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Community Health Workers and Community Advocacy: Addressing Health Disparities

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Abstract The Community Health Worker model is recognized nationally as a means to address glaring inequities in the burden of adverse health conditions that exist among specific population groups in the United States. This study explored Arizona CHW involvement in advocacy beyond the individual patient level into the realm of advocating for community level change as a mechanism to reduce the structural underpinnings of health disparities. A survey of CHWs in Arizona found that CHWs advocate at local, state and federal political levels as well as within health and social service agencies and business. Characteristics significantly associated with advocacy include employment in a not for profit organization, previous leadership training, and a work environment that allows flexible work hours and the autonomy to start new projects at work. Intrinsic characteristics of CHWs associated with advocacy include their belief that they can influence community decisions, self perception that they are leaders in the community, and knowledge of who to talk to in their community to make change. Community-level advocacy has been identified as a core CHW function and has the potential to address structural issues such as poverty, employment, housing, and discrimination. Agencies utilizing the CHW model could encourage community advocacy by providing a flexible working environment, ongoing leadership training, and opportunities to collaborate with both veteran CHWs and local community leaders. Further research is needed to understand the nature and impact of CHW community advocacy activities on both systems change and health outcomes.

Keywords Community Health Worker · Policy · Advocacy · Leadership · Health disparities

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Introduction

The Community Health Worker model is recognized nationally as a means to address glaring inequities in the burden of adverse health conditions that exist among specific population groups in the United States. Community Health Workers (CHWs), also known as promotores de salud, community health advisors, community health representatives, lay health advisors, outreach workers, and community health advocates have been working with marginalized populations since the 1960s. CHW*s* are characterized as community leaders who share the language, socioeconomic status and life experiences of the community members they serve [1]. The use of CHWs has become almost obligatory in programs that address health disparities because of their proven effectiveness in increasing healthcare utilization, providing health education, and advocating for individual patient needs [2–7]. Research shows that CHWs have successfully increased health knowledge and/or health service utilization in many areas including nutrition, diabetes, chronic disease screening, and cancer screening [8–12]. CHWs have also been attributed with individual changes in health behavior and health status [13–15].

What current research has not adequately considered, however, is the extent to which CHWs address the root causes of health disparities. The tendency, and in many cases necessity, of health programs to focus on individual

health outcomes has resulted in a failure to investigate or promote the role of CHWs in affecting social change. CHWs have an intimate knowledge of community needs, extensive awareness of community resources, and are considered leaders among their peers. These qualities place CHWs in a unique position to represent their communities and advocate on a community level by pressuring lawmakers to pursue structural changes that will address health inequities. Literature on community development offers support for the idea of the CHW as an advocate for community-level change. Wakefield & Poland suggest that in order to achieve larger-scale change such as improvement in the service delivery system, CHWs must mobilize the members of their community to become activists for social justice [16]. However, there is scant reference in public health literature regarding the potential of CHWs to conduct advocacy on a community level.

The few examples of CHW involvement in social change efforts justify further research. Williams describes the importance of the CHW model in addressing organizational changes within a community clinic that increased access to care for a Latino community in Texas [17]. A program entitled "People Improving the Community's Health" stresses the need to improve social connections as a means to build social capital and improve community health [18]. In this program, CHWs mobilized community members to become civic participants and problem solvers, resulting in the delivery of health services directly in neighborhoods, development of a farmer's market, and decreased use of emergency rooms for primary care. Another program recruited well-respected residents of a public housing development to serve as advocates on health and community issues and provided training on advocacy and leadership skills. Residents of the housing development demonstrated higher levels of community engagement and participation following the intervention [19]. The Poder es Salud/Power for Health intervention in Multnomath County, Oregon provided leadership training to CHWs in local politics and governance structure, advocacy, and community organizing. Preliminary evidence suggests that CHWs engaged in community advocacy by forming racially/ethnically diverse groups of community members to address important issues such as police and gang violence [20].

There are also efforts on a national level to capture CHW roles and activities. In 2007, the Health Resources and Services Administration (HRSA) completed the Community Health Workers National Workforce Study [21]. The study provides a comprehensive snapshot of the field with a focus is on service delivery. To the extent that the study investigates the involvement o f CHWs in initiating community level change, it was documented that nationally CHW training may not currently prepare CHWs for this role. The study found that 38% of CHWS received leadership training from their employer compared to 79% receiving training on health issues and 64% on specific diseases. It is noteworthy that the study found that 14.2% of the organizations hiring CHWs are social advocacy organizations, suggesting a role of CHWs that is not being fully captured by this survey. Furthermore, 53.0% of employers reported that community advocacy was a work activity of CHWs, while 34.9% cited increasing community capacity as one of their activities. However, these activities were not described.

Since the launch of *Comienzo Sano* in 1987, a prenatal outreach and education intervention in Yuma County, researchers in Southern Arizona have collaborated with Latino communities to develop, implement and evaluate programs utilizing the CHW model. This public health intervention was eventually sustained as a line item of the Arizona Department of Health Services budget and is now implemented in rural and underserved communities throughout Arizona [22, 23]. The pressure to sustain grant initiated programs influenced partners to focus evaluation efforts on documenting the effectiveness of CHW programs in improving health outcomes, in spite of the fact that CHW activities often included efforts to mobilize the community in creating an environment more conducive to health. One example is the Border Health Strategic Initiative funded by the Centers for Disease Control and Prevention from 2000 to 2003. Border Health ¡SI! was a comprehensive diabetes prevention and control program which centered around the use of CHWs to work across multiple domains of the community [24]. CHWs were crucial both in engaging the community to address environmental changes and in successfully mobilizing program participants to lobby local politicians for increased funding for recreational areas [25]. In Arizona, as CHWs have become increasingly recognized as an effective means to conduct community outreach, health care providers such as community health centers have incorporated the use of CHWs in their clinical programs. While clearly positive from the standpoint of sustainability for CHW programs and improving the cultural competence of clinical services, there is some question as to whether the role of the CHW has been limited in the context of specific program delivery.

This study is an investigation of how CHWs in Arizona view their role in representing community health needs and to what extent they communicate with elected officials and political bodies as well as with health and social service agencies about making changes in their community. In addition, the study seeks to identify attributes of CHWs and their working environment that are associated with community advocacy.

Methods

For the purposes of this study, cross-sectional survey data were collected from CHWs affiliated with the Arizona Community Health Outreach Worker Network (AzCHOW). AzCHOW is a statewide organization designed to provide an opportunity for CHWs to develop a collective voice in addressing relevant policy and sustainability issues, as well as the expansion of the CHW field. AzCHOW provided researchers with a cumulative mailing list of all active and inactive CHW members as well as organizations known to employ CHWs and/or support the CHW field. A 43-question, bilingual (English and Spanish) self addressed survey was mailed directly to the home addresses of affiliated CHWs (N = 97) and a packet of surveys with self addressed, paid envelopes were sent to agency directors (N = 118). A cover letter endorsing the study and signed by the current AzCHOW president was included which explained the components of the study and encouraged participation. Also included was the human subject protection disclaimer form which gave greater details of the purpose of the study and the confidentiality of shared information. Of the total 86 completed surveys returned, 34 (39.5%) came from mailings to organizations, and 33 (38.4%) were from individuals, and 19 (22%) are unknown.

Socio-demographic measures included age, gender, race/ethnicity, employment status, annual family income, education level and access to health care. Independent variables included CHW specific training, job description, leadership activities, and perceived role as a CHW. Outcome variables included ever having talked with or written a letter to an elected official, political governing body, a clinic/hospital, social service agency, law enforcement agency or local business about making changes in the community. For the purpose of analysis, outcome variables were collapsed into the following domains: locally elected government (school board, city council, county board of supervisors, planning and zoning commission); state/federal elected government (State or U.S. representative/senator or governor) clinic/hospitals, social services agencies (Department of Economic Security, Housing Authority), law enforcement agencies, and local businesses. In addition, all dependent variables were collapsed into a total community advocacy variable for which results are presented. Logistic regression assesses CHW characteristics associated with community advocacy at all levels. A two-tailed alpha level of 0.05 was used to define statistical significance for statistical tests.

Results

There were a total of 86 CHW participants. The majority of respondents were Hispanic (44.6%) women (87%) with a mean age of 45 years (range 21–71 years) (Table 1). Two-thirds had some college education (74.4%) and worked full time as a CHW (83.7) with access to private health insurance (58.1%). Annual family income varied with 28% earning less than $25,000, one-third $25,001-$50,000 and the remaining 23% more than 50,000. The mean years of employment as a Community Health Worker for the sample was 8.86 years (SD = 9.0). Place of employment was somewhat evenly distributed among clinic/hospital settings (37.3%), health departments (31.3%) and non-profit (25.3%). When compared to the corresponding variables of the HRSA workforce study, the AzCHOW sample is similar to the national population of CHWs in gender (87% vs. 81.5% female), but has a higher representation of Hispanics and American Indian CHWs than was documented in the HRSA Study (44.5% vs. 35.2% and 20.5% vs. 5.0%, respectively). The AzCHOW sample also had a higher percentage of respondents with some college education (74.4% vs. 51%).

The majority of CHWs had received specialized CHW training or had shadowed or been mentored by another

Table 1 Selected demographic characteristics of Arizona Community Health Workers

Total	86 (%)
Gender	
Female	75 (87%)
Male	9 (10.5%)
Age	
Range, y	21–71
Current age, mean (SD)	45 (12)
Ethnicity, no. (%)	
White, Non-Hispanic	24 (28.9)
Hispanic	37 (44.6)
American Indian	17 (20.5)
Other	3 (3.6)
Highest level of education no. (%)	
<High school	10 (11.6)
High school graduate	11 (12.8)
College	31 (63.9)
Annual family income, no. (%)	
<25 000	33 (38.4)
26 000–50 000	29 (33.7)
>50 001	20 (23.3)
Place of work no. (%)	
Clinic/hospital	31 (37.3)
Health Department	26 (31.3)
Not for profit	21 (25.3)
Tribal program	3 (3.6)
Other	2 (2.4)
Years employed, y mean (SD)	8.86 (9.0)

CHW (79.5% and 68.6% respectively), while a third (32.9%) had attended a community college CHW certification program. Nearly all of the CHWs (84.9%) worked with both individuals and groups and two-thirds (66.3%) reported working with community leaders. With respect to the work environment, 69.7% reported having flexible hours, 58.3% reported the flexibility to start new projects, and 63.3% the autonomy to start new projects. In terms of self perception of leadership, 68.6% of respondents said they know who to talk to in terms of community leaders, 47.6% believe they can influence community decisions, and 52.4% consider themselves to be a leader in the community.

Engagement in Community Advocacy

Sixty-two percent (62.8%) of CHWs reported that they had participated in community advocacy, which was defined as talking with and/or writing a letter to an elected official, a governing body, a clinic or hospital, a social service or law enforcement agency or a local business about making a change in their community. (Table 2) CHWs most frequently advocated for community change on a local level with an elected official or governing body (43%), a clinic/hospital (43%), a social service agency (40.7%) or local businesses (40%). Advocacy with state elected officials (i.e. Governor, Senator, Congress person) was less frequent (24%).

Community Advocacy and CHW Characteristics

Tables 3 and 4 provide a comparison of all types of community advocacy (local, state, clinic/hospital, social survives and business) by selected socio-demographic variables, work characteristics, CHW training experiences, and leadership qualities. The percentage of CHWs engaged in any type of community advocacy varied slightly across socio-demographic variables. (Table 3). For ethnicity, 70.8% of Whites reported engaging in community advocacy, versus 56.7% of Hispanics and 64.7% of Native Americans. A greater percentage of those earning less than $25,000 were engaged in community advocacy compared to 58.6% of those earning between $25,000 and $50,000 and 60% of those earning more than $50,000. Almost half of CHWs with a high school education demonstrated advocacy engagement (47.6%) compared to those CHWs with some college (67.7)% or a diploma college (67.7%). However, none of these differences demonstrated statistical significance. However, for every year increase in age a significant increase in advocacy was observed for both state government and social service agencies (OR 1.06, $P = 0.017$ and OR 1.04, $P = 0.045$, respectively).

CHWs working in non-profit organizations were significantly more likely to engage in community advocacy than those working in health departments (OR 6.9, $P = 0.021$). CHWs working in clinic/hospital and/or employed in a tribal program were no more likely to advocate than health department workers. Experience was associated with community advocacy; for every increase in

Table 2 Arizona Community Health Worker advocacy with elected and non-elected individuals and agencies

Total	83 (%)
Total Advocacy, all levels, no. (%)	54 (62.8)
Locally elected governmental official or body*	37 (43.0)
State/Federal elected governmental official or body**	21 (24.0)
Clinic/hospital	37 (43.0)
Social service agencies***	30 (40.7)
Law enforcement agency	17 (19.8)

* Local government is defined by school board, city council, county board of supervisors, planning and zoning

** State/Federal government is defined as State Representative, US Representative, Governor

*** Social service agencies include Department of Housing and Urban Development, Department of Economic Security

Table 3 Comparison of advocacy participation* rates by selected demographic characteristics among Arizona Community Health Workers

	Advocacy participation		
	Frequency (%)	OR (95% CI)	*P*-value
Sex			
Female	47/75 (62.6)	(ref)	–
Male	6/9 (66.6)	1.2 (0.2, 5.1)	0.814
Ethnicity			
White, Non-Hispanic	17/24 (70.8)	(ref)	–
Hispanic	21/37 (56.7)	0.5 (0.1, 1.6)	0.270
American Indian	11/17 (64.7)	0.8 (0.2, 2.8)	0.678
Other	0/3 (0.0)	–	–
Family Income			
≤25,000	23/33 (69.7)	(ref)	–
26,000–50,000	17/29 (58.6)	0.6 (0.2, 1.7)	0.365
≤50,000	12/20 (60.0)	0.6 (0.2, 2.0)	0.471
Education			
≤High school graduate	10/21 (47.6)	(ref)	–
Some college	21/31 (67.7)	2.3 (0.7, 7.2)	0.150
≤College graduate	22/33 (66.7)	2.2 (0.7, 6.7)	0.168

* Advocacy participation rates includes having talked with or written a letter to the following people/organizations about making changes in the community: school board, city council, county board of supervisors, planning and zoning (local government); State Representative, US Representative, Governor (State/Federal Government); Social service agencies, Clinic or Hospital, Business and Law enforcement agencies

Table 4 Comparison of advocacy participation* rates by selected characteristics among Arizona Community Health Workers

	Advocacy participation		
	Frequency (%)	OR (95% CI)	*P*-value
Employment type			
Health Department	15/26 (57.7)	(ref)	–
Non for profit organization	19/21 (90.5)	6.9 (1.3, 36.3)	0.021
Clinic/hospital	15/31 (48.4)	0.7 (0.2, 1.9)	0.484
Tribal program/other	3/5 (60.0)	1.1 (0.1, 7.7)	0.924
CHW training experience			
Attended a CHW certificate course offered at a Community College			
No	36/55 (65.6)	(ref)	–
Yes	14/27 (51.9)	0.6 (0.2, 1.4)	0.238
Attended a training designed for CHWs			
No	9/17 (52.9)	(ref)	–
Yes	43/66 (65.2)	1.7 (0.5, 4.8)	0.356
Mentored or shadowed by a CHW			
No	16/27 (59.3)	(ref)	–
Yes	38/59 (64.4)	1.2 (0.4, 3.1)	0.647
Attended a leadership training			
No	12/34 (35.3)	(ref)	–
Yes	40/50 (80.0)	7.3 (2.7, 19.6)	<0.001
Work environment			
Works with individuals and groups			
No	4/13 (30.8)	(ref)	–
Yes	50/73 (68.5)	4.9 (1.3, 17.5)	0.015
Works with community leaders			
No	10/28 (35.7)	(ref)	–
Yes	43/55 (78.2)	6.4 (2.3, 17.5)	<0.001
Works on projects with other CHWs			
No	5/14 (35.7)	(ref)	–
Yes	48/71 (67.6)	3.8 (1.1, 12.4)	0.031
Flexible work hours			
No	11/26 (42.3)	(ref)	–
Yes	43/60 (71.7)	3.4 (1.3, 9.0)	0.011
Flexibility at work to start new projects			
No	16/35 (45.7)	(ref)	–
Yes	38/49 (77.6)	4.1 (1.5, 10.5)	0.003
Autonomously initiates new projects			
No	11/29 (37.9)	(ref)	–
Yes	40/50 (80.0)	6.5 (2.3, 18.1)	<0.001
Leadership			
Knows who to talk to in community			
No	9/27 (33.3)	(ref)	–
Yes	45/59 (73.6)	6.4 (2.3, 17.1)	<0.001
Believes he or she influences community decisions			
No	20/43 (46.5)	(ref)	–
Yes	32/39 (82.1)	5.2 (1.9, 14.4)	0.001
Considers self a leader			
No	16/40 (40.0)	(ref)	–
Yes	38/44 (86.4)	9.5 (3.2, 27.6)	<0.001

* Advocacy participation rates includes having talked with or written a letter to the following people/organizations about making changes in the community: school board, city council, county board of supervisors, planning and zoning (local government); State Representative, US Representative, Governor (State/Federal Government); Social service agencies, Clinic or Hospital, Business and Law enforcement agencies

years of CHW employment, CHWs were significantly more likely to advocate at the levels of local government (OR 1.07, $P = 0.023$), clinic/hospital (OR 1.10, 0.005), social service agency (OR 1.12, $P = 0.002$), business (OR 1.07, $P = 0.018$) and law enforcement (1.06, 0.044). CHWs who reported more flexible working hours, flexibility to start new projects, and autonomy to initiate new projects at work were all significantly more likely to participate in community advocacy than those who did not. CHWs who stated that they work with community leaders were significantly more likely to participate in community advocacy, as were those who reported working on projects with other CHWs. CHWs who identified with leadership characteristics were more likely to engage in community advocacy, specifically, those CHWs who expressed knowing who to talk to in the community, believing they can influence their communities' decisions, and considering themselves leaders. In terms of job training, CHWs who attended leadership training were significantly more likely to participate in community advocacy than were CHWs who received no leadership training or were unsure. A significant trend for leadership training and advocacy participation rates held constant for local, state, clinic/hospital, social service and business. There was no significant relationship between advocacy participation and having attended a training specifically designed for CHWs, mentoring or shadowing an experienced CHW or attending a CHW course offered at a community college.

Discussion

There is a growing body of literature examining the role of CHWs in addressing health disparities by improving individual health outcomes, particularly in chronic disease, HIV/Aids, and maternal and child health. While improving individual health among populations suffering health disparities is essential, this singular focus fails to recognize that these efforts have made little progress in closing the gap. Community-level advocacy is considered a CHW core function and has the potential to address structural issues such as poverty, employment, housing, and discrimination. However, extensive review of the literature reveals very little about the role of CHWs as community representatives with either institutions and lawmakers. This study investigates the existence and extent of CHW advocacy efforts on both a local and state level in Arizona, and identifies those CHW characteristics that are associated with engagement in community advocacy. As members of a professional CHW organization such as AzCHOW and with an average 9 years of work experience, it is possible that CHWs responding to this survey are more likely to be engaged in advocacy activities, resulting in over-reporting compared to the all CHWs in the state. In fact, many of the respondents may have received leadership training through AzCHOW. However, as leaders in their field, they provide an appropriate role model in considering the future direction of the profession.

Results of the survey demonstrate that more than half of CHWs are engaged in some type of community advocacy. They are more often involved on a local than state level, and have actively advocated for health-related policy change with local health and service providers, as well as local school board, city council, or county board of supervisors. While fewer CHWs have contacted state legislators, one-fourth of the respondents have written a letter or telephoned a State Senator or Governor, a substantially greater proportion than seen in the general population. It is evident from this survey, that experienced CHWs in Arizona are engaged in community level advocacy.

Analysis of CHW characteristics reveal that the work setting, the level of autonomy experienced in the work environment, and self perception of leadership have a greater influence on the likelihood that CHWs will participate in community advocacy than do socio-demographic variables of ethnicity, income, or education. Place of work had a strong influence on likelihood of participation, with 90% of those working in not-for-profit organizations reporting community advocacy versus approximately half of those working in health care agencies or health departments. The reason for this difference might be explained by attributes of the work environment that are also highly associated with engagement in community advocacy, such as flexible work hours, flexibility and autonomy to start projects, and working with community leaders. When compared with health care agencies that tend to focus on individual clinical care, and health departments which are often supported by categorical funding with strict reporting requirements, non-profit organizations may be providing environments in which CHWs can engage in a broader range of activities in response to community needs.

With the exception of the Indian Health Service training for Community Health Representatives, there is currently no standardized training curriculum or program for CHWs, and this reflects the grassroots nature of the CHW profession and the fact that it responds to diverse needs of communities, organizations, and tribes. Given the entrenched nature of health inequities and growing recognition of and reliance on CHWs as a means to close the gap, training designed to build their capacity to engage in community mobilization and development and to represent the needs and rights of their communities in the public sphere is essential. Leadership training was the only type of training significantly associated with participation in community advocacy identified in this study. Yet, both age and years of experience were associated with community advocacy and

community advocacy was high among CHW who had mentored or shadowed other CHWs (64.4%) as well among CHWs who had participated in a training designed specifically for CHWs (65.2%). A training combining mentorship/shadowing with experienced CHWs in conjunction with ongoing leadership training and broader CHW-specific education could provide the opportunities and situations necessary to model community level advocacy. Potential training venues include national conferences or training forums and through professional organizations such as AzCHOW. The inclusion of information on community advocacy is also important to include in CHW certificate programs, not only as an education component, but also to validate the activities that many of these natural leaders are already engaging in when they enter a certificate program. Finally, it is important to recognize that many organizations, such as clinics and health department, are not designed to engage in community advocacy, but are utilizing the CHW model to address equally important issues related to health care access and cultural sensitivity of services. Administrators of these programs would benefit from education about the diverse strengths of the CHW model.

Findings from this study have implications for the areas of CHW research, practice and job preparation. This study is limited in that it documents the extent of community advocacy but does not describe actual effort or impact in addressing structural change. However, the finding that nearly two-thirds of this sample of CHWs is engaged in community advocacy provides the impetus for CHW research to broaden its scope to include the nature of advocacy activities and their influence on systems change on a local and state level with both organizations and legislators. One example would be an investigation of the extent to which CHW programs located in community health centers impact how clinical care is delivered and whether those changes impact use of the health care delivery system. Another would be to understand if CHWs in non-profits actually mobilize the community to speak out for improvements in the city infrastructure and whether this results in increased opportunity for physical activity. While the long term implications of policy and environmental change on health disparities would be difficult to isolate and verify, this type of study is also warranted given the need for research to focus on the social determinants of health in order to fundamentally address inequities.

Conclusion

Experienced CHWs in Arizona are engaged in advocating for community change at multiple levels. Agencies utilizing the CHW model could encourage community advocacy by providing a flexible working environment, ongoing CHWs leadership training, and opportunities to collaborate with both veteran CHWs and local community leaders. Further research is needed to understand the nature and impact of CHW community advocacy activities on both systems change and health outcomes.

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