Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs)

Session 2: Current Issues for the CHW Workforce

Session Overview

The objectives for this session include:

- Describe the current status of the CHW occupation
- Name at least six major issues within the CHW field
- Discuss the central importance of community vs. institutional accountability in the role of the CHW

Audio Transcript

In this session, we will look further at some of the subtleties of the CHW workforce that anyone intending to work on CHW workforce policy must understand.

These “fine points” are important in explaining the CHW workforce effectively to stakeholders and in working with CHWs themselves in a responsive and respectful way.

The CHW has often been described as an “emerging occupation.” What does this mean? We will look at employment conditions for CHWs and recognition of the CHW as an occupation. To clarify the dynamics of CHW organizations and the actions and beliefs of individual CHWs involved in policy action, we will look at a range of issues being discussed and debated within the field.

We will examine one of these issues in more detail: To whom is the CHW accountable? Accountability is a central theme, and a possible dilemma, in the nature of the CHW and her relationship to community and employer. If a CHW’s effectiveness depends on a special relationship with the community, how does her accountability to an employer create divided loyalties? By pressuring a CHW hard to meet institutional objectives, does the employer risk losing the unique benefits of the CHW’s community connection?

Status of the CHW Occupation

The status of the CHW occupation is as follows:

- The CHW occupation is recognized by U.S. Dept. of Labor, but not most states
- Many potential employers are unaware or have a limited understanding of the occupation
- There are a proliferation of job titles related to funding
- The occupation is typically supported by short-term “silo” funding
- There is a range of federal support, but no systematic review of field until recently

Audio Transcript

The CHW occupation is now officially recognized by the U.S. Department of Labor, but most state governments do not have a distinct category for CHWs in their human resources systems. For example, the University of Texas system has had dozens of CHW projects on various campuses, but the system does not recognize CHWs (or promotores) as a distinct category of employee, so they are classified in various ways, including “research aide.”

Virtually no systematic efforts have been made to reach out to employers about CHW employment, and so no systematic studies exist of employer awareness regarding CHWs. In 2005, when a team of graduate students assisting in HRSA’s CHW workforce study attempted to canvass likely employers to solicit participation in an employer survey, they had difficulty in most organizations identifying anyone who knew what a CHW was. Even among known CHW employers, the students encountered resistance because the organization used some other job title. Also, many employers think of CHWs strictly in terms of outreach and education functions.

Current efforts to establish the term “community health worker” as an umbrella title for the occupational category are meeting with some success; however the occupational identity is not yet strong even among CHWs.

Some of this lack of occupational identity can be attributed to the persistent pattern of short-term grant funding. Studies estimate that 70% to 80% of CHW positions are paid out of “soft money” on projects that may last from one to five years. No other health-related profession is predominantly financed this way, and this pattern of funding results in a number of issues for the CHW occupation.

Status of the CHW Occupation (Cont.)

Much work remains to be done to clarify boundaries between CHWs and other professions. The current status of the CHW occupation is as follows:

- There is marginal or casual employment in many cases
- Little thought is given to:
  - Systematic job design
  - Standardized training
  - Career advancement
- There are no common standards or definitions across programs
- Boundaries with other occupations often unclear

Audio Transcript

Because of the short-term nature of most CHW positions, many employers view CHWs as marginal to their operations, and little thought has been given to systematic job design, standardized training, or career advancement. As short-term project employees, CHWs also often do not receive the fringe benefits offered to other employees.

Various federal agencies have supported CHW activities since the 1960s, again generally through short-term grants, but only recently have these agencies taken a systematic look at their investment in CHW interventions or CHWs as a workforce. Key agencies such as CDC, HRSA, the Centers for Medicare & Medicaid Services, or CMS, and the National Institutes of Health, or NIH, are currently reviewing their activities with a view toward more coordinated policies.

Within the last 10 years, the field of community-based participatory research has gained prominence, becoming an agency-wide interest within NIH. This type of research attempts to remedy some of the past shortcomings of empirical social research, whose practitioners and funders have been accused of exploiting communities and abandoning them after short-term research studies. Community-based participatory research creates partnerships between communities and researchers, who collaborate on design and implementation of the research itself and invest in building long-term community capacity. Researchers have begun to discover the potential of CHWs as leaders in this type of research.

Within a given community, and certainly within a state, CHW programs may operate with widely different definitions, standards, training, and patterns of compensation. This variation is due in large part to persistent “silo” funding, in which CHW interventions are designed and implemented according to the needs of a particular health condition, disregarding organizations and CHWs “across the street” who are performing similar functions to address a different health condition. Although programs have legitimate requirements for job- specific training and information, they have generally missed opportunities to collaborate with other programs on the common functions and core competencies CHWs need to work on all health issues.

Studies estimate that volunteers constitute one-fourth to one- third of all CHWs. Volunteer CHWs are fundamentally different from volunteers in other health professions in that they do not also hold paid positions as CHWs. Other volunteers, such as nurses, are usually either retired or contributing time outside their regular paid positions. Although self-organized groups of community members sometimes undertake community health initiatives, many special projects are organized by institutions, such as large medical providers, that rely on volunteers to carry out their objectives. This is a frequent practice in the case of research projects with modest funding. These projects operate in an ethical “gray area.” This use of volunteers might be considered exploitive.

Lastly, much work remains to be done to clarify boundaries between CHWs and other professions. As the definition of the CHW occupation becomes clearer, these boundaries should also be clarified. We will return to this topic in the next few slides.

Building an Occupational Identity

Most people, including health care administrators, are not familiar with the term "community health worker." This is because:

- "CHW" has only been widely used as an umbrella term in the past 10 years
- Diverse job titles have been encouraged by "silo" funding, "innovative" grant requirements
- Some CHWs prefer to use existing job-specific titles
- Other professionals have a limited view of CHW roles and abilities

Audio Transcript

The lack of a distinct occupational identity might be described as the "elephant in the room" when talking about CHW policy. People in most health-related professions, as well as the wider community, have a fairly clear picture of what their occupation is. A nurse, for example, could give a fairly clear description of her profession. Similarly, people in the general population and within health care organizations generally understand what nurses do. But ask most people, including health care administrators, and you will find that they are not familiar with the term "community health worker," and others will have limited or incorrect impressions of a CHW's roles and functions.

So we are presented with a challenge: to build an occupational identity. As noted earlier, the term CHW has only recently come into widespread use. Persistent patterns of "silo" funding mean that positions are often created with titles tied to specific interventions, such as "community asthma educator" or "HIV peer counselor." Another factor is the tendency of grant programs to favor "innovative" pilots and demonstrations, a practice that may lead proposal writers to use job titles and descriptions that appear unique but in fact describe CHWs.

Many communities have a long history of CHW interventions in specific fields, such as maternal and child health or cancer. In these programs, CHWs have come to identify themselves strongly, even passionately, with the health issue they are addressing—saying, for example, "I'm proud to be a maternal and child health worker." This sense of pride and identification with a particular health issue can make it difficult for these CHWs to identify with those working in other fields, although experience suggests that when they are brought together to discuss common concerns, the similarities emerge rapidly. Still, we may need to proceed cautiously in persuading someone who has worked for 20 years or more in a particular field to accept a different occupational identity.

As noted earlier, other professionals and administrators may have a limited view of what CHWs do. You may need to keep in mind, in groups of different stakeholders, that they may be unaware that they are talking about different aspects of the same phenomenon.

We will discuss occupational identity again later in the series, but for now, bear in mind the importance of engaging key institutions, professional groups, and CHWs in any effort to popularize the idea of the CHW as an occupational identity.

Major Issues within the Field

Before embarking on policy initiatives, we need to become familiar with the culture and complexities of the CHW workforce. Major issues within the CHW field include:

- Boundaries with other occupations
- Preserving community trust and credibility
  - Community goals vs. the employer's goals
  - Professionalization and credentialing
  - "Community membership" as essential qualification; what is a "peer?"
- Potential barriers to entry into the profession
- Is CHW employment a "pathway" or a career?
- Self-determination

Audio Transcript

Before embarking on policy initiatives, we need to become familiar with the culture and complexities of the CHW workforce, including forces other than "silo" funding that challenge efforts to bring the field together. We will discuss each of these in turn:

- Boundaries with other occupations
- The theme of preserving community trust and credibility, which includes a number of issues, including:
  - Potential differences in the CHW's mind between community priorities and the employer's immediate goals
  - Professionalization and credentialing of CHWs
  - The dilemma of "community membership" as an essential qualification
  - The definitions of "peer-ness" and "community"
- Potential barriers to entry into the profession
- The question of whether CHW employment is a "pathway" or a career; we mention this as an issue now, but we will actually discuss in depth in Session 3 under Workforce Development
- Self-determination for CHWs as an occupation

Boundaries with Other Occupations

Dealing with workforce policy will inevitably involve related occupations, so boundaries are an issue. Boundaries with other occupations include:

- Practitioners often act as CHW supervisors
- Clarification of scope-of-practice boundaries a vital early step in systems change
- Avoid implication that functions may be "pushed down" to CHWs

Audio Transcript

Dealing with workforce policy will inevitably involve related occupations, so boundaries are an issue. Buy-in from professions such as nursing and social work is essential. In most states, we have seen some form of "pushback," notably from nurses, but this is usually subtle. In one state, nurses questioned the need for a "new occupation." In another, Ohio, the State Board of Nursing assumed control of the certification of CHWs. Boundary issues are especially important with professions that may supervise CHWs. In Ohio, regulations now clearly lay out the conditions in which nurses may delegate certain "nursing tasks" to CHWs.

Clarification of scope-of-practice boundaries is an important early step in policy and systems change in any state.

One sensitive issue in introducing the CHW occupation is suspicion on the part of other professionals that functions may be transferred to CHWs because they may be paid less. This notion can become a major distraction, particularly with professions that have attempted to add to their responsibilities over time. It may be useful to work with various audiences to identify the activities that are unique to CHWs or that they perform uniquely well and seek an agreement that CHWs will be valued for these capabilities. The point can be made effectively that it is not in anyone's interest to transfer functions now performed by other professionals to CHWs purely because they may be paid less. That strategy would disrespect and exploit CHWs and violate the interests of other professionals.

You may recall that we discussed in Session 1 a number of other occupations with functions which might overlap with those of CHWs. Of all these occupations, the last, direct care, is the only one in which there really should be no overlap, since CHWs generally do not provide direct care. People unfamiliar with CHWs often assume that CHWs might provide direct care, even though CHWs are distinguished by their expertise in community- related matters and in working with hard-to-reach populations rather than their levels of clinical skills. In the workplace, administrators may attempt to assign paraprofessional direct care or administrative duties to CHWs, precisely because of a poor understanding of occupational identity and of scope-of- practice boundaries. In this case, the employing organization will not fully benefit from employing CHWs. The objective is to let CHWs do what CHWs do best.

Possible Tools for Resolution

There are several possible tools for resolution of the boundaries that exist between CHWs and other occupations. These include:

- Specify roles for CHWs in overlapping areas
- Define circumstances in which CHWs may perform certain duties
- Require that CHWs act only under clinical supervision

Audio Transcript

Here are some things to keep in mind when addressing scope- of-practice boundary issues:

One way to minimize confusion and resistance is to identify areas of overlap and specify CHW duties in more detail in these areas. Another method is to define the circumstances in which CHWs may perform certain duties, as we will see in a later session when we discuss the regulation of CHW certification by the Ohio Board of Nursing.

A third strategy is simply to require that CHWs act only under clinical supervision. Minnesota used this strategy in authorizing Medicaid payments for CHW services. We will discuss that experience in Session 6.

Tightly Focused Interventions Limit Flexibility

Earlier, we discussed the tendency to fund CHW services in narrowly focused interventions on specific health issues, a practice that runs against the natural tendency of CHWs to move fluidly between roles in their interactions with community members. Tightly focused interventions limit flexibility in the CHW workforce as:

- CHWs play multiple roles and move fluidly among them
- There is a need for flexibility: CHWs tend to “do whatever it takes”
- Limiting CHW roles can undermine their credibility
- CHWs often spend extra time per client

Audio Transcript

Earlier, we discussed the tendency to fund CHW services in narrowly focused interventions on specific health issues, a practice that runs against the natural tendency of CHWs to move fluidly between roles in their interactions with community members. CHWs are often involved in population-based outreach, but they also follow up with individuals or families identified in the course of this outreach, applying a somewhat different skill set.

Further, as noted in Session 1, a CHW usually responds to the entire range of needs of an individual or family, doing “whatever it takes” to meet those needs. This tendency carries over to outreach programs. To develop the credibility necessary to deliver her outreach message, a CHW may need to help people meet other, more immediate needs first. One example of this occurred in an outreach program to promote well-child exams under Medicaid, the Early Periodic Screening, Diagnosis, and Treatment Program, or EPSDT. CHWs working for one community-based organization complained that they were allowed to talk to families only about the EPSDT program, when it was clear that the families had other needs with which the CHWs could assist. Another group of CHWs asked to help enroll children in Medicaid responded, “don’t limit us to talking about Medicaid; they will look at us like salespeople.”

One possible reason for CHWs’ effectiveness is the fact that they often are able to spend more time with an individual or family than other health professionals can. Research on health literacy and health education has shown that effective

communication often takes time and patience, particularly in stressful situations. Also, differences in perceived status and power between a medical professional and patient may limit the patient's willingness to be fully candid about his or her situation. Time and trust can allow a CHW the opportunity for more complete communication with the patient or client. The limitations of a tightly focused intervention may limit CHWs' ability to capitalize on this strength.

Community Trust and Credibility

The companion piece to the CHW's expertise in understanding the community is the ability to establish trusting peer-to-peer relationships as a basis for pursuing mutual goals. Community trust and credibility are current issues in the CHW workforce.

- Mutual trust and respect are essential
- CHWs may have to overcome mistrust of institutions, medical providers, and research
- CHWs must constantly balance objectives with relationships: over-emphasis on one hinders the other
- Capacity-building: central to CHW philosophy

Audio Transcript

The companion piece to the CHW's expertise in understanding the community is the ability to establish trusting peer-to-peer relationships as a basis for pursuing mutual goals. The CHW must secure and maintain trust and credibility in the community to be effective.

Perhaps this ability can be taught, but numerous sources credit the fact that community members see the CHW as "someone like us." Patients often do not have the chance develop close working relationships with busy health professionals, but relationships between CHWs and patients can help create the candor and openness necessary for efficient, accurate diagnoses and effective treatment.

At the same time, in many communities, particularly among people of color, mistrust of major institutions, medical providers, and research—especially medical research—is deep and historic. CHWs' peer relationships in the community may help to open the door, but the CHW must act thoughtfully and deliberately to avoid being lumped together with institutions and researchers as an object of mistrust.

Because relationship is so central to effectiveness, the CHW must be on guard to effectively balance creating and maintaining good relationships with the need to meet assigned objectives. She must monitor the quality of her relationships but also think of "getting the numbers"; that is, delivering the interventions or results expected by her supervisor. If she spends all of her time and attention on task and results, she risks alienating the people she serves, but if she spends all her time on relationship, she may never get the results for which she is responsible.

Many employers, including direct supervisors, fail to understand this dynamic.

One way CHWs create and maintain trust in the community is by devoting attention to developing the community itself. Many CHWs do not see themselves as service

providers at all; they see themselves as “lifting up” their community, which means leaving individuals, families, and the entire community stronger than they were. This outcome requires, in part, that the CHW devote attention to the family’s stage of development and be prepared to phase out of the relationship when a certain degree of self-sufficiency is reached.

A significant thread running through the philosophy of CHW training and education is the notion of dealing with individuals, families, and communities according to their strengths and resources rather than according to their deficiencies. This approach begins with “strengths-based assessment” and tailoring approaches to the family’s goals by cultivating and supplementing the family’s own resources and strengths. It also involves cultivating and strengthening the social networks and resources available to the family. In fact, some researchers are pursuing the hypothesis that CHWs produce change not by direct individual interventions but by building “social capital,” or the degree of connectedness within a community.

Community Trust and Credibility (Cont.) Community vs. Employer Accountability

Community trust and credibility are current issues within the CHW workforce. This leads some to ask the question:

- How do CHWs balance meeting institutional goals with maintaining community credibility?
- CHWs and promotores
    - Originally promotores were accountable only to the community
    - Some see promotores as fundamentally different
- Continuum of accountability

Audio Transcript

Like all professions, CHWs have a set of values concerning ethical obligations to the individuals they serve and how to balance those obligations with responsibilities to an employer.

This value set relates to the previous point about CHWs’ need to maintain balance between relationship and task. CHWs cannot be effective without a strong sense of commitment to the community they serve. But if they are also responsible to an employer who provides a paycheck, they can find themselves balancing conflicting values and accountabilities. The employer may ask the CHW to provide services that the community does not regard as a high priority or, in a more extreme case, that the community regards as risky or dangerous, such as promoting immunizations.

Traditionally, Latin American promotores were grassroots volunteers who defined the community’s priorities and learned the skills necessary to help pursue those priorities. Few CHWs employed by U.S. health care institutions have the same latitude to define and pursue community interests. This difference has led some in the U.S. to describe promotores as fundamentally different from CHWs, even though the CHW occupation grew out of the promotora tradition.

National leaders in the CHW movement are attempting to gain acceptance for the term "CHW" as an umbrella category including promotores. The most accurate depiction of the accountabilities of CHWs is probably a continuum with grassroots volunteer CHWs and promotores at one end, accountable only to the community, and CHWs who are purely accountable to an employer at the other end. In practice, most CHWs operate somewhere toward the middle.

Potential Barriers to Entry into the Profession

There are many potential barriers that may block people from entering into the CHW profession. Some of these include:

- Education and work experience requirements
- Language preferences
- Immigration policy
- Criminal background

Audio Transcript

CHWs are hired from the communities to be served, in part because they have survived the same kinds of challenges that members of those communities have experienced. The nature of the work of CHWs makes such background an asset rather than a liability.

The conventional policies and practices of human resources, especially in large organizations, may create some problems with this method of hiring. It is entirely possible that good candidates will have had limited success in conventional education and limited work experience. Organizations often insist that all employees have a working command of English, and many positions require applicants to be bilingual, but many non-English-speaking people are successful CHWs. In the face of these requirements, undocumented immigrants have been known to serve successfully as volunteer promotores, receiving at most such noncash stipends as supermarket gift cards, but immigration policy prohibits them from actual employment.

The issue of criminal background is especially interesting in this context. Many organizations require criminal background checks on all new employees. However, in some programs, a CHW who has been through the criminal justice system may actually be more effective than one who has not. In recent revisions to its CHW certification regulations, Texas considered looking only at criminal history that might have a bearing on the actual duties of a CHW and allowing people with convictions for minor, nonviolent offenses to be considered for employment or certification as a CHW. This modification was dropped, however, because it would have made the review of background checks too complex.

Professionalizing the Field

Professionalizing the CHW field is also a current issue for the CHW workforce.

- CHWs are often called paraprofessionals, “lay” workers, peer educators
- CHWs may seek credentialing to increase recognition of their profession
- Professional expertise and credibility in official roles will help professionalize the field
- CHWs want to be viewed as professionals that provide services that improve, not impair, the health of community members.

Audio Transcript

CHWs, who are variously referred to in the literature as paraprofessionals, “lay” workers, and peer educators, find themselves working in a system that affords them little recognition and often no respect. Some CHWs are reaching for status as a credentialed profession as a way to gain that respect.

Some other professionals, however, are reluctant to value CHWs’ unique expertise. It is understandable that professions founded on clinical expertise should be reluctant to recognize an entirely different source and type of expertise. Yet that expertise must be officially recognized if CHWs are to be fully accepted.

Also at issue, however, is the CHW’s potential loss of accountability to the community—the sense that the CHW is becoming a profession like any other.

Not all CHWs want to be recognized as a profession. Some believe that their unique identity will be lost if their work becomes “just another profession.” For others, the resistance runs deeper. As noted earlier, some residents of underserved communities resent or distrust health professionals, institutions, and researchers. Some commentators link this resentment to the sense of professional distance or detachment that these people associate with medical professionals. Others think the health care industry has failed low-income populations and that highly paid professionals often come into underserved communities to conduct a project and then depart, leaving little behind. Some CHWs associate “becoming professional” with adopting the same “professional behaviors” that they consider arrogant.

Differences over professionalization are not the only divisions you may observe among CHWs.

As mentioned, some promotores de salud consider themselves quite separate from other CHWs. Leaders of a statewide association of promotores in California have repeatedly referred to promotores and CHWs as “different” and on opposite ends of a spectrum of accountability. Although many volunteer promotores do function in a “traditional” manner, as community organizers rather than service providers, many more promotores currently work in paid positions for institutions. And CHWs of any racial and ethnic background can be effective in their respective communities using methods and techniques in common with promotores. The goals of the HHS Promotores de Salud/Community Health Workers Initiative are to:

1. Recognize the important contributions of promotoras in reaching vulnerable, low income, and underserved members of Latino/Hispanic populations, and

2. Promote the increased engagement of promotores to support health education and prevention efforts and access to health insurance programs.

Divisions also exist in education level. The national CHW workforce study for HRSA found that a significant percentage of CHWs have a bachelor's or higher degree. The percentage appeared to be slightly higher in the Northeast, partly based on surveys conducted in Massachusetts, which may simply have attracted more respondents with higher education levels. A sampling of CHW position announcements suggests that most employers require a high school diploma or equivalent. In some states, in the absence of CHW credentialing, employers have required a bachelor's degree as a job qualification. The educational attainment of volunteer CHWs may well be lower than that of paid CHWs. If CHWs with college degrees receive a disproportionate share of advancement opportunities, difficulties may develop within the workforce.

Some older CHWs, and many promotores, refer to what they do as a "calling." As the number of paid CHW positions increases, this distinction may become less clear. Some of the same individuals who consider promotores "different" also refer to CHWs as "career-driven." As the momentum for CHW credentialing builds, divisions among the CHW workforce on this dimension may become more apparent.

Similarly, paid CHWs are understandably concerned about compensation, benefits, and working conditions, whereas volunteer CHWs may be focused entirely on their work in the community. Certification and more secure employment may create divisions between paid and volunteer CHWs. Some CHWs, as well as a number of prominent researchers, believe that volunteers are the only "legitimate" CHWs because they are truly acting only out of commitment to the community or to addressing a particular health issue. These people also believe that the work of the CHW is about mobilizing the community as a group of peers rather than about conducting interventions or providing services. Authors and groups such as APHA have been deliberate in recognizing and honoring the contributions of volunteer CHWs as equal to the contributions of their paid counterparts.

Dilemma of Community Membership as Essential Qualification

The dilemma of community membership as an essential qualification is another current issue facing members of the CHW workforce.

- Assumption that CHW is a "member" of the community being served
  - Validates their experience-based expertise
  - But difficult to implement and to define as a skill set
- Geographic requirements may violate Equal Employment Opportunity requirements
- Definition may limit CHWs' job mobility

Audio Transcript

Community membership is deeply embedded in traditional definitions of the CHW workforce. The assumption is that someone from the community knows its people, has credibility, and may already be known as a leader or "natural helper." This community membership criterion also validates one of CHWs' main domains of expertise, namely their claim to knowledge based on personal experience, as distinct from "academic learning."

In practical terms, however, an employer may find this criterion difficult to implement. How does one assess whether an individual is a member of a particular community? If an individual comes from a similar socioeconomic and cultural background as the population served, does it matter whether she has actually lived or worked in the specific geographic community to be served? Is it possible for someone from "outside" a particular community to gain credibility based on performance? Can we reduce this quality of membership and credibility to a trainable skill set?

Various attempts have been made to capture "community membership" in law or regulation. One bill introduced into Congress in the 1990s defined CHWs as residing in the same ZIP code as the population to be served. Such crude measures clearly leave something to be desired, but employers need and deserve guidance in how best to implement this kind of qualification.

Another side of this question is what happens when experienced CHWs move from one community to another. Can they meet this criterion in a new community? What happens to a small rural community that has no one qualified for or interested in CHW positions? Can it recruit from outside the community?

Definition of "Peer-ness" and "Community"

What is the definition of "peer-ness" and "community" as it relates to the CHW workforce?

- Trust and relationship based on shared socioeconomic and cultural background, or
- Shared experience with a health condition?
- Example: chronic disease management
  - Ideal is CHW who shares both types of experience
  - If you can have only one, which is more important?

Audio Transcript

In the community health field, "community" can be more than a strictly geographic concept. We see it in terms of trust and relationship based on shared socioeconomic and cultural background, but is that the only basis for "community"?

Some programs focused on a specific health issue, such as diabetes or cancer, rely heavily on peer relationships that are based on shared experience in living with the condition or caring for a loved one who has. HIV peer educator programs follow this pattern. In many cases, the commitment to work on that particular health issue is moral and emotional. In designing effective community programs, however, we must ask whether one kind of shared experience is more important than another. As an HIV peer

educator for low-income African-American women at risk of HIV exposure, will a middle-class gay white male or a low-income African-American woman who is not HIV- positive be more effective? Perhaps the ideal is a CHW who shares both kinds of "community" with the priority population, but how do you choose if you can't find someone who meets those qualifications?

Self-Determination

The last of the major issues within the CHW workforce is that of self-determination.

- Members of any occupation want and deserve a voice in defining themselves
- Self-determination as part of community empowerment philosophy
- Many CHWs leery of regulations imposed from "above"
- Challenges in mobilizing CHW leadership

Audio Transcript

The last of the major issues within the CHW workforce is that of self-determination. Because of historic patterns of short-term, marginal employment and low levels of respect for CHWs among other professionals, some may presume that they can make decisions with only limited or token input from CHWs themselves. In most occupations, however, practitioners want to assert their right to define themselves, especially once they are well established. For CHWs, this philosophy of self- determination is also partly rooted in their historic values and beliefs based on their experience in empowering communities to solve their own problems.

CHWs appear to value their sense of unique local identity and tend to favor local and state-level solutions to major issues affecting them. In Texas, for example, local CHW networks are proceeding cautiously toward developing a statewide association, believing that regional cultures within Texas are too different to be brought together quickly. Because relatively few CHWs are actively involved in national policy development, making major policy decisions at that level may well be resisted.

We should not underestimate the challenge of mobilizing CHW leadership at the local, state, and national levels. Because of the current employment structure and fragmented loyalties of the CHW workforce, incentive for CHWs to come together for their common interests has been limited. Opportunity is also limited. For example, employers working under grants with specific deliverables are often reluctant to let CHWs attend meetings or even continuing education on "company time." CHWs have not developed some of the norms found in other professions, in which practitioners are expected to participate in association life and in advocacy on issues related to their profession.

Session Takeaways

The following are takeaways for this session:

- The CHW workforce is not yet unified
- CHWs need to resolve boundary issues with other professions, rather than "CHW workers"
- CHWs must maintain community connection and credibility while meeting employers' needs

Audio Transcript

Take a moment to reflect on your "takeaways" from this session. Here are some you might consider:

- The CHW workforce is not yet unified
- CHW workers need to resolve boundary issues with other professions
- CHWs must maintain community connection and credibility while meeting employers' needs

The next session looks at workforce development, covering both training and education for CHWs and career development.

Thanks for participating!