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The Impact of Integrating Community Advocacy Into Community Health Worker Roles on Health-Focused Organizations and Community Health Workers in Southern Arizona

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Abstract: Organizational environments may encourage community health workers (CHWs) to engage community members in improving their communities. We conducted open-ended interviews and focus groups to explore how participation in the Acción intervention, which trained CHWs in community advocacy, affected organizational capacity to support their CHWs. Supervisors described improved organizational recognition and trust of CHWs. Organizational leaders reported organizational benefits and increased appreciation of CHW leadership. Both expressed increased interest in future advocacy trainings. Limiting factors included organizational mission, CHW position descriptions, and funding. Findings indicate that, with training and funding, CHW community advocacy can be integrated into organizations with congruent missions. **Key words:** *community advocacy, community health workers, qualitative research*

GIVEN the persistent health disparities in disadvantaged communities (Centers for Disease Control and Prevention, 2013), increased training and support for community health workers (CHWs) working for a positive change in their communities are imperative. Historically, CHWs have advocated not only for individuals but also for the health of their communities (Rosenthal et al., 1998).

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With growing recognition for the importance of the social determinants of health (Commission on Social Determinants of Health, 2008, p. 26), the promotion of CHWs to help reduce health inequities is currently experiencing a resurgence (American Public Health Association, 2009; Pérez & Martinez, 2008).

A CHW is a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." Community health workers "serve as a liaison/link/intermediary between health/social services and the community" and build "individual and community capacity . . . through a range of activities such as outreach, community education, informal counseling, social support and advocacy" (American Public Health Association, 2014).

THE *ACCIÓN PARA LA SALUD* INTERVENTION IN SOUTHERN ARIZONA

The Arizona Prevention Research Center (AzPRC), funded by the Centers for Disease Control and Prevention's Prevention Research Centers Program, has engaged CHWs—known as *promotoras* in Hispanic communities—to reduce chronic disease health disparities through individual behavioral change and address the social determinants of health for almost 15 years. In 2009, the AzPRC began to collaborate with 5 health-focused organizations to develop and implement Action for Health (*Acción Para La Salud*), an intervention designed to train and guide CHWs in community advocacy to address the social determinants of health as described by Schachter et al. (2014) and Ingram et al. (2014). *Acción*'s curriculum is "grounded in the theory and principles of action learning, emphasizing learning by doing, teamwork, real-world projects, and reflection." We delivered *Acción* in 4 workshops over 13 months and included in-class exercises; longitudinal, community-based, team advocacy projects; peer-support conference calls; and field technical assistance visits. The curriculum focused on developing 5 core competencies: "(1) identifying community values, culture, and leadership styles; (2) identifying community needs and issues; (3) developing a shared vision; (4) identifying and maintaining community partners; (5) skills-building and tools for advocacy and leadership; celebration and evaluation" (Schachter et al., 2014, p. 41). Participating *Acción* CHWs chose advocacy and policy projects relevant to their organizations and communities. Projects included championing the establishment of a local bus route, advocating for expanded clinic hours, and advocating for policies to reduce youth energy drink consumption (Ingram et al., 2014). Here, we describe how participation in *Acción* affected the organizational commitment to CHW community advocacy and the role of organizational environments in promoting CHW community advocacy.

ACCIÓN, ADVOCACY, AND COMMUNITY ORGANIZING

There is a tendency for the terms "advocacy" and "community organizing" to elide in the CHW literature. Therefore, it is relevant to define "community advocacy" as used in *Acción*. "Advocacy" is defined as acting as a spokesperson or intermediary for individual clients, and as representing and working for the needs and perspectives of whole communities (Rosenthal et al., 2011). There is also a strong historical record of CHWs engaging in "community organizing" (Arizmendi & Ortiz, 2004), defined as the process in which CHWs engage community members as leaders in identifying and solving community issues (Wiggins et al., 2013). "Community advocacy" borrows from both CHW roles. The CHW community advocates engage community members in the process of working for a systems-level or policy change within an organization, civic institution, or governmental body that will positively impact the community (Sabo et al., 2013). The term "advocacy" indicates a commitment to engaging in the political or decision-making process, while the term "community" indicates the importance of engaging community members as leaders in that process. The act of engaging community members in the community advocacy process is distinctly defined as "community

organizing." Thus, in *Acción* we intentionally use the term "community advocacy" to convey the involvement of members of the community who are experiencing health inequities as leaders in the advocacy process.

"Community advocacy" encompasses a set of specific skills and activities that involves engaging community members in prioritizing a community issue and directly addressing the decision makers who have the authority to institute a policy solution. Toward the end of the intervention study, the *Acción* CHWs defined community advocacy as a distinct skill in which they engaged community members as leaders who would represent and advocate for the needs of their community with those in power (Ingram et al., in press). The *Acción* CHWs also identified the development of a clear advocacy goal in which the final objective was broken down into clear advocacy strategies as a specific community advocacy skill (Schachter et al., 2014).

STUDY SETTING

All partner organizations were represented on the AzPRC Community Action Board (CAB) and included 3 federally qualified health centers (FQHCs), 1 health and social service community-based organization, and 1 county health department. All organizations are located at the Arizona border and serve predominantly Mexican origin populations.

The FQHCs share a mission of providing culturally appropriate primary care and community-based education, regardless of a patient's ability to pay. They employ experienced CHWs to reach out to underserved communities and provide an array of services ranging from community outreach and education to patient navigation, personal assistance, and referrals to other health and social services. At one FQHC, CHWs are part of a semi-independent health promotion department attached to the community health center.

The community-based organization was founded by CHWs. This organization employs CHWs to empower underserved individuals and communities by providing culturally appropriate information and access to health and social services, housing rehabilitation, and workforce development. It explicitly engages in advocacy to promote long-term strategies and solutions to address needs identified by community members.

The county health department promotes healthy lifestyles through culturally appropriate community education, outreach, and intervention programs. One of 5 programs offered through the Prevention Services Division within the Health and Social Service Department is implemented by CHWs. This program is funded by the state health department.

METHODS

Acción Para La Salud was a CHW community advocacy project designed and implemented in collaboration with 5 partner organizations and some of their CHWs over the course of 5 years (Ingram et al., 2014). *Acción* took a community-based participatory research approach (Minkler & Wallerstein, 2003) that was operationalized by a research committee composed of university-based researchers and CAB representatives. Interest in the role of organizations in promoting community advocacy was initially expressed by members of the CAB research committee, several of whom are CHW supervisors. Research committee members reviewed and revised all research materials used in the study. The University of Arizona institutional review board approved all aspects of the research project. Study participants were recruited by sending formal invitations via e-mail. All participants gave informed consent before participating.

Data Collection

To better understand the organizational conditions and the impact of CHW community advocacy, we employed qualitative methods (Table 1). Prior to the *Acción* training (Schachter et al., 2014) and in the final year of the intervention, research team members interviewed at least 4 representatives with varying levels of responsibility from each partner organization. The interview instrument

Table 1. Overview of Qualitative Data Collection

Data Collected	Date	Participants
Structured interviews		
Face-to-face, open-ended, structured interviews	Fall 2010	22 organizational leaders and CHW supervisors from 5 organizations
Revised face-to-face, open-ended, structured interviews	March 2014	16 organizational leaders and CHW supervisors from 4 organizations
Focus groups		
Focus group	October 2012	8 CHWs (conducted in Spanish)
Focus group	December 2012	4 CHW supervisors
Focus group	March 2013	3 organizational leaders
Discussions		
Discussion based on analysis	April 2014	16 community partner representatives during Arizona Prevention Research Center CAB meeting
Conference call discussion based on analysis	July 2014	6 CAB Research Committee members (including 2 researchers)

Abbreviations: CAB, Community Action Board; CHW, community health worker.

focused on organizational mission or goals, CHW programming, advocacy readiness and experience, position descriptions, history of advocacy activities, training, and potential advocacy issues. All interviews were conducted in English and handwritten or typed notes were taken during each of the interviews. Interview duration ranged between 25 and 90 minutes.

During the course of the *Acción* intervention, we conducted 3 separate focus groups with participating CHWs, CHW supervisors, and organizational leaders via conference calls to accommodate the geographical dispersion of our project partners. The CHW focus group participants discussed the effects of the *Acción* community advocacy intervention on their work, the quality of support from supervisors and other organizational staff, and their suggestions for additional support and assistance from their organization to help them pursue community advocacy. Focus groups with CHW supervisors and the organizational leaders solicited feedback on selected aspects of the preliminary analysis of baseline interviews including CHWs and community advocacy, and CHW supervisors' and organizational commitment to support future CHW community advocacy. In addition, the direct supervisor focus group offered an opportunity to reflect and debate on supervisors' experiences helping CHWs engaging in community advocacy through *Acción*. All 3 focus groups were tape recorded and transcribed. Focus groups, conducted in English except for the CHW group, which was conducted in Spanish, lasted between 40 and 80 minutes.

Finally, following preliminary analysis of the interviews and focus groups, we solicited feedback on study outcomes from our community partners. We discussed analysis results with the CAB members at a quarterly meeting. We also discussed the interpretation of our analysis via conference call with 6 CAB Research Committee members (including 2 researchers) during a 1-hour call conducted in English and documented with typed notes.

Analysis

The first author, a trained qualitative researcher with more than 20 years of experience, analyzed all data inductively; 2 other researchers analyzed about 10% of the various data sources. The pre-*Acción* organizational interview data were used to extract frequent terms and phrases that were noted in a table format. Preliminary observations from the first reading and the table extracts served to develop a code book. The codes were applied to the interviews using the qualitative data analysis program QSR NVivo 10. Themes and patterns within and across the coded interviews were extracted by combining the inductively based analysis with a deductive approach by running data queries based on the project's research questions. Selected findings from the preinterview served as a basis to solicit feedback and further data during the focus groups. Focus groups and the post-*Acción* interviews were analyzed by searching for the themes and patterns that had been established, while keeping an open mind for emergent ones. Analysis results from all data sources were triangulated and interpreted as a whole. These findings were presented to the AzPRC CAB and CAB research committee members for feedback before the analysis was finalized.

RESULTS

Analysis uncovered 5 themes: Organizational Perspectives; CHW Community Advocacy; Barriers; Organizational Support; and Impact. We describe these themes and their patterns organized by data collection tool to give a temporal perspective.

Findings from organizational interviews before the *Acción* training

Results reflect organizational perspectives prior to exposure of CHWs, CHW supervisors, or their organizations to *Acción* training and community advocacy activities.

Organizational perspectives

Interviewees from all partnering organizations explained that their organizations' visions or missions focused on medical and preventive health care, including education and outreach services, and increasing access to health care. Organizational visions, missions, and programming included community advocacy at the local, state, and national levels. Interviewees from all organizations drew attention to the need of drawing a line between "political" and "community advocacy" and described their advocacy activities as "apolitical." One FQHC interviewees expressed this perspective:

> We have not been involved with political advocacy at the local level. We stay away from politics. We advocate for the things we like, like health education, but we don't do political advocacy at the local level.

Ideas about what community advocacy was differed. County health department interviewees talked about advocating with the state health department for services within their community, while interviewees from the community-based organization stressed that their organization was born out of the idea of advocacy and hence all of their programs were community advocacy.

CHW community advocacy

Direct CHW supervisors and organizational leaders at FQHCs made clear that CHW roles were tied to their employing organizations and respective missions. The CHW roles were described as versatile and focused on advocating for clients within their organizations or the community. The described activities corresponded to various already defined roles of CHWs (Gutierrez Kapheim & Campbell, 2014; Rosenthal et al., 1998), including home visits; outreach for patient or program recruitment at health fairs; education of individuals or groups; helping community members access health or social services; and communicating needs of community members to their respective health organizations. Interviewees from all organizations pointed out that CHW programs symbolize community advocacy. One FQHC medical director acknowledged the CHWs' impact on individual and community health:

We believe that clinical care alone cannot efficiently change health status of individuals or communities. It is best to work at the community level with people from the community who are trained and work with the people. We believe our success in different programs proves that CHWs have the ability to affect change that clinicians don't.

Interviewees from 4 of the 5 organizations thought that CHWs could get more involved in community advocacy. They suggested that CHWs could take on more leadership through their programs, could get involved at community meetings, could further pursue policy change with elected officials focused on fitness and nutrition, or could organize themselves to tell state legislators about community needs.

Barriers

Barriers ranged from lack of funding for CHW community advocacy, to organizational leaders' perceptions of CHW roles and skills, to the absence of a community advocacy role in CHW job descriptions, and to a lack of CHW training in community advocacy. Grant-funded CHW programs have typically focused on management of specific diseases, which might include individual patient or client advocacy. The importance of funding and accountability for specific CHW activities was expressed. Leadership perceptions of CHW roles and skills posed another barrier to CHW community advocacy. Some organizational leaders thought that senior managers, not CHWs, should express views as organizational representatives and viewed CHWs as paraprofessionals. These views, illustrated by the quotes below, were associated with the county health department and FQHCs alike:

It is important that any advocacy made by individuals on [behalf of] the organization reflects the purpose of the organization. Those decisions are to be made with the senior managers to express views on behalf of the clinic.

CHWs provide services of lower acuity that complement the services provided by professionals.

Barriers to community advocacy also included the absence of a community advocacy role in CHW job descriptions and a lack of CHW training in community advocacy. The importance of training was highlighted by one of the FQHC interviewees: "Usually we don't allow them [CHWs] to do anything unless they are trained for it."

Focus group findings during the intervention

Focus groups took place after CHWs were exposed to community advocacy training and had engaged in the intervention. Thus, responses reflected the actual experience of how CHW community advocacy might impact their organization, their clients, and their communities.

CHW community advocacy

Both direct supervisors and organizational leaders from the 3 FQHCs and the community-based organization expressed their views that CHWs had engaged in community advocacy before the *Acción* training without labeling it as such and without documenting their activities. Supervisors expressed their understanding that individual advocacy could lead to community advocacy. The quotes below illustrate these points:

. . . I noticed that they really weren't documenting what they were doing. Or, they themselves did not see it as community advocacy, but just as part of helping people . . .

. . . the trainings that they were provided with really allowed them to see the big picture, not only that direct service that they were giving, but also the impact that this was going to have on the whole community.

As a result of the *Acción training*, participating CHWs began documenting their various advocacy activities on the basis of greater advocacy awareness and knowledge and, also, experienced a shift in roles and activities. Direct supervisors reported that *Acción* had provided tools to plan and document community advocacy activities and that *Acción* CHWs trained other CHWs in their organizations. Similar observations were shared during the CHW focus group. Community health workers expressed their perception of being more organized and

seeing better outcomes from their work. Supervisors and leaders had observed, and CHWs confirmed, that CHWs had incorporated community advocacy into their daily work and had expanded their support role to helping individuals help themselves and helping their communities by training community members to engage in advocacy. Community health workers also broadened their scope of work by engaging with local leaders.

Organizational support

With *Acción* still in process, supervisors and leaders expressed organizational support for CHW community advocacy. They specified that now they perceived of CHWs as leaders in community advocacy and that they valued this advocacy as it had strengthened their CHW programs and raised the profile of their organization in the community. They found that CHWs were more engaged in community-level advocacy on a daily basis. They identified organizational support and interest in future CHW community advocacy trainings, an interest that was shared by CHWs. One leader expressed the role of the organization in continued trainings:

> . . . there is a need to better prepare CHWs for this role of advocacy. Again, this takes a push from the senior leadership, the board and directors. I think this is something that has to happen.

Organizational support for CHW community advocacy, however, was not expressed by everyone in a leadership position. Several leaders thought that CHW community advocacy could be viable in their organizations only if supported by top leadership. One FQHC leader stated that "there used to be much more involvement at the CHW level for advocacy and I think leaders, higher levels of leadership, are the only ones that can make that happen." This leader suggested that while community advocacy was not part of current CHW position descriptions, it could be added.

Barriers

The need to engage in community advocacy without employing political advocacy was a challenge expressed by supervisors and organizational leaders. They explained the tension between political and community advocacy by pointing to the relational nature of advocacy that might include dependency on political figures on the part of organizations. One of the community-based organization's supervisors expressed this concept:

> Even though we tend to stay away from any political issue that affects our community, we still work around those issues. . . . I think that there is a fine line between the work that we are doing but at the same time the line is . . . crossed over. There is no way that we can advance advocacy without really involving the political figures, and involving all the stakeholders in our community. . . . we express it [support] in a way that we do business with them, how we partner with them, how we collaborate with them.

Findings from organizational interviews during the final year of *Acción*

The purpose of these interviews was to capture changes in the organizational climate toward CHW community advocacy at various managerial levels.

CHW community advocacy

On a basic level, direct CHW supervisors and organizational leaders from all 3 FQHCs and the community-based organization distinguished between CHW clinical roles and community outreach roles. Community health workers were also described as (1) liaison between medical providers and patients; (2) connectors between the organization and the community; (3) as filling a need of service in the community; and (4) as voices for the community that draw attention to community needs.

Supervisors and leaders acknowledged the CHWs' community advocacy work. Describing *Acción* as a platform for CHWs to engage with the community, they observed that CHWs had engaged community members to advocate for community-level issues and worked with local leaders/organizations for social or environmental change. Reiterating findings from the focus groups, supervisors and leaders stressed that CHWs had gained knowledge about community advocacy,

acquired the skills and tools to document their activities, become more engaged in community advocacy, and grown personally and professionally.

The definition of "community advocacy" continued to differ among organizations. One FQHC supervisor's comment provides insight: "Well, see, when I talk about patients, it's the community." In contrast, one of the community-based organization's supervisors stressed that their CHWs had always been engaged with the broader community in addressing social issues. In this case, however, it was suggested that CHWs' perception of themselves had changed:

> *Promotora* engagement in community advocacy has not changed. The only change is in the recognition to themselves as being trained; realizing they did advocacy without knowing what it was. They adopted that they are advocates. Two *promotoras* got [organizational] recognition as experts on advocacy and they felt a little more empowered.

The CHWs' community advocacy accomplishments did not go unnoticed in any of the organizations and they were rewarded with organizational level recognition.

Barriers

In spite of increased knowledge, practices, and support, organizational representatives acknowledged that CHWs faced barriers to community advocacy. Perhaps, the biggest barriers were that, typically, CHW job descriptions focused on individual services and CHW grant-based funding sources did not allow for community advocacy activities. Organizations thus lacked time and funding for CHW community advocacy. Several interviewees reiterated the importance of CHWs *not* crossing the line between community and political advocacy.

Impact

The CHW engagement in community advocacy impacted programs, organizations, and communities. At the programmatic level, engaging in community advocacy empowered CHWs, confirmed or made their supervisors aware of their leadership capacity, and led to expanded CHW advocacy roles. Community health workers who participated in the training also began to share their knowledge with their CHW colleagues. Engagement in CHW community advocacy enhanced organizational visibility and status in the community. At the community level, advocacy had brought awareness of services, improved health by increased patient compliance, and increased community involvement.

A couple of interviewees expressed very divergent impressions from the general perceptions of the impact of CHW community advocacy. One interviewee who had been tangentially involved with *Acción* voiced the opinion that there was no need for CHW community advocacy and that it might be out of the scope of their work. Another interviewee from the community-based organization stated that CHW community advocacy had only become "formalized" through *Acción*.

AzPRC CAB and CAB Research Committee feedback to analysis results

The AzPRC CAB and the CAB Research Committee provided community perspectives to the initial analysis. Community partners confirmed that community advocacy and individual advocacy often overlap as CHWs infuse individual advocacy with community advocacy, and that it can be difficult to discern where one starts and the other ends. The CAB members agreed that both employee and organizational growth were *Acción* outcomes, that is, while CHWs benefitted personally and professionally, organizations also benefitted by being able to better pursue their goals. One person stated that "it was a revelation that CHWs turned around and trained others." There was general agreement that organizational support was crucial for CHW community advocacy. However, there also was agreement that not all organizations might be able to change CHW position descriptions because of funding requirements. At the CAB meeting, participants agreed that CHWs should continue working in community advocacy and that supervisors should continue

to promote their activities, given the broader reach of community advocacy compared with individual advocacy. One CAB member from a public health department emphasized the value of *Acción* and the resulting data for workforce development.

DISCUSSION

Our research showed that *Acción* impacted CHW community advocacy roles, enhanced organizational support for those roles, and highlighted factors in the organizational environment that promoted CHW community advocacy. The CHW advocacy roles were tied to the employing organizations with missions and visions focused on improving the health of their communities. Before *Acción*, leaders were seen as the ones engaged in community advocacy, while CHW community advocacy activities were either not acknowledged or not documented. Engagement in *Acción* led to shifts in both CHW community advocacy roles and organizational perceptions and support of these roles. The *Acción* training increased CHW knowledge of community advocacy, provided needed tools and skills, and led to increased community advocacy engagement. In their various community advocacy activities, CHWs engaged in community organizing, involving community members who experienced health inequities as leaders in the advocacy process. They also advocated with local decision makers and political leaders themselves. By expanding and broadening their scope of work, CHWs were reported to have grown professionally and personally, and to have demonstrated improved community advocacy results. *Acción* provided training and helped shape a supportive work environment (Sabo et al., 2013), thus enabling CHWs to engage in organizing and advocacy to help communities address social determinants of health, or, in other words, to enact historically practiced roles as agents of social change (Rosenthal et al., 2011).

Acción brought community advocacy roles of CHWs into focus among organizational leaders whose changed perceptions of CHWs as leaders led to increased organizational support for that role. Realizing benefits of CHW community advocacy to their organizations, leaders expressed increased interest in further community advocacy trainings. By providing CHWs with training, *Acción* alleviated an important limiting factor for CHW community advocacy. Other limiting factors, including CHW position descriptions and lack of funding for CHW community advocacy, were not directly addressed by *Acción*. The current findings help explain why some CHWs are less involved in political advocacy (Sabo et al., 2013), because of the need to draw a distinct line between political and community advocacy. Factors in the organizational environment that promoted CHW community advocacy included an organizational mission that allowed for CHW community advocacy and higher-level leadership support. Organizational support of CHW community advocacy was fundamental since CHW roles were closely tied to their employing organizations and their missions. This insight was supported by the finding that the county health department ended participation in the project because of structural barriers to shifting CHW roles. Alleviating such limiting factors and promoting enabling factors for CHW community advocacy are essential to strengthening CHW workforce development and creating organizational environments supportive of CHW community advocacy. This, in turn, will increase potential of CHWs and their organizations to address social determinants of health and reduce health inequities (American Public Health Association, 2009; Commission on Social Determinants of Health, 2008, pp. 26, 206).

This research has response bias as a limitation since interview and focus group participants may have responded on the basis of their perceptions of expected research contributions or outcomes. We counteracted this bias by triangulating various data sources, by having more than 1 researcher analyze data, and by soliciting feedback from CAB members. While we worked with a diverse range of agencies, these agencies may not be fully representative of other agencies employing CHWs.

CONCLUSION

The CHW engagement with community members in improving the quality of services and in working for broader community changes is essential in effectively addressing the social determinants of health that underlie continuing health disparities. CHW-employing organizations and their leadership are pivotal in creating an environment in which CHWs can engage in community advocacy. Based on our experience, successful CHW community advocacy requires that CHW organizations have missions that are congruent with community advocacy, CHW position descriptions that include community advocacy, and funding sources that support all CHW roles. In addition, CHWs need to be trained in community advocacy, and their supervisors and organizational leaders need to commit to support CHW community advocacy.

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