

# Being a Community Health Worker Means Advocating

## Participation, Perceptions, and Challenges in Advocacy

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**ABSTRACT:** Community health workers (CHWs) participate in advocacy as a crucial means to empower clients in overcoming health disparities and to improve the health and social well-being of their communities. Building on previous studies, this article proposes a new framework for conceptualising CHW advocacy, depending on the intended impact level of CHW advocacy. CHWs participate in three 'levels' of advocacy, the micro, the macro, and the professional. This article also details the challenges they face at each level. As steps are taken to institutionalise these workers throughout the United States and abroad, there is a danger that their participation in advocacy will diminish. As advocacy serves as a primary conduit through which to empower clients, enshrining this role in steps to integrate these workers is essential. Finally, this article provides justification for the impacts of CHWs in addressing the social determinants of health and in helping their communities strive towards health equity.

**KEYWORDS:** advocacy, community health workers, health equity, health disparities, Indiana, social determinants of health

Advocacy is perhaps the most unique component of the community health worker (CHW) model. The American Public Health Association (APHA 2018) defines a CHW as 'a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served'. The APHA also states that these workers draw on the 'trusted relationship' that they have with their clients to serve as an intermediary between health and social services. Furthermore, the APHA definition of a CHW also states that he or she builds individual and community capacity through fostering self-sufficiency by participating in variety of activities including community education, outreach, social support, and advocacy (APHA 2018). Participation in advocacy is central to the CHW–client relationship and can be defined as empowering not only the

client and but also the broader community so as to overcome social determinants of health and thereby attain health equity and social well-being.

CHWs have been documented participating in advocacy for their clients, their communities, and their position in the United States and abroad (Closser 2015; Ingram et al. 2008; Maes 2015; Nading 2013; Sabo et al. 2013, 2015; Wiggins et al. 2014). Especially as these workers typically come from the communities with which they work, their intimate knowledge and shared structural vulnerability with their clients provides them with a foundation from which to effectively participate in advocacy. The term 'community', for the purposes of this article, refers to the often politically and socially marginalised (including African American, immigrant, and refugee) populations within which CHWs in the below sample operate.



Their participation and membership within these communities also aids in demonstrating the dynamic nature of this term and highlights the shared and unique social determinants affecting each of these marginalised populations. Their participation in advocacy serves as a means to address social determinants of health and empower their clients and communities (Ingram et al. 2008, 2014; Rosenthal et al. 2011; Sabo et al. 2013; Silverman et al. 2018). As a result, CHWs participate in advocacy in order to move their clients and communities towards greater health equity. This important contribution has also been recognised in federal legislation in the Affordable Care Act of 2010 (ACA), which emphasised the role of CHW advocacy as a means to improve individual and community health (Bovbjerg et al. 2013a; Martinez et al. 2011; Shah et al. 2014).

As CHWs have found increasing acceptance within the healthcare workforce of the United States, steps have been taken within states to formalise and integrate these workers into larger systems of care. Several states have successfully integrated CHW programmes within their broader healthcare workforces, including Massachusetts, Minnesota, and Oregon (Kangovi et al. 2015; Rosenthal et al. 2010). However, as governments and stakeholders integrate CHWs into their workforces, there is a risk of over-medicalising their roles and diminishing their involvement in advocacy (Nading 2013; Pérez and Martínez 2008; Rosenthal et al. 2011). It is vital that CHWs be allowed to take part in official decisions in the development of their position and that steps to integrate these workers do not sacrifice their role in advocacy.

Building on previous research regarding the categorisations of CHW advocacy (Ingram et al. 2008; Sabo et al. 2013, 2015), the purpose of this article is to reframe discussions related to the advocacy of CHWs into three primary levels of impact. Previous research has analysed survey data from CHWs and has categorised civic, organisational, and political advocacy (Sabo et al. 2013). I assert that CHW advocacy occurs at three primary impact 'levels': the micro-level, the macro-level, and the professional level. Each level corresponds to the primary health and social service needs of the CHW's client or broader community and/or the professional impact of the CHW's advocacy. In recognising these various levels and distinguishing them as such, further insights can be gained regarding the specific impact of CHWs and regarding the retention of their unique contribution to healthcare. Finally, this article concludes with a discussion of the challenges of advocacy, a theoretical analysis of the impact of policy development on

advocacy, and an explanation of the need to maintain advocacy in formal steps towards CHW integration.

## Methods

The themes discussed in this article come from findings from a dissertation project carried out in the state of Indiana between 2017 and 2018. The project was qualitative in nature and utilised a collaborative approach between the researcher and CHW participants. Several methods were utilised throughout this project including semi-structured interviews, participant observation, focus groups, and photovoice. Participants were recruited through snowball sampling and were asked whether they identified with the title 'community health worker'. As this occupation was not and has not been fully integrated within the workforce, participants were employed under a variety of different titles (e.g. health access advocate, patient advocate, community liaison). However, participants in this sample all self-identified with the title 'community health worker' despite potentially having worked under a different title. These participants had been employed to fulfil a number of roles but typically included working closely with clients and communities in health education, preventative healthcare, chronic disease management, nutrition, and/or advocacy.

The bulk of the data collected for this project came from interviews, in which 47 self-identified CHWs participated. These interviews were approximately 45 to 60 minutes in length, audio-recorded, and transcribed verbatim for further data analysis. All data were de-identified to protect the privacy of the participants, and the names in this article are pseudonyms. The use of qualitative methods in this project was vital in order to explore the nuances of advocacy conducted by CHWs and to gain a deep understanding of their engagement in the three above-mentioned levels. The project was approved by the University of South Florida Institutional Review Board.

## Findings

### *Levels of Advocacy*

Participation in advocacy is a crucial component of the CHW model and sets CHWs apart from other members of the healthcare workforce. As many CHWs in the sample came from structurally marginalised populations, participating in advocacy was viewed as a crucial means of garnering positive health and

social outcomes for their communities. Lucia, a CHW, explained where this motivation to participate in advocacy emerges:

[CHWs] because they are from the community, they are from an oppressed people group. Naturally. We are first from an oppressed group. And we are learning to stand up to defend our people and what happens is you come against resistance and . . . we need to understand that we have a right [to advocate] and we *were* one of the oppressed and we do have the voice to speak for all the people behind us.

In taking on the mantle of the CHW position, Lucia asserted that these workers have a right and the voice to speak up for their clients and broader communities. In using their voice for advocacy, CHWs promote positive health and social well-being.

While previous research has assessed survey data regarding CHWs and advocacy, the findings in this article reframe CHW advocacy regarding its primary area of impact. The findings in this article build on a framework from a 2010 study on CHW advocacy (Sabo et al. 2013) but also provide additional nuances regarding advocacy, its challenges, and issues of institutionalisation. During data collection, I encountered CHWs participating in several different forms of advocacy, which they argued had a positive impact on their clients and communities at various levels. Additionally, CHWs described having to advocate for the legitimacy of their position and at other times advocated to their own employers for their own needs. Thus, I assert that CHW advocacy can be divided into three distinct levels: the micro-level, the macro-level, and the professional.

While there is some overlap in impact between micro- and macro-level advocacy, micro-level advocacy seeks to create smaller-scale change that benefits individual clients and makes organisational changes whereas macro-level advocacy tends to focus on advocacy that creates broader community and societal impacts. Professional-level advocacy consists of advocacy in which the CHW advocates for awareness and for the legitimacy of their job (Sabo et al. 2015). Moreover, this includes CHWs advocating to their employer or other staff for resources that are needed in their organisations. Previous scholarship has documented CHWs advocating for the legitimacy of their own occupation to employers, medical professionals, and non-governmental organisations (Closser 2015; Sabo et al. 2015).

I have arranged these three distinct levels of advocacy in Table 1 in order to show the primary impact area of each in addition to a brief listing of example activities. Parsing out the advocacy of CHWs in this manner provides simple grouping structures that demonstrate the various activities and impact areas that each advocacy level is aimed at addressing. These categorisations also provide practical means for employers, potential employers, and medical professionals to view this kind of work and how they can work towards incorporating these into the work of their current [or future] CHW employees.

#### *Micro-Level Advocacy*

All of the CHWs in the sample participated in micro-level advocacy. This level of advocacy focused on creating impacts predominantly with clients but

Table 1. Examples of Activities at Each Level of Advocacy.

<b>Advocacy Level: Level of Impact</b>	<b>Micro- Individual</b>	<b>Macro- Community/Society</b>	<b>Professional- Professional/Employer</b>
<b>Examples</b>	Changing hospital, clinic, and/or organisational policy	Attending political rallies and/or demonstrations	Advocating to employer to keep a specific programme
	Speaking up to medical professionals and/or insurance company representatives on behalf of clients	Participating in community coalitions and in community mobilising to address issues	Advocating for the legitimacy of their position directly to a medical or social services professional
	Locating resources for clients to improve their health and living situation	Meeting and/or working with politicians to address health and community needs and other issues	Finding ways to spread awareness and legitimacy of their position to the public and broader workforce
	Educating and empowering clients towards self-sufficiency	Encouraging clients to meet/contact political representatives	

also within organisations and clinics/hospitals. The ultimate goal of micro-level advocacy was described by participants as achieving self-sufficiency and empowerment on the part of the client (Bovbjerg et al. 2013b; Brownstein et al. 2011; Ingram et al. 2014). A commonly discussed form of micro-level advocacy was connecting clients to resources and doing so via through follow-up. This included connecting them with transportation options (Medicaid cabs, public bus passes), making them aware of insurance benefits, signing them up for insurance, and helping them purchase minutes on their cell phone. Depending on their employers, some CHWs had access to bus passes or small amounts of funds to help their clients. Others had to occasionally draw on their connections within the community to negotiate with utility companies to delay turning off their clients' utilities and to help locate resources for their clients, one such resource being a new furnace, which was donated by a local organisation in Indianapolis.

The CHWs would then follow-up with clients to ensure that the resource was acquired and, if so, that it was satisfactory. Additionally, the participants stressed that they would teach their clients skills to effectively advocate or seek resources themselves so that there would be 'transference of power' from the CHWs to their clients. While the participants identified empowerment of their clients as the primary goal of the CHW-client relationship, they stressed that they were always available to help their clients if additional issues were to come up.

Other forms of micro-level advocacy included advocating on behalf of their clients in order to change hospital, clinic, or organisational policies to better facilitate their clients' care. Examples of this included changing signs to help clients find the resources or services they needed in addition to advocating for providing forms in Spanish or in other languages, depending on the client's needs. For many CHWs in the sample, it fell on them to either translate the forms themselves, find these forms online to provide to their clients, or advocate on behalf of their clients to the organisation in order to have the organisation provide these forms. Other CHWs, who worked predominantly in the Latino immigrant community, served as trustworthy individuals in accessing healthcare. Camila, a CHW who worked in one of Indianapolis' largest hospitals, explained that she tells immigrant clients where they can get care and that she assures them that they will not be reported to Immigration and Customs Enforcement (ICE) if they go and seek care.

Several CHWs explained how they have spoken up to insurance company representatives and medi-

cal professionals in order to get a client's question answered, receive a clearer diagnosis for their client, and address issues of discrimination against their client. Additionally, CHWs identified that a crucial aspect of this level of advocacy was to empower their clients, as was demonstrated by their own efforts to learn how to advocate for themselves. Many of the participants asserted that the end goal was not to perpetually 'hold the client's hand' but rather to empower them to gain the self-confidence to speak up on their own behalf.

### *Macro-Level Advocacy*

This level of advocacy sought to effect change in the community and society. Previous scholarship has noted that broader involvement in the community, political engagement, and the addressing of social justice issues were often primary markers of this category (Findley et al. 2014; Ingram et al. 2008; Sabo et al. 2013). However, CHWs in this sample were also involved in community coalitions that were focused on fostering non-political community events. While this level of advocacy was not as prevalent as micro-level advocacy in this CHW sample, there were still many CHWs who participated in a variety of macro-level activities. These activities included attending political rallies (such as those in support of Deferred Action for Childhood Arrivals [DACA], those in support of the ACA, and those whose aim it was to stop deportations of undocumented immigrants), mobilising the community to address various issues, encouraging clients to attend public meetings and/or meet with their representatives, and participating in community coalitions. Some CHWs were present at social justice demonstrations revolving around such issues as socio-economics, race, and healthcare. These various macro-level activities were a unique and vital component of the advocacy practised by many CHWs with the aim of fostering steps towards health equity.

Unlike micro-level advocacy, macro-level advocacy was almost always done off the clock – especially due to the fact that the pertinent activities could blur into political issues and/or were not considered as fulfilling the specific job responsibilities set out by the CHWs' employers. Beverly, a CHW, explained that, while not working, she volunteers her time for a coalition that seeks to improve the life of a community in a major city in Indiana with a large African American population. She described advocating for a variety of needs for the African American community that are already available in other parts of the city. Her participation in this coalition is an important way to help implement positive policy changes that will benefit

her community, which is in dire need for changes in order to produce improved health outcomes. However, Beverly advocated at the macro-level during her free time – often after having put in a full day's work. This demonstrates her commitment to her community, but also highlights the unpaid labour component of her identity as a CHW. Thus, even if unable to participate in macro-level advocacy during work hours, CHWs are making strides in fostering broader community and societal changes that ultimately influence the health and well-being of those living around them.

Similarly, other participants volunteered as members of collaborative groups or coalitions in order to improve their communities by uniting a neighbourhood or a minority group in order to network and pool resources. This might include reaching out to local, state, or federal politicians or at least implementing measures to improve an issue in the community such as addressing 'food deserts' (areas lacking healthy and affordable food choices, especially fruits and vegetables), crime rates, or public transportation. Others encouraged their clients to write letters to their local, state, and federal legislators or call on them to seek positive changes. Patricia, a CHW, remarked how she would tell her clients to ask 'who has the power?' when considering what changes need to be made in the community. She argued that she simply 'transferred the power' to her clients in giving them the tools to be able to seek the change they wanted for their communities.

The CHWs themselves were also directly involved in political forms of macro-level advocacy. Marcia, who is a CHW and the executive director of a health outreach organisation in a large city in Indiana, called her local legislators to inform them of health and social issues occurring in the community. Marcia also invited her legislators to town halls that she organizes quarterly in order to discuss community issues. She then had two other CHWs employed in her organisation do outreach and find people affected by the problem to speak with these legislators. Marcia explained that she and her colleagues had been involved in helping to inform their legislators on transportation, potable water, infant mortality, and health translation issues in their community. Other CHWs spoke about writing letters to their politicians in support of DACA and/or meeting with politicians in person to express their support for the ACA and Indiana's version of the Medicaid expansion called the 'Healthy Indiana Plan (HIP) 2.0'.

Other participants also took part in macro-level forms of advocacy that were not part of a political

trend or movement. Several took part in chamber of commerce meetings and neighbourhood committees to address various issues in their communities or even to plan events such as a Latino heritage festival. CHWs also blended macro-level advocacy into micro-level changes. For example, Miguel took part in several forms of macro-level advocacy during his free time, participating in numerous fundraising events to provide aid and resources to Puerto Rico following the devastation of Hurricane Maria in 2017. He also blended micro-level advocacy in his overarching work to help bring 30 families from the island and help to find them jobs and address their other needs. As illustrated by Miguel's case, CHWs are able to seamlessly blend advocacy at a variety of levels to foster positive effects for individual clients and the broader community.

#### *Professional-Level Advocacy*

Professional-level advocacy occurs in two distinct forms. The first includes activities in which CHWs must advocate for the legitimacy of their profession to their employer, potential employers, medical professionals, the public, and any other stakeholders. Previous scholarship has documented CHWs expressing their need to advocate for their jobs and to medical professionals for the legitimacy of their position (Closser 2015; Sabo et al. 2013, 2015). The second form of this level of advocacy is when CHWs advocate directly to their employers for the particular needs of their clients. This is similar to how CHWs participated in micro-level advocacy in that they advocated for an organisation, hospital, and/or clinic to make specific changes to better serve a client or population; however, in this case, the CHWs advocated directly to their employing organisations, clinics, or hospitals and advocated to their bosses or medical professionals for change. Other scholarship has examined how CHWs abroad have formed labour movements in order to protest for fairer wages and rights (Closser 2015; Maes 2017).

Several CHWs in the sample were actually employed as medical interpreters (a field in which they had also received professional training and certification) rather than as CHWs. These participants worked as medical interpreters in a hospital or clinic and revealed that they had advocated to doctors and other medical staff. At the same time, many of these 'medical-interpreter-employed' CHWs felt restricted in their scope of care, since they were unable to advocate while in their role as interpreter during their official working hours. They explained to me that as interpreters their sole responsibility was to translate,

word-for-word, between the medical professional and the patient. As a result, they were unable to advocate for the patient or serve in any capacity as a CHW while on the clock as an interpreter. However, these participants still advocated to medical staff to increase the number of interpreters, for more resources for their clients, and for the expansion of their responsibilities as interpreters so they could provide better care to the patients they encountered. At other times, medical-interpreter-employed CHWs stepped out of their roles as interpreters. For example, Carmen explained that she would advocate by asking the doctor if the patient's medication was the cheapest alternative. She explained that engaging in this professional-level advocacy almost served as a 'reality check' for some doctors, who were unaware that their patients may be unable to afford the medications that they were being prescribed.

Still at other times, participants described having to advocate to their employers in order to have them not cut CHW programmes and interventions from their organisations. For example, Marcellus, a CHW, explained:

Because I'm always advocating for the community, it's not just about the programme itself . . . basically every time the community loses a programme it's a disadvantage but if they have to lose a community health worker programme it's double the disadvantage.

His professional-level advocacy highlights the need for CHW integration into the broader workforce but also the need to institutionalise funding streams for CHWs and/or CHW programmes. Many CHW positions are grant-funded positions and thus exist only for the short term. Similarly, Alisha has argued with her employer for a larger role in the implementation process of CHW programmes. In justifying the benefits of employing a CHW, she asserted, 'community health workers are the ROI [return on investment], we are the ROI'. This is a pertinent issue, as there are several studies that have demonstrated the cost-effectiveness or positive return on investment of CHWs. These studies have positively demonstrated their cost-effectiveness both with regard to short-term health outcomes (Allen et al. 2014; Cross-Barnet et al. 2018; Fedder et al. 2003; Krieger et al. 2011) and with regard to long-term cost-effectiveness (Brown et al. 2012). In these ways, the CHWs participated in professional-level advocacy in order to secure and justify funding for their positions.

Overall, participants in this sample described the need to advocate for the legitimacy of their position

and/or the retention of CHW programmes, thereby highlighting their professional-level advocacy. One CHW, Mike, explained some of his interactions with medical professionals: 'If we didn't have to explain what we were doing every time we talked to someone first, it would be easier'. As a result, professional-level advocacy served not only as a means for CHWs to advocate for the legitimacy of their roles but also as a way to make changes within their employing organisations so as to better facilitate their work and produce additional positive outcomes for their clients.

### *Challenges of Advocacy*

Despite the wide prevalence of advocacy on one or multiple levels among the CHWs in the sample, there were several who discussed specific challenges regarding this role. There were unique challenges for each of the levels in addition to some that cut across each of the levels. At times, clients who seemingly were disinterested or not meeting expectations in terms of empowerment presented a challenge for CHWs in micro-level advocacy. For Frank, and for many of the participants, there was an expectation that his clients would eventually be empowered to become self-sufficient through his advocacy work. Frank stressed that knowing when to step back was vital in his work: when his clients seemingly refused to become self-sufficient. Other CHWs expressed similar sentiments in that through micro-level advocacy clients should eventually become empowered. Frank and these other participants still expressed their willingness to help and stand up for their clients, but they expected their clients to eventually take control of their own health and/or other concerns even if they might sometimes be unwilling to do so.

For some participants, macro-level advocacy was not about participating in social justice activism or demonstrations related to some political leaning but about making broader positive changes to the health and well-being of their communities. These CHWs explained that they would rather not be involved politically and that they simply wanted to do what was best for their communities. Similarly, other CHWs eschewed participating in advocacy that could be construed as political activism, such as public demonstrations or protest marches. Valeria explained: 'I try to steer clear of political agendas. Only because I see myself as a community advocate for good. I don't want to be seen as I'm on this side or on that side. I try to keep myself neutral'. She expanded that having a level of neutrality was vital in order for her clients to be more readily able to identify with her. For the majority of CHWs, participating in micro-level

forms of advocacy or in professional-level advocacy was how they believed they could make the most of their advocacy work. Several CHWs explained that participating in macro-level forms of advocacy was either too much for them or that they did not feel comfortable doing so.

For some participants, advocacy at the macro-level or advocacy that consisted of working with a larger group of actors was challenging. Frank, a CHW and probation officer, explained that collaborating with people can be tiring, and that, when the overarching system itself is broken, participating in advocacy can cause disillusionment. Challenges that lead to disillusionment and/or demoralisation notwithstanding, other CHWs stated that they do not have the time to do much more than what they do on the clock. Carmen explained that she was already overstretched in terms of her obligations but that she did participate off and on in activism. Patricia also expressed that she wished that she could participate more in advocacy for her community but felt overcommitted and was busy in her current state of employment.

There were also challenges at the professional level of advocacy. There is a lack of a central hub where CHWs can air their grievances or find support. Furthermore, regardless of advocacy at the professional level, many CHW-trained medical interpreters are unable to take on more roles due to hospital policy regarding the scope of care of interpreters. This is why, in my sample, professional-level advocacy did not result in expanded roles for medical interpreters in the form of more CHW-specific responsibilities. In spite of these challenges, the CHWs continued to practise all forms of advocacy in the fight to improve the health of their communities.

Finally, at the time of this project, the state government had convened a workgroup, which comprised various stakeholders, in order to develop policy regarding the integration of the CHW model into the workforce in addition to a set of services that would be reimbursable through Medicaid. Although the overarching goal of the workgroup was to ameliorate health issues through the professional integration of CHWs, the reimbursable services currently do not include activities that specifically address social determinants of health, and this devalues the contributions of advocacy. Employers (and potential employers) will likely have their CHWs focus on activities that are reimbursable. Thus, aside from the above-mentioned issues faced by CHWs at the three levels of advocacy, the steps that have been recently taken to develop policy and institutionalise the CHW

position in the health workforce may challenge their ability to even participate in advocacy.

## Discussion

Building on previous research, this article reframes approaches to CHW advocacy and seeks to determine the specific impacts that CHW participation has in these three different levels of advocacy. Advocacy serves as a central aspect in the CHW–client relationship and can instil empowerment at both the individual and community levels to improve well-being. Previous public health literature has documented the important role that advocacy plays amongst these workers (Ingram et al. 2008, 2014; Rosenthal et al. 2011; Sabo et al. 2013, 2015). The qualitative findings presented here help to further contextualise advocacy at the three above-mentioned levels. Parsing out the various advocacy activities in which CHWs are involved reveals the particular successes that they have enjoyed and the specific challenges that they have faced at the grassroots level. Overall, advocacy serves as the conduit through which CHWs can empower their clients and broader communities.

Micro-level advocacy was a ubiquitous activity for all participants in this study. As many CHWs come from politically and/or socially marginalised populations, it is precisely the political economic environment that spurs both their desire and their entitlement to advocate for their respective populations. For those CHWs who came from the communities they worked within, this commitment to advocacy was an obligation: they had to give their communities a voice to speak out against injustice. This shared structural vulnerability is crucial in understanding the position of these workers in relation to not only what their community members experience in terms of health and social disparities but also in relation to the exclusion that CHWs may face from the broader medical workforce (as indicated by their need to participate in professional-level advocacy). Other scholars have noted how these workers share the structural barriers experienced by their fellow community members (Closser 2015; Nading 2013; Sabo et al. 2015). This sense of shared vulnerability strongly shapes the obligation that participants felt towards their communities. This form of advocacy, though, came with an expectation that the client would eventually gain self-sufficiency and become empowered through the guidance of the CHW.

CHW participation in micro-level advocacy is a vital service and a unique contribution to the current

healthcare landscape of the United States. Moreover, this level of advocacy is crucial because it guides clients towards empowerment and self-sufficiency, specifically through overcoming social determinants of health. Since this level involves the most direct connection between the CHW and their clients, the former are able to work closely with the latter in order to help them develop the skills and strategies required to address their individual struggles.

Macro-level advocacy was a more divisive topic amongst CHWs in the study sample. For some, political and/or social justice activism was not appealing. This sentiment was seemingly echoed by employers, as those CHWs that did participate in macro-level advocacy did so off the clock. While it is understandable that employers may not want their employees participating in political causes on the clock, non-political forms of community mobilisation or participation in community coalitions may qualify as effective time spent in working hours. It should be noted that macro-level forms of advocacy may remove the strictly political aspect of this designation and instead consist of activities that are performed in order to create an impact within the community or broader society. This was especially true, as several participants were part of coalitions that sought to unite the community and have it participate in local events (e.g. health fairs, food festivals, fundraising events, cultural events). In this way, macro-level forms of advocacy are nuanced and include activities that are not strictly political in scope.

However, which levels of advocacy and the extent to which CHWs should engage in advocacy activities stands as an issue that may affect their integration within the healthcare workforce. These workers may be hindered from participating in macro-level advocacy, at least while they are on the clock. This might also include not being allowed to encourage their clients to speak with their representatives or meet with politicians during community outreach events. Moreover, as the CHW model becomes formalised and integrated within the healthcare workforce, there is concern that advocacy will be a role that becomes diminished (Nading 2013; Rosenthal et al. 2011). This highlights how – despite sharing structural vulnerabilities with their client population – CHWs as advocates may not be welcome within the broader healthcare workforce.

Anthropologist Miriam Ticktin's (2011) 'regimes of care' concept provides a top-down theoretical framework that considers movements, groups, and other responses to iniquity as a set of discourses that start out with a moral imperative to relieve suffering. Re-

gimes of care are seen in Indiana with regard to governmental action regarding the institutionalisation, funding, and hiring of CHWs as part of the broader healthcare workforce and as part of Medicaid-reimbursable activities. Many organisations may receive a short-term grant that will fund such a position. As a result, these positions may not last more than one to two years and may be dependent on securing additional grant funding. Marcellus invoked this time constraint in his defence that it is a 'double disadvantage' to the community if his employer decided to stop funding his CHW position. While his position may help to improve the health of the community and ameliorate social determinants of health, the suffering would only be removed temporarily unless his position can become permanently funded. This overarching discourse related to how suffering is relieved (i.e. the regime of care) crafts the political economic context in which CHWs operate.

Alex Nading (2013) has detailed that a shift away from the social justice and advocacy component of the CHW model began in the 1990s in favour of an 'apolitical, "technical orientation"'. He describes how steps towards the institutionalisation of the CHW position risks a loss of the CHW's role as an advocate. This is being potentially seen in Indiana, as reimbursable services currently do not cover time spent helping clients address the social determinants of health – issues best ameliorated through advocacy. This echoes the warnings posited by scholars that speak to issues arising from the institutionalisation, and potential medicalisation, of this position (Bovbjerg et al. 2013a; Nading 2013; Rosenthal et al. 2011). Thus, reassessing the nuances of advocacy and the potential for salutogenic health impacts is vital to ensuring that the integration of these workers does not risk losing this vital role.

Other scholars have cautioned against the loss of this core role of CHWs and the fundamental change that it would have on the position (Bovbjerg et al. 2013b; Pérez and Martínez 2008). In order to ensure the inclusion of the advocacy component, scholars have argued for CHWs to be included in the creation, development, and institutionalisation of programmes and policies regarding their workforces (Catalani et al. 2009; Pérez and Martínez 2008; Rosenthal et al. 2011; Sabo et al. 2013). These steps will help ensure that CHWs are the primary directors of their positions and can advocate for their jobs in this position of power.

In conclusion, while previous research has assessed CHW advocacy through survey data and as civic, organisational, and political advocacy (Sabo et



al. 2013), reframing advocacy with regard to levels of impact presents one strategy to further assess their inclusion within the unique contributions of CHWs. Previous research has assessed CHW advocacy through survey data, and this article highlights the nuanced experiences of CHWs who participated in micro-, macro-, and professional-level advocacy. Stakeholders, employers, and potential employers can view the various effects of CHW advocacy through the lens of the three different levels. Moreover, employers should consider advocacy at the micro- and macro-levels as additional means of overcoming social determinants of health that will ultimately result in a reduction of health disparities. These forms of advocacy have the potential to lead communities to greater health equity. Additionally, institutionalising the funding of CHW positions will help maintain the positive benefits of their advocacy. Finally, CHWs must maintain autonomy over the development of legislation regarding their positions – especially in order to ensure that advocacy will not be lost in the steps that will be taken towards further integration. Advocacy is a vital component of the CHW–client relationship and can help achieve greater health equity for the most vulnerable populations in the United States.

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### Acknowledgements

Many thanks to the research participants in this study. Without their collaboration and their critique of my research, this article would not have been possible.

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