COMMUNITY HEALTH WORKERS

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Introduction

Policymakers are increasingly showing interest in the 'unregulated' health workforce, which has been largely under-recognized in Canada. Among this workforce include community health workers (CHWs) which can be sorted into two categories: CHWs who participate in health promotion (leading to community mobilization and empowerment) and education activities (focused on the prevention and management of infectious and chronic diseases) and CHWs who provide medical care or clinical support for patients (such as oral care and vaccinations), especially in rural or remote areas (Torres et al., 2017).

In general, CHWs focus on increasing access to health and/or social services for marginalized groups and on building community capacity. They assist marginalized individuals and those receiving various levels of care ranging from preventive to chronic care services, and are able to provide culturally responsive services to the populations they serve.

A key characteristic of CHWs is that while their initial work starts with one individual seeking help, it generally transforms into finding supports for the whole family, and in particular for issues related to the social determinants of health (Torres et al., 2020; Ratnayake et al., 2022).

Who are CHWs?

Community health workers (CHWs) are frontline health workers who are members of the communities they serve. Often an invisible and unrecognized workforce, CHWs can be the bridge between communities on the margin — such as immigrants, Indigenous peoples and persons with disabilities — and health professionals. CHWs generally have a deep understanding of the issues these communities face in accessing health and social services (Torres, Labonté, Spitzer, Andrew, & Amaratunga, 2014). In addition, CHWs often share the language, beliefs and sociocultural characteristics of their communities. For example, CHWs working with immigrant, refugee or Indigenous populations are able to offer linguistically and culturally appropriate services and support.

CHWs focus more broadly on health education and health promotion, with their activities aimed at helping individuals, groups and communities to change behaviours, improve access to health and other essential services, build community capacity, and address health inequities among marginalized populations.

Alternative job titles for CHWs include multicultural health brokers, cultural brokers, lay health workers, *promotoras de salud* (Spanish for health promoters), peer support workers, community health representatives,

women's health educators and non-traditional health care workers (Torres, 2013).

Evolution of CHW Roles

The early history of CHWs

CHWs have existed for several hundred years in low-income countries, with names such as the 'Feldshers' in the 1700s in Russia and 'barefoot doctors' or 'village workers' in the 1950s in China (Lehmann & Sanders, 2007). In Latin America, the work of liberation theologists such as Paulo Freire helped to popularize the term '*promotoras de salud*' (health promoters) in the 20th century. In high-income countries such as Canada, CHW models were introduced in the 1960s to address a variety of health issues among marginalized communities. Books such as *Where There is No Doctor* (Werner, 1977) and its sequel, *Helping Health Workers Learn* (Werner & Bower, 1982), popularized the CHW role worldwide.

The origin of CHWs in Canada

CHWs have existed in Canada since 1962, when community health representatives (CHRs)—funded by Health Canada and administered by band councils—worked with Indigenous communities. In 2000, the National Indian & Inuit Community Health Representatives Organization (NIICHRO) won a court case that redefined CHRs' job classification and brought their wages in line with that of Health Canada workers doing the same or similar job (NIICHRO, 2008). After this decision, Health Canada's funding to band councils was restructured, with the new model not reflecting the reclassification or new wage rate. While band councils could hire CHRs, they often worked under a different title and therefore did not fall within the new CHR classification. As a result, wages were just $10 per hour rather than being comparable to those of Health Canada workers (Dedam-Montour, 2010).

Within the CHW field serving newcomers in Canada, the Multicultural Health Brokers Coop has the longest history (25 years) in the country as an arm's length organization using cultural brokering theory to guide their work. Cultural brokering is "the act of bridging, linking, mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict and producing change" (Jezewski, 1990, p. 497). Cultural brokering has been adopted by the CHW Network as an approach that recognizes both experiences and cultural diversity of communities and systems (CHW Network 2019), and also incorporates processes in democratic governance, direct responsiveness, accountability, equity and social justice (Campbell et al, 2021).

Community Health Worker Education in Canada

CHW training and education

Because CHWs in Canada are not formally organized as a recognized public health occupation, the level of training, education and experience can vary widely from one CHW to the next. For example, while some have completed various levels of post-secondary education, others have been unable to access formal education, often due to their social and economic circumstances. In addition, many are foreign-trained professionals who have been unable to find jobs in their original fields upon arriving in Canada. A small number are graduates of Canadian universities who are committed to working as CHWs for their communities, even though wages and salaries may not be comparable to other positions in the health-care field (Torres, 2013). Regardless of their level of training and education, CHWs often have a deep knowledge of the communities they serve and of how Canadian health and social services systems work.

Training for CHWs is typically subject-matter specific and conducted while on the job, and is generally based on the needs identified by the entities that hire them (e.g., public health units, community health centres, community-based organizations) (Torres, 2013).

CHR training and education

In contrast to other CHWs, CHRs have fought for many years for recognition in Canada. As a result, there are a number of training programs provided by educational institutions to meet the health needs of Indigenous populations. Among these are programs provided by the Cree Board of Health and Social Services of James Bay; Confederation College in Thunder Bay, Ontario; and Alberta Vocational College in Lac La Biche, Alberta (Najafizada, Bourgeault, Labonté, Packer, & Torres, 2015).

Scope of Practise for Community Health Workers

There are several roles, principles and characteristics that guide CHW practise (Lewis & Craig, 2014; Torres, 2013; Wolfe, 2010). Depending on the mandate of the agencies where CHWs work, their tasks might involve a combination of some or all of the following:

1. Outreach and mobilization

CHWs reach out to individuals and families who may be unable to access or effectively use health services due to factors such as low socioeconomic status, lack of fluency in English or French, isolation, gender marginalization and discrimination. CHWs provide health-related information to these people about disease prevention and management, encourage participation in health programs, and accompany them to medical appointments. CHWs also mobilize lobbying and advocacy efforts in their communities to address issues relating to the social determinants of health.

2. Community and cultural liaising

CHWs create and foster connections among individuals, families and communities; they also act as intermediaries between these groups and health and social services providers, working to translate issues related to cultural beliefs, needs and behaviours (Lewis & Craig, 2014). This includes helping mainstream health and social services professionals understand, for example, how immigrant and refugee populations adapt to their new communities.

The roles of Community Health Workers/Cultural Brokers, cannot be seen in isolation from the social, political and economic realities of migration to the country. Whether a naturalized Canadian citizen, permanent resident, refugee, temporary migrant worker, asylum seeker or undocumented person, migration status informs and shapes the support that individuals or families (and communities) seek from CHW/CBs. For example, during the COVID-19 pandemic, the precarity of newcomers' lives and the existence and pervasiveness of health disparities was highlighted. This palpably demonstrated the inequities experienced by these communities (Spitzer, Torres, 2020; Spitzer et al., 2019), and increased the time and demands — e.g., online functioning — on CHWs/CBs to support families (Campbell et al., 2021).

3. Case management, care coordination and system navigation

CHWs help individuals and families assess, plan, facilitate and advocate for services while also assisting them to navigate and understand their options, take care of their health, manage crises and access services (Lewis & Craig, 2014).

4. Program planning and advocacy

CHWs plan, organize and develop health promotion programs and initiatives that help people exercise control over their health and its determinants, thereby improving their health (World Health Organization Commission on the Social Determinants of Health, 2005). These include activities that foster equity, holism, intersectorality and an ecological approach (Rootman et al., 2001). For example, CHWs help individuals (especially women) referred to them for perinatal or health-related services secure the support they need, helping them address financial and housing difficulties or issues such as family violence. As a result, CHWs work to find multi-faceted solutions to their clients' problems by drawing on resources from government ministries and health and social service agencies, and by enlisting women to support other women and their communities (Torres, 2013; Torres et al., 2014).

Models of practise

Peer-reviewed literature on the models of practise used by CHWs is scarce. In Canada, a case study of multicultural health brokers in Edmonton revealed that their practise is driven by a theoretical understanding of what strengthens communities and families (Torres, 2013). They are influenced by cultural brokering theory/multicultural health brokering theory (Jezewski, 1995; Ortiz, 2003) and by a health promotion empowerment approach (Labonté, 1993). Other CHW programs (such as the CPNP, which is delivered by both volunteers and paid CHWs) are more strongly influenced by biomedical approaches to health education and promotion. In general, CHWs exist due to gaps in health and social services. By complementing other workers, CHWs help public systems fulfill their mandates to serve all populations.

The Community Health Workers Network of Canada

In 2014, CHWs created the Community Health Workers Network of Canada (CHWNC). As of April 2023, a name change to Cultural Brokers Network of Canada (CBNC) is in process. Since its inception the network has tackled issues such as

- who does what across the country;
- the merits of developing a common definition for CHWs;
- the scope of CHWs' practice;
- the potential for developing core competencies for CHWs;
- promoting formal recognition for the CHW workforce by the Canadian Association of Public Health and other entities; and
- conducting further research on CHWs and the potential for their work to address health inequities among marginalized populations (CHWNC notes, 2013–2023; Torres et al., 2014).

CBNC members are from two different CHW models: those operating within the formal health-care system (e.g., public health units, community health centres, hospitals) and those operating independently of the health-care system (e.g., in ethno-specific and multicultural community-based organizations and provincial organizations) (Torres, 2013). Network members deliver CHW programs that include prevention and management of infectious and chronic diseases (cancer screening and diabetes and HIV education); support for people with disabilities; community development promotion; and other activities that address the social determinants of health (https://culturalbrokers.ca/).

Regulation of Community Health Workers in Canada

In Canada, CHWs are not regulated and professionalization is not yet prominent on Canadian CHWs' agenda; however, it is a topic that has been addressed in some research studies (Torres, 2013; Wolfe, 2010). This may change as CHWs become more visible as health workers in Canada.

Community Health Worker Demographics

The lack of regulation of CHWs in Canada makes it difficult to capture any demographic details about this group of health workers. The closest national occupation classification code from CHWs is 42201, which includes social and community service workers.

Further insights can be garnered from data from the United States where the CHW workforce has also been better documented.

Ethnicity of CHWs

As indicated in the 2007 U.S. CHW National Workforce Study, CHWs usually mirror the demographic characteristics of the communities they serve. While there is a lack of similar aggregate data in Canada, this finding appears to correlate with what is known about CHWs in this country. For example, a case study of 54 CHWs in Edmonton (where they are referred to as 'multicultural health brokers') found that CHWs of various ethnic backgrounds typically work in their own communities (Multicultural Health Brokers Co-operative, 2004).

Gender of CHWs

The U.S. survey also indicates that CHWs are mostly women between the ages of 30 and 50. The predominance of women is partly due to the focus of many programs on underserved children and their mothers (HRSA, 2007). Although Canada does not have data regarding the number and gender of CHWs, it reasonable to assume that many CHWs are women because they are often the targets of a variety of

health-related programs. For example, CHWs participate extensively in Canada's Prenatal Nutrition Program (CPNP), which targets 18,000 mothers who are at risk of delivering low birth weight and/or pre-term babies (PHAC, 2010). The U.S CHW National Workforce Study found exceptions in certain programs where male CHWs predominated, such as nutrition, fatherhood, HIV case management programs and some youth programs (HRSA, 2007). This is also true in Canada, where male CHWs are working to help youth in large cities leave street gangs (L. Carrillos, personal communication, May 28, 2014).

Community Health Workers in the United States

CHWs in the United States have a longer history of organizing to have their profession formally recognized as a public health occupation.

Since 2010, CHWs have had their own Standard Occupational Category — 21-094 Community Health Worker — recognizing these workers as a distinct occupation (Balcázar et al., 2011; Federal Register, 2009). The 2010 Patient Protection and Affordable Care Act also recognizes the role CHWs play in improving health outcomes and containing costs (Martinez et al., 2011).

Currently there are over 40 organizations representing CHWs in 26 states (Sabo et al., 2017). A total of 16 states have established standards or certification laws in place for CHWs (Findley et al., 2012). The Bureau of Labour statistics estimate that there were over 61,000 CHWs in 2021 (https://www.bls.gov/oes/current/oes211094.htm).

Data from the 2007 CHW National Workforce Study conducted by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HRSA, 2007) found that CHWs are mostly women between the ages of 30 and 50. The predominance of women is partly due to the focus of many programs on underserved children and their mothers (HRSA, 2007). Exceptions were found in certain programs where male CHWs predominated, such as nutrition, fatherhood, HIV case management programs and some youth programs (HRSA, 2007).

There have been debates related to regulation between CHWs in the U.S., especially among those who believe standardization and regulation would deter the independence and integrity of their work (CHWNC, 2014; Torres, 2013). Some CHWs worry that regulation may move CHW roles toward technical tasks and practices that are traditionally performed within the scope of health services—and away from intersectoral actions, community development and social participation (Rodrigues Fausto et al., 2011).

Funding of Community Health Workers and Coverage of Services

Salaries and benefits for CHWs vary depending on whether the hiring body is within the health-care system (e.g., public health units) or a non-governmental organization (e.g., ethno-cultural groups). CHWs within the health-care system usually receive benefits and have reasonable work hours and caseloads; this is often not the case for CHWs operating independently of the health-care system (Torres et al., 2014). Many CHWs forego pay and benefits, choosing to volunteer within health-care system institutions and community-based organizations.

According to the Government of Canada Job Bank, the median hourly salary for social and community service workers, which includes CHWs, is $23.50 as of November 2022.

Key Issues for Community Health Workers

Wages and credential recognition

While CHWs are finding a niche in the economy (Calliste, 2000), there are still many CHWs who can find only part-time positions (Ghorayshi, 2002). Many CHW positions are defined as low-skilled (Armstrong & Armstrong, 2010; Ghorayshi, 2002). Workers are also exploited, frequently not being paid enough to make living wages (Wolfe, 2010). Many female immigrant CHWs have more education than their Canadian-born counterparts (Ghorayshi, 2002), but because their professional credentials are not recognized, they cannot work in their chosen field and opt to become CHWs.

Access to services

CHWs connect marginalized people to the services and support they need, a service that health and social services agencies staff are often unable to offer. Similar to those they serve, CHWs face many barriers in facilitating access to health and social services, both personally and professionally. These barriers include language, racism, gender and low socioeconomic status (Torres, Balcázar, Rosenthal, Labonté, Fox & Chiu, 2017).

Breaking new ground

CHWs are forging a new type of relationship between clients and workers—and between communities and their health and social services agencies—that both differs from and complements the practises of other health-care professionals such as nurses, doctors and social workers.

As a workforce, the recognition of this work (both with individuals and communities) is a priority for the CHW Network. Some glimpses of hope are on the horizon. First time funding has been obtained for a national study (2022-2025) on CHWs and the cultural brokering model and their role in achieving health and wellness equity for newcomers, along the full continuum of settlement, integration, and social inclusion.

Impact of the pandemic on Community Health Workers

During the COVID-19 Pandemic, CHW/CBs saw first-hand the challenges newcomer communities experienced with social distancing and stay-at-home measures, but also saw the pressure to work outside the home faced by essential workers in low skills occupations and the job losses that resulted from the crisis (Campbell et al., 2021). Testimony from members of the CHW Network (chwnetwork.ca) from across the country confirmed the increased vulnerability experienced by families and individuals owing to the pandemic. They noticed enhanced levels of stress and powerlessness stemming from the drastic health mesures. CHW/CB network members spent a significant amount of time explaining to families, not only what the pandemic was, but also informing them about following public health measures. This was particularly important for families whose cultural or religious beliefs made them hesitant to get vaccinations. Other examples, include newcomer families who faced war trauma before arriving to Canada feeling triggered by measures such as, store closings and requirements for personal distance (causing store line ups). As well as being made fearful by empty streets and social isolation (Spitzer, Torres, 2021). Before, during the pandemic, and in the now emerging post-pandemic, CHW/CBs have provided culturally-appropriate services to individuals and families. For example, pre-pandemic they helped families secure and accompany them to in-person medical appointments, which shifted during the pandemic to virtual accompaniment. Additionally, during the pandemic, they created new ways of supporting families, including establishing grocery runs, offering crafts instruction, yoga classes, and religious prayer over the internet (CHW Network, 2021). A key component of CHW/CB work, however, focuses on building resilience among communities through "identifying and leveraging community strengths and social capital within and between communities, as well as with formal systems" (Campbell et al., 2021, p.31). This was particularly challenging to accomplish online.

Conclusion

This chapter adds to the literature describing the context of the work CHWs do in Canada and their roles within the health workforce. CHWs complement and supplement the work of other health-care professionals, yet they occupy the lower echelons of the hierarchical health-care system CHWs have the potential to promote individual and community capacity and empowerment. Given the critical roles these workers play in Canada's health and social systems, they should be better recognized and better compensated for the work they do. Furthermore, robust research will be needed to gain a deeper understanding of the individuals who comprise this workforce, their scope of practise and the challenges they face.

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The views expressed in this publication are the views of the authors and do not necessarily reflect those of the Province of Ontario.

Acronyms

ACCC	Association of Canadian Community Colleges
CHR	Community health representative
CHW	Community health worker
CHWNC	Community Health Worker Network of Canada
CPNP	Canada Prenatal Nutrition Program
HRSA	U.S. Department of Health and Human Services – Health Resources and Services Administration
NIICHRO	National Indian & Inuit Community Health Representatives Organization
PHAC	Public Health Agency of Canada
WHO	World Health Organization

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