor **huidig** wetenschappelijk onderzoek.
Ik ben ervan op de hoogte dat mijn geanonimiseerde gegevens gebruikt kunnen worden voor **toekomstig** academisch wetenschappelijk onderzoek in het kader van hetzelfde/een vergelijkbaar onderzoeksdomein. Dergelijke nieuwe studie dient steeds ingediend en goedgekeurd te worden door het ethisch comité. Indien ik wens dat mijn gegevens niet gebruikt worden voor toekomstig onderzoek, zal ik de DPO contacteren (zie contactgegevens onder sectie 7).
Mijn huisarts wordt niet ingelicht over mijn deelname aan deze studie tenzij ik mijn goedkeuring hiervoor geef.

Naam en voornaam van de deelnemer	Handtekening	Datum
Naam en voornaam van de arts-onderzoeker	Handtekening	Datum

2 kopieën dienen te worden vervolledigd. Het origineel wordt door de onderzoeker bewaard gedurende minstens 10 jaar, de kopie wordt aan de deelnemer gegeven.

Ik verklaar de benodigde informatie inzake deze studie (de aard, het doel, en de te voorziene effecten) mondeling te hebben verstrekt evenals een exemplaar van het informatiedocument aan de deelnemer te hebben verstrekt.	

Ik bevestig dat geen enkele druk op de deelnemer is uitgeoefend om hem/haar te doen toestemmen tot deelname aan de studie en ik ben bereid om op alle eventuele bijkomende vragen te antwoorden.	

Aankruisen door de getuige/tolk indien akkoord

Ik was aanwezig tijdens het volledige informatieproces en ik bevestig dat de informatie over de doelen en procedures van de studie op de juiste manier werd gegeven, dat de deelnemer de studie begrepen heeft en dat toestemming voor deelname aan de studie vrijwillig is gegeven.		
Naam, voornaam en hoedanigheid van de getuige/tolk	Handtekening	Datum

FORMULAIRE DE CONSENTEMENT POUR LES PARTICIPANTS AUX RECHERCHES

J'ai lu et compris le document "Lettre d'information pour les participants à une expérience" pages 1 à 6 et j'en ai reçu une copie. On m'a expliqué la nature, le but, la durée, les effets prévisibles de l'étude et ce que l'on attend de moi. On m'a expliqué les risques et les avantages possibles de l'étude. J'ai eu la possibilité et le temps de poser des questions sur l'étude et j'ai reçu des réponses satisfaisantes à toutes mes questions, y compris d'ordre médical.
Je comprends que la participation à l'étude est volontaire et que je peux me retirer de l'étude à tout moment sans avoir à justifier ma décision et sans que cela n'affecte en quoi que ce soit la poursuite de mon traitement.
Je comprends que les auditeurs, les représentants du client, la Commission de déontologie médicale ou les autorités compétentes peuvent souhaiter consulter mes données pour vérifier les informations collectées. À tout moment, ma vie privée sera respectée.
Je sais que cette étude a été approuvée par un comité d'éthique médicale indépendant affilié à l'hôpital universitaire de Gand et à l'université de Gand et qu'elle sera menée conformément aux lignes directrices relatives aux bonnes pratiques cliniques (ICH/GCP) et à la déclaration d'Helsinki, rédigée pour protéger les personnes participant à des expériences. Cette approbation n'a en aucun cas motivé la décision de participer à cette étude.
J'ai été informé(e) que les données à caractère personnel et les données relatives à ma santé seront traitées et conservées pendant au moins 10 ans après la fin de l'étude. Je suis informé(e) que je dispose d'un droit d'accès et de rectification de ces données. Comme ces données sont traitées à des fins médicales et scientifiques, je comprends que l'accès à mes données peut être retardé jusqu'à la fin de l'étude. Si je souhaite avoir accès à mes données, je m'adresserai au médecin-chercheur responsable du traitement.
Je suis conscient(e) que mes données anonymes seront utilisées pour la recherche scientifique en cours.
Je suis conscient(e) que mes données anonymes peuvent être utilisées pour de futures recherches scientifiques universitaires dans le même domaine de recherche ou dans un domaine similaire. Une telle nouvelle étude doit toujours être soumise et approuvée par le comité d'éthique. Si je souhaite que mes données ne soient pas utilisées pour des recherches futures, je contacterai le DPD (voir les coordonnées au point 7).
Mon médecin traitant ne sera pas informé de ma participation à cette étude, sauf si j'en donne l'autorisation.

Nom et prénom du participant	Signature	Date
Nom et prénom de l'enquêteur	Signature	Date

2 copies doivent être remplies. L'original sera conservé par le chercheur pendant au moins 10 ans et la copie sera remise au participant.

Je déclare avoir fourni verbalement les informations nécessaires concernant cette étude (la nature, le but et les effets prévisibles) ainsi qu'une copie du document d'information au participant.	
Je confirme qu'aucune pression n'a été exercée sur le participant pour qu'il accepte de participer à l'étude et je suis disposé à répondre à toute question supplémentaire.	

Cocher par le témoin/l'interprète s'il est d'accord

J'étais présent pendant tout le processus d'information et je confirme que les informations sur les objectifs et les procédures de l'étude ont été données de manière appropriée, que le participant a compris l'étude et que le consentement à participer à l'étude a été donné volontairement.		
Nom, prénom et qualité du témoin/interprète	Signature	Date

APPENDIX C: original quotes

Quotes from the text

CHW 1 : “ (...) quand on est entrés, on a eu des formations en déontologie, en littératie de la santé, comment travailler avec des publics vulnérables, etcetera. Voilà, c'étaient des formations assez courtes, je trouve, pour être honnête. Je pense que c'était encore flou pour tout le monde, de ce qu'on attend de nous, donc les formations étaient un peu générales. ”
CHW 2: “(...) Moi, je trouve qu'on fait le pas entre un service de médiation en santé, entre les bénéficiaires et les professionnels de soins. Nous, on est au milieu, je dirais, et c'est un outil. S'ils savent qu'on est là, qu'on existe et que dans un certain degré, on peut faciliter la tâche entre eux et les bénéficiaires, de communication, d'interprétation linguistique et culturelle, je pense qu'ils feront appel à nous.”
RAQ 1 : “ Le fait que tout le monde soit dans le même bâtiment facilite beaucoup la communication. (...) Souvent, c’est dans les échanges informels qu’on est plus créatif et que des idées fusent, alors que dans le cadre des réunions formelles, on est parfois moins à l’aise, plus contraint. ”
ARTS 2: “Ja, ik denk vooral elkaar leren kennen.
Dat is het eerste, allez zich een keer voorstellen van “wat doen wij?” Want allez wat waar werken wij op, waar kan er samenwerking zijn, waar kunnen we elkaar aanvullen, ... Voilà maar ik denk dat het vooral is dat we elkaar te weinig kennen, dat dat het grote minpunt is en dat dat dus verbeterd kan worden en dan start alles (= de samenwerking).
Want allez ja als je niet weet dat het bestaat (het CHW project) dan ja leef je ernaast hè ik zal het zo zeggen (lacht). Ze mogen zich dus meer kenbaar maken.”
ARTS 5: “ (...) Maar eerlijk gezegd vraag ik me soms af of dit op lange termijn bestendig zal zijn. Ik twijfel of het gefinancierd zal blijven. Deze mensen hebben immers niet dezelfde wettelijke bescherming als artsen, verpleegkundigen of vroedvrouwen. Ze lopen dus het risico om bij besparingen als eersten te worden geschrapt.”
CHW 2 : “ Je pense que s’ils connaissaient mieux notre rôle, nos missions, ce qu’on fait et ce qu’on ne fait pas, ils feraient plus souvent appel à nous. Pour moi, on joue un peu le rôle de médiateur en santé, entre les bénéficiaires et les professionnels. On est au milieu, et si les soignants savaient qu’on peut faciliter la communication, y compris sur le plan linguistique et culturel, ils nous solliciteraient davantage.”

Quotes from the table

CHW 3: “moi j'ai toujours travaillé un petit peu dans la santé publique, la santé communautaire et tout ça. Et avant, j'ai travaillé avec Médecins Sans Frontières aussi dans tout ce qui est santé communautaire, par rapport aux violences de genre, violences sur partie d'un intime. J'ai aussi travaillé avec d'autres organisations, surtout par rapport à la sensibilisation par rapport au cancer, dépistage et tout. ”
CHW 3: “Quand le projet a commencé, on a eu une semaine de formation (...) On a aussi eu une formation sur l'attitude à adopter face aux personnes en situation de vulnérabilité, ainsi que sur les préjugés liés à la pauvreté : définitions, chiffres, pourcentages. On nous a également appris à mieux communiquer, à rester compréhensibles et objectifs, sans imposer nos propres idées.”
CHW 1: “Et pourquoi ? Parce que pour moi, ce projet avait du sens. J’aimais être en contact avec les gens, les aider dans leurs démarches administratives et surtout pouvoir leur proposer des pistes de changement. C’était très motivant. Avant cela, je travaillais déjà dans le social avec Médecins Sans Frontières, donc je voulais rester dans ce domaine. Et ce projet tombait parfaitement bien, car celui avec MSF se terminait juste quand celui-ci commençait.”

CHW 1: “(...) Moi, je trouve qu'on fait le pas entre un service de médiation en santé, entre les bénéficiaires et les professionnels de soins. Nous, on est au milieu, je dirais, et c'est un outil. S'ils savent qu'on est là, qu'on existe et que dans un certain degré, on peut faciliter la tâche entre eux et les bénéficiaires, de communication, d'interprétation linguistique et culturelle, je pense qu'ils feront appel à nous.”
CHW 2: “Les plus fréquentes, par exemple, des factures, des demandes de handicap, la reconnaissance d'handicap, des difficultés dans les logements sociables pour l'insubébrité, etc. Des accompagnements chez les médecins parce qu'il n'y a pas une bonne communication.”
Assistante sociale: “Le truc qui marchait bien pour les RAQ qui étaient sur le terrain de Molenbeek, c'est qu’ils louaient une tonnelle et un stand d'information au marché du jeudi. Alors là, ça ramassait beaucoup, beaucoup, beaucoup de personnes. Et là, ils arrivaient à avoir du contact, énormément.”
CHW 1: “Et sinon, les infirmières en santé communautaire, dans les maisons médicales par exemple, on les rencontre lorsqu’on y tient une permanence. Et quand on effectue un suivi, on est aussi en contact avec les médecins, l’assistant social de l’hôpital ou encore un spécialiste hospitalier. Dans ce cas-là, on est en contact direct avec eux, en présentiel.”
RAQ 1: “(...) Le fait que tout le monde soit dans le même bâtiment facilite beaucoup la communication. C’est un bâtiment circulaire, au rez-de-chaussée, ce qui rend les échanges faciles. (...)”
RAQ 1: “À côté des réunions formelles, il y a beaucoup d’échanges informels. Par exemple, l’assistante sociale travaille dans le bureau à côté du mien, donc on s’échange des informations régulièrement, par mail ou en personne. (...)”
CHW 1: “(...) C’est vraiment à travers ces réunions (d’équipe) qu’on arrive à mieux collaborer.”
CHW 1: “On a remarqué, en tout cas moi, une amélioration de la visibilité : les prestataires et acteurs nous connaissent mieux, les bénéficiaires nous font plus confiance. Comme ça fait maintenant trois ans qu’on est là, on a pu débloquer certaines situations, accompagner des personnes. Les retours positifs ont renforcé le projet et notre mission, et on nous fait plus confiance.”
CHW 2: “Mais ils ne savent pas qu'on existe, sauf au moment qu'on fait l'accompagnement.”
ARTS 1 : “Moest ik het hebben geweten in de prestatiegebonden praktijk? Ja, dan zou ik dat wel fantastisch hebben gevonden.”
CHW 2: “Moi, le premier, je trouve que comme il n'y a pas une reconnaissance professionnelle des CHW... Je pense aussi que ça difficultait un peu cette communication, cette accessibilité.”
CHW 2: “Oui, c'est au moment qu'on est chez lui dans la consultation. Mais d'appeler le médecin directement ou d'avoir directement parlé avec lui, non, jamais, ça ne m'est jamais arrivé.”
ARTS 2: “Ja, ik denk dat het vooral begint bij elkaar leren kennen. Zich eens voorstellen: “Wat doen wij, waar werken wij op, waar kunnen we samenwerken of elkaar aanvullen?” Het probleem is dat we elkaar te weinig kennen, en dat is een groot minpunt. Als dat verbetert, kan de samenwerking echt starten.
Want als je niet weet dat het CHW-project bestaat, dan leef je er gewoon naast. Ze mogen zich dus meer zichtbaar maken.”
CHW 1: “Honnêtement, [les médecins généralistes] ne sont pas très accessibles malheureusement, mais ce n’est pas de leur faute. Il y a vraiment... enfin... un vrai manque de médecins, en tout cas dans la zone. Moi, je suis à Anneessens. Si un nouvel affilié veut, demain, un nouveau médecin généraliste, c’est devenu compliqué. Dans les maisons médicales aussi, pour les rendez-vous, les patients doivent attendre que des plages horaires se libèrent, et tout ça prend du temps. Donc je sais que, pour les personnes, des fois, c’est compliqué, même quand elles sont affiliées à une maison médicale : elles ont quand même du mal à obtenir un rendez-vous facilement [et rapidement, surtout en cas de besoin urgent].”

CHW 3: “(…) Mais je comprends aussi que, pour le médecin, ce n’est pas une garantie suffisante : on n’est pas médecins, et ce contrat n’est pas signé avec lui, donc il peut rester méfiant. Malgré tout, on essaie d’avoir un accord tacite entre nous : ce qui se dit là doit rester confidentiel. Je pense que le vrai défi, c’est ça : le respect de la vie privée, le RGPD, les dossiers médicaux, les données personnelles.”
ARTS 5: “ (…) Maar eerlijk gezegd vraag ik me soms af of dit op lange termijn bestendig zal zijn. Ik twijfel of het gefinancierd zal blijven. Deze mensen hebben immers niet dezelfde wettelijke bescherming als artsen, verpleegkundigen of vroedvrouwen. Ze lopen dus het risico om bij besparingen als eersten te worden geschrapt.”
CHW 1: “(…) Et au début, le projet n'était que là pour 6 mois ou 7 mois, c'était jusqu'à décembre. Et donc personne ne voulait collaborer avec un projet qui allait peut-être finir dans 6 mois. (…)”
CHW 3: “Il y a encore des communes où il y a encore des besoins. (…) Même avec les deux projets, de toute façon, on ne sait pas couvrir toutes les communes et même tous les quartiers sur une commune, on ne sait pas. On ne sait pas le faire.”
ARTS 5: “(…) Volgens mij moet er echt een verduidelijking komen van hun vaste activiteiten op beleidsniveau, en moeten ze deze ook kunnen communiceren aan de medische teams”
ARTS 5: “(…) Enerzijds via de universitaire opleidingen, door hen bijvoorbeeld een plaats te geven binnen een interdisciplinaire week. Dat ze zich daar kunnen voorstellen, kunnen meedenken, en eventueel ook samen met studenten oefeningen kunnen doen.”
CHW 3: “(…) Par exemple, en ce qui concerne la confidentialité, il faudrait peut-être un cadre structurel clair, un statut officiel qui impose aux CHW le respect du secret professionnel. Entre nous, on sait qu’on ne doit pas divulguer d’informations, mais contrairement aux médecins, il n’existe rien d’officiel qui nous y oblige légalement. Ce n’est donc pas à nous ou aux médecins de régler ça, mais plutôt aux concepteurs du projet. (…) ”
ARTS 2: “(…) En ja, we kennen ze ook niet. Ik denk echt zich voorstellen en dat met een vergadering doen.”
RAQ 2: “Et ensuite, bien sûr, subsidier à la fois les services de soins et les services sociaux.”
ARTS 4: “(…) Wat beter kan, is zijn integratie in het team. Niet via het medische overleg, maar misschien via een aparte vergadering rond sociale en preventieve noden.”