

Global and Local Community Health Workers as a lifeline for communities facing inequities in the midst of COVID-19 and beyond

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“A community member called in panic because her husband had been recently diagnosed with COVID-19. She immediately felt it was a death sentence for her and her family who could not self-isolate based on current living conditions. A Community Health Worker called her daily and guided her step by step on what to do for isolation, sanitization, documentation, resources, and provided inspiration towards hope. She now has hope”

COVID-19 has had global and local implications in highlighting inequities that exist for marginalized populations. Many communities are facing the challenges of a system that decides who lives and who dies based on available resources (The Toughest Triage, NEJM <https://www.nejm.org/doi/full/10.1056/NEJMp2005689>). For many communities already facing severe inequities in terms of poverty, lack of access to quality health care, lack of access to healthy food, lack of constant water supply, and lack of stable electricity pre-COVID-19, this pandemic has further highlighted increased inequities. The authors

having had combined knowledge of more than 100 years of experience in engaging people with lived experience of inequities, highlight the important role of Community Health Workers in serving as advocates for populations most impacted by inequities in the midst of the COVID-19 pandemic and beyond. In this paper, the authors outline the essential role of Community Health Workers (CHWs) in fighting the COVID-19 pandemic from a historical lens to present.

Community Health Workers’ roles in addressing the COVID-19 epidemic: a view from around the corner and around the world

Who are the Community Health Workers from a global and local context?

Community Health Workers (CHWs) -- trusted community members who participate in training so that they can

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promote health in their own communities – have played a vital role in health systems around the world for more than 60 years. While recognition of CHWs' role by the formal health system is a recent occurrence, the CHW profession has its roots in natural helping systems that have existed throughout history. These systems became formalized in areas where large sectors of the population lacked health care and the conditions for good health. As such, since its inception, the CHW profession has been dedicated to addressing and eliminating social and health inequities.

Formal CHW programs have existed in the United States (US) since at least the 1960s, when programs were funded to address health issues in urban communities of color, migrant and seasonal farm working communities, and Native/American Indian communities. Support for CHW programs has waxed and waned since then, but the overall trend has been towards greater recognition and support, thanks largely to the organizing efforts of CHWs and their allies. Passage in 2010 of the Patient Protection and Affordable Care Act, which highlighted the actual and potential role of CHWs, and inclusion of "community health worker" as a standard job classification in the 2010 census, were both major milestones in US CHW history. Multiple states have developed policies relating to CHWs and some are working to sustainably finance CHW programs. Building on multiple existing statewide associations, the National Association of Community Health Workers (NACHW) was launched in 2018.

Community Health Worker's and Popular Education Model

A crucial feature of many CHW programs both in the United States and around the world has been their use of "popular education." Also referred to as "people's education," popular education creates settings in which people most affected by inequities can share what they know, pool their knowledge with others in their community, and then use their knowledge to solve problems and create a more just society. Popular education and the CHW model grow out of many of the same historical roots and share key principles, such as the ideas that people most affected by inequity are the experts about their own lives, and that experiential knowledge is just as important as academic knowledge.

When used in CHW training, popular education counteracts negative messages that many CHWs have received about their own wisdom and capacity, supporting their self-empowerment. These CHWs then become more likely to work in empowering ways in their own communities, producing a multiplier effect.

Community Health Workers – Many roles to fit the equity needs of community

One of the reasons that CHWs and CHW programs are so effective is that they adapt to meet the unique needs of particular communities. This flexibility has sometimes made it challenging to describe and define the CHW profession in ways that people outside the field can understand. However, a series of participatory research projects that have centered CHWs have produced a list of 10 core roles of CHWs, along with their essential skills and qualities. CHW roles span all levels of the socio-ecological model, from connecting individuals to existing health and social services, to sharing culturally appropriate and accessible health education with groups, to organizing whole communities to identify and address the causes of health inequities. During the current epidemic, CHWs continue to play all these roles, though some have become even more essential and acute.

Global and Local Perspective of Community Health Workers and COVID-19 from a Health Equity and Race Equity Lens

Covid-19 Pandemic has brought to the forefront the pervasive effects of systemic racism that we have historically felt in the United States. On March 28th US HHS (United States Department of Health and Human Services) sent out a "Memorandum on Identification of Essential Critical Infrastructure Workers During COVID-19 Response" that not only recognizes the workforce but encourages that CHWs be recognized as essential care workers during the COVID-19 Pandemic. Director of United States Homeland Security states, "Functioning critical infrastructure is imperative during the response to the COVID-19 emergency for both public health and safety as well as community well-being"

(<https://www.cisa.gov/publication/guidance-essential-critical-infrastructure-workforce>).

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Misclassification of CHWs as nonessential workers in some regions in the midst of COVID-19 and severe inequities

However, a number of organizations are not employing CHWs but rather institutionally made the decision that CHWs can be cut from payroll since they are not considered essential workers despite their ability to have a trust worthy relationship and understanding of their community. This not only reinforces the state of inequity of our workforce but also the dismissiveness given to our communities of color who have historically been oppressed and where CHWs can serve as their advocates. From Detroit to New Orleans and across the United States disparaged communities do not have the resources and are under resourced to protect themselves or their families – they are dying because of race inequities. Neighborhoods in Detroit have issues where they have no water, communities in New Orleans live in cramped housing so they cannot stay 6 ft away, communities of color throughout the country have a lack of access to COVID-19 testing, live where food is even more scarce at this time, children do not have the ability to learn from home due to no access to wi-fi, and parents and their children wonder when they can have their next meal since it is now not provided through school (<https://www.theatlantic.com/ideas/archive/2020/04/sto-p-looking-away-race-covid-19-victims/609250/>). Not only are those who have been historically oppressed facing inequities to access their most basic needs, but Black communities have a proportionally higher percentage of COVID-19 than White communities (<https://www.usatoday.com/story/news/nation/2020/03/30/coronavirus-cases-could-soar-blacks-latinos-and-native-americans/2917493001/>).

It is abhorrent to think in a country where everyone has “equal opportunity” and we are a first world country – our system is very much broken where it has come to light that we face barriers similar to 2nd world and 3rd world countries. Not because we are economically depressed but because we have pervasive systemic racism within disparaged communities. COVID-19 brings to light the inequity and racism that is embedded into our system. Most disturbing is now that these systemic racism issues are affecting those who are more privileged it has become

a public health concern

(<https://www.usatoday.com/story/news/nation/2020/03/30/coronavirus-cases-could-soar-blacks-latinos-and-native-americans/2917493001/>). Yet, the one workforce who understands oppressed communities and gives them the ability to have equitable access has been delegitimized as well and even more so during COVID-19. Systemic racism is not only within our communities but even within our workforce for CHWs who provide necessary services and advocate for the marginalized.

Community Health Workers as advocates for Social Determinants of Health Interventions

CHWs can not only show return-on-investment for healthcare interventions but most importantly are effective to provide social determinants of health interventions such as access to healthy food, housing, solving water inaccessibility issues, provision of navigational services for the healthcare – all roles where if CHWs are effectively implemented and recognized on a national scale our communities of color as well as ourselves could very much see a shift in this pandemic. But what is most pertinent and honorable about this workforce is how the change agents help those who experience race inequities become equitable individuals within our society. It is imperative to recognize that CHWs are needed to be at the forefront during this pandemic to serve these communities of color and that equity is not just used as a loose term thrown around but should be a recognized outcome tied to race equity where CHWs are able to bring about a significant positive impact.

Multiple Roles of Community Health Workers during the COVID-19 Pandemic: Real Life Case Examples from a Community Health Worker on the frontlines

Theory to Practice: What does the role of CHWs look like in the COVID-19 pandemic?

We can better understand the role of Community Health Workers (CHWs) on the front lines of the COVID-19 pandemic through these real-life case scenarios who have been assisted by a Community Health Worker. The author shares her experience as a Community Health Worker working with the Latinx and faith-based

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communities as part of her job in serving as a bridge between the health system, immigration system, education system, criminal justice system, and Latinx communities. The author also supports Latinx CHWs during this critical period to bridge inequities.

CHW as Advocate and Resource: Story of a Factory Worker

Maria's Story: Maria works in a factory where they make windows and doors. She was very scared when she realized that one of the workers had been diagnosed with the COVID-19. There was no warning from the owner and rumors were spread throughout the factory.

After 5 days another case appeared, and the manager told everyone about the situation. Maria was very scared because the second person was positively diagnosed with COVID-19. The person diagnosed is a mechanic who interacts with many people in the factory. As a result, she felt that she was going to be infected and for that reason she called a Community Health Worker to ask about the situation. She did a report about the factory because she felt that the factory was not taking care of their workers. Specifically, she felt the manager was not following the guidelines to control the spread for COVID-19 that had been shared through various media outlets.

Maria was also scared because she said that if she gets infected then her husband, who is in the high-risk category would get sick and need special attention at the hospital. By going to the hospital, Maria's concern was the impact on immigration status due to the 2019 public charge (<https://www.ilrc.org/public-charge>) issued by the current administration. As a result of the public charge, community members are afraid to seek care because of impact on legal status and fears for deportation. Since the COVID-19 pandemic, messaging has been shared that this should not impact immigration status but this continues to be a concern in the communities served.

Additionally, the Community Health Worker contacted several organizations and found an occupational safety and health organization who could ensure that the factory was keeping the health and well-being of the employees at the forefront through practicing social

distancing. The Community Health Worker was an advocate and resource in helping to improve the situation.

CHWs as cultural mediator and support: Story of understanding concerns of the immigrant community and Isolation

Mario's Story: Mario's friend called the Community Health Worker asking for the Community Health Worker to contact Mario because Mario was recently diagnosed with COVID-19. He lived with his family of 7 in an apartment. The doctor at the urgent care told him to isolate and put himself in quarantine in a room. He did not understand exactly what isolation and quarantine meant and this was the reason he was connected with a Community Health Worker. The Community Health Worker explained the concepts. The Community Health Worker also shared how to do a deep cleaning and how the others in the household could support this process. The Community Health Worker also spoke with his daughter who started to have fever and there was fear from the mom that her daughter might be infected from her dad. The Mom was also scared because the state called and she was worried about the public charge (<https://www.ilrc.org/public-charge>) and use of state assistance which was previously being held against immigrant communities in terms of negative impact in applying for legal status and resulting deportation challenges. The author encouraged the community member to call the state back but the fear regarding public charge, immigration, and legal status impacted further follow-up. In the author's role, she educated the state on how to communicate in a culturally appropriate way with community members. For example, the introduction is important and calls should not be led with "I am calling from the state", because it introduces fear of deportation for many immigrant communities. Calls that lead with a check-in on the community members well-being and then subsequently an introduction of the department was received more positively. The Community Health Worker was the only one to call Mario and monitor his symptoms. Mario is getting better and after talking with him he believes that he got infected with COVID-19 at his workplace since they do not provide masks, gloves, and gowns. He and co-workers are required to open plastic bags with dirty clothes that they put in the

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washing machines. On one of the days as they were loading the bags into the washing machine without protective gear, one of the truck drivers told them that those bags were coming from a hospital where all the people were infected with COVID-19. Four days later Mario started to get sick and tested positive for COVID-19.

CHW as service and resource navigator: CHW helping another CHW

Vanesa's Story: She is a Latinx CHW who called another CHW for help with services for a community member who is working in a butcher shop. A person infected with COVID-19 died in the butcher shop and the shop owners were forcing employees to work without having cleaned thoroughly, and without respecting social distance. The workers were afraid to work because they felt that they were going to be infected. This Community Health Worker referred the incident to the local occupational safety and health organization. Unfortunately, many employers and owners of workplaces do not care about their workers and want them to continue the same level of productivity even with fewer people. Some employers mistreat and shout at employees for lack of productivity even though they are less staffed.

As part of the author's voluntary work in the Latinx and the faith-based communities, people connect her with community members who are in need of help and support pre-COVID-19 and now even more so during the COVID-19 crisis. Therefore, during this COVID-19 pandemic there are many roles that the author has delivered services in for the community including: 1) Cultural mediation between individuals and health, housing and labor services, 2) Financial: Explaining to community members how the system is working at this moment. 3) Navigator between the health system: For example, calling the Nurse to ask for information about what is planned for one of the community members who have questions about what to do during home isolation and quarantine. 4) Providing cultural health education and information: Explain in a very culturally appropriate form new concepts, such as, telemedicine, Dr. tele visit, isolation, and quarantine. 5) Translating not only in Spanish but understanding the culture and transmitting the message in a form that community members can really understand. 6) Teaching

community members how to deep cleaning, how to take care of the sick person and how to take care of others so as to prevent infection. 7) Provide Direct Services: Bringing cleaning supplies, food etc. 8) Case Coordination, System Navigation. 9) Calling to find out information about what to do when a person is COVID-19 positive and is in quarantine and not able to work, pay the rent, or the bills. 10) Assistance with finding cleaning supplies, gloves, disinfecting cleaning agents such as Clorox, soap etc. 11) Assistance with food resources, resources for rent and utilities. 12) Providing social support: Individual, family and community support. 13) Motivating and encourage community members, providing hope when there is fear and pain. 14) Motivating community members to obtain other services of mental health. 15) Listening to concerns and providing referrals to other services in the community (school systems, health system services, immigration system services, food and nutrition services, criminal justice etc.). 16) Advocating for individual and communities. 17) Asking for the Spanish translation information that is crucial for the Latinx community, such as, social distance, signs and symptoms of COVID-19, what to do if they have COVID19, etc. and finding other ways to communicate this information to the Latinx community because some are not accessing the Health Department webpages, some do not have the knowledge, some do not feel comfortable, or their technology is not enough (for example, some phones are not smart phones).

Community Health Workers play a big role in building individual and community capacity. For example, community members were very concerned about safety in their workplace due to confirmed COVID-19 cases and the factory did nothing about cleaning or social distance. The workers felt the factory only cared about productivity and not their health and well-being. The community members started to feel empowered to ask for protections for health and well-being because they realized that that they have the right to work in an environment that is safe and free of fear. Community organizing around the themes of safe environment and human rights will also be the focus post COVID-19.

The author has also found in her volunteer work that community members who had questions about social distancing, said that "it is not that we do not want to

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respect social distancing, it is that we do not understand.” Community members were associating social distancing with the past experience of what happens during a fire. Community members believed that as long as they are inside with friends and family members in the house then they are safe. As a Community Health Worker, the author was able to explain the concept in simple words, such as what is “flattening the curve?” and how staying at home will help with this. The author also designed cultural special messages for the Latinx community that are relevant to the community.

Community Health Worker’s as Indigenous Agents of Support for Communities Experiencing Loss, Death and Dying

Due to quarantine and physical isolation measures for COVID-19, this has brought about increased challenges for social norms surrounding loss, grief, death, and dying. Unfortunately, people are suffering and dying alone with family and friends unable to support loved ones. Given the many cultures that have norms of gatherings during the loss of a loved one, there are many having to re-evaluate what this means. Wakes to celebrate a lost life are no more. In many cultures, wakes are a place for preserving individual histories. What are we losing and how can Community Health Workers fill a gap? How does one grieve the loss of a loved one alone? What does it mean for someone to die alone? For example, community members are unable to visit loved ones in hospitals and those who are hospitalized have limited to no emotional support. Cultural practices of grieving are no longer, for example, jazz funerals in New Orleans are prohibited and Jewish people cannot sit Shiva. Some of the impacts of isolation measures on long held generational cultural practices are increasingly coming to light during COVID-19, some of which will be seen for many years and generations to come.

Community Health Workers can help because CHW practice is built on a foundation of supporting the preservation of cultural practices. Some of the areas that Community Health Workers can assist in filling this critical void include:

1. Encourage individuals and community members impacted to reflect and write down their experiences with

sickness, loss, death and dying in this era. Journal. Journal. Journal.

2. Encourage virtual communication and connection. Skype, viber, zoom, facetime.

3. Assume responsibility for preserving the story of the life and times of loved ones

4. Helping community members realize that if you do not preserve and share what you know about a loved one, it will be lost.

5. Assisting community members with awareness of the difference between physical distancing and social distancing.

6. Assisting community members with being available to family and friends. We can still connect, albeit virtually sometimes.

Conclusion

Community Health Workers have and will continue to have a critical role in addressing the needs of those most impacted by societal inequities. These roles assist in filling a much-needed gap both globally and locally to ensure that all have a right to increased well-being, justice, access and equitable opportunities.



Figure 1: Equity Photovoice - Bernice B. Rumala in Nepal connecting with our shared humanity through global and local cultures (December 2019)

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About the Authors:



Bernice B. Rumala

With more than 15 years of experience in systems transformation, Dr. Rumala earned a PhD and three masters degrees from Columbia University and served as a Fogarty-Fulbright and Harvard Fellow. She has contributed her interdisciplinary expertise as a change agent in the public, private, academic and international sectors. Her areas of interest and expertise include equity, health equity, authentic engagement of people with lived experience of inequities, social justice, diversity, inclusion, discrimination, interdisciplinary solutions, advocacy, community engagement, and systems transformation. Dr. Rumala has lived experience of the ongoing challenges of severe inequities and the detrimental impacts to individuals and communities. This is unacceptable to her and should not be the norm. Dr. Rumala also considers herself a global citizen based on international experiences in more than thirty countries. She has had global experiences in stable regions as well as regions impacted by war, conflict, and instability, including Iraq where she worked for the United Nations. She continues to contribute her expertise as a global and local leader and consultant.



Rumana S. Rabbani

Rumana received her Master's in Healthcare Administration from the Health Policy and Management (HPM) Department at Gillings School of Global Public Health, University of North Carolina at Chapel Hill (UNC). She continued in this department as a Doctoral student with a minor in Implementation Science. Rumana is the Chair of the Awards committee and Chair of the Policy Committee for the Community Health Worker (CHW) Section within American Public Health Association (APHA), and Chair of the pre-APHA CHW Summit. She also serves as the co-President for the Implementation Science Student Group at UNC. Rumana is an Evaluator for Action Communities to help improve health and race equity for underserved communities sponsored by Robert Wood Johnson Foundation and 100 Million Healthier Lives. She helps to develop Implementation Science tools/frameworks and training guides for the Family Planning National Training Center for Title X services with a focus on advancing health equity. Rumana serves as a faculty member for the Wandersman Center. She has been a Principal Investigator for the last six years about sustainability and implementation of integrated CHW programs with a focus through the lens of implementation science and systems thinking tools.



Teresa Campos-Dominguez

Teresa Campos-Dominguez has over 30 years' experience as a Community Health Worker. Ms. Campos-Dominguez works for the Multnomah County Health Department and has presented at over 50 states, national and International conferences and is a well-known trainer and advocate for Community Health Worker and Popular Education. She served on the Advisory Council of the National Community Health Advisor Study and she was the formal chair of the Community Health Workers Special Primary Interest Group of APHA Community Health Worker 2000-2002. She is very involved with faith communities in the Latinx Community. She is a member of the American Diabetes Association "Cultural Competency Work Group" and the National Diabetes Education program NDEP Hispanic/Latino Stakeholder Group for about 2 years 2017-2019. Most important Ms. Campos she is a certified Nia Instructor and Trauma Informed-Brain Sensitive Yoga Teacher and Social Justice and YOGA Certify Teacher, she uses these skills to teach and provide tools to several community members and groups to support and bring individual and community healing and empowerment.



Sergio Matos

Sergio Matos has been a Community Health Worker for over 30 years and has worked to help communities organize around issues of environmental and social justice; worked with families in crisis intervention for violence, suicide, hunger, chronic disease management and housing issues and has trained others to help families identify the root causes of their condition and develop strategies to improve their well-being. Mr. Matos is a cofounder and executive director of the Community Health Worker Network of NYC, a professional association of CHWs that works to advance the CHW workforce while preserving the integrity of the practice through research, education and advocacy. The Network has trained over 4000 CHWs and set up CHW programs throughout the US and the Caribbean. He is a past chair of the Community Health Worker Section of the American Public Health Association, where he developed a national platform that promotes standards for the practice and the integration of CHWs into health and social systems with recognition, dignity and respect. In this capacity, Mr. Matos led a campaign that developed a national CHW definition and secured a unique standard occupational classification (SOC # 21-1094) for CHWs. Sergio serves on the NYS governor's Medicaid Redesign Team and is a member of the Milken Institute Center for Public Health Advisory Board. He has co-authored a book "Bridging the Gap – How Community Health Worker Improve the Health of Immigrants."

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