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Realistic Expectations: The Changing Role of Paraprofessional Health Workers in the First Nation Communities in Canada

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ABSTRACT

Context: First Nation communities in Canada rely on a mix of non-Indigenous professionals and large numbers of Indigenous paraprofessionals to deliver healthcare. Formerly allowed to perform controlled acts in emergencies, the direct care role of paraprofessionals is now restricted because of concerns about liability and accountability. As such, they are limited to health promotion and prevention activities.

Objectives: Focusing on the largest group of Indigenous health workers, viz. Community Health Representatives (CHRs), for illustration purposes, this paper (1) examines the evolving role of First Nation health workers, and (2) discusses the proposed introduction of competency-based standards for their education, certification and regulation.

Methods: The paper is informed by findings from open ended, semi-structured and focus group interviews, as well as qualitative survey data, derived from seven studies done in Ontario, Canada.

Outcomes: Paraprofessionals face conflicting and sometimes unrealistic expectations. Past practices have accustomed community members to hands-on care, however, professionals will no longer delegate tasks requiring clinical skills to them. Moreover, First



Nation leaders are concerned about liability for their paraprofessional employees' actions. The paper discusses issues related to paraprofessional competence, preparation for practice, and continuing health education. It then presents the National Indian and Inuit Community Health Representatives Organization's proposal to establish a scope of practice and set of competencies that can form the basis for national practice and training standards, accreditation and regulation.

Conclusions: In Canada or elsewhere, changing practice environments may require adjustments in the roles played by Indigenous health workers. The case of First Nation Community Health Representatives illustrates a strategy for role transformation.

Keywords: American native continental ancestry group; Canadian First Nations healthcare; paraprofessionals; Indigenous health workers; health human resources; lay health workers.

Context

Like other Canadians, members of First Nation communities rely on both professional and paraprofessional health workers for care. However, in their case the proportion of the latter group is much greater than it is for the general population. In the province of Ontario, for example, over 40 percent of all health providers working for a First Nation fall into the paraprofessional category (Minore *et al.*, 2008). This ratio reflects a number of factors. For many First Nations people, the chance of training as a health professional is impeded by inadequate early education, or geographic and funding barriers that restrict access to the training required (National Aboriginal Health Organization, 2003). As a result, the majority of professionals who work in these communities are not of First Nations ancestry and, in many cases, are reluctant to commit to work for a significant period of time in places where the health needs are high and the working conditions often difficult. Paraprofessionals tend to stay, providing a measure of stability and continuity. Moreover, because they are usually recruited from the communities, they are aware of local cultural beliefs and practices, as well as of the Indigenous languages and dialects used. While not always ideal, a staffing model that mixes professionals with substantial numbers of paraprofessionals has proven workable in such situations, which demand both clinical and cultural competence.

However, the roles played by First Nation paraprofessional health workers are in flux due to increasing uneasiness on the part of the workers and their supervisors about issues of liability and accountability. The outcome of comparing comments and observations from two interviews done by the authors in northern Ontario communities, illustrates the magnitude of the change occurring.

About fifteen years ago, the Community Health Representative (CHR) in one small, remote place talked about what happened for a couple of months every year when ice, forming in early winter and breaking-up again in springtime, prevented airplanes bringing visiting nurses from landing on a nearby lake. During these periods, she said: "I did nursing duties . . . emergency care, giving needles and suturing." She added, "I was not qualified . . . [but] was persuaded to do them." At the same time, she continued her usual tasks: "...collecting water samples, teaching prevention about AIDS and HIV . . . [and giving] fluoride rinses to school kids" (Kinch *et al.*, 1994). In interviews done twelve years later, it was reported that health program administrators in a larger community would not allow the CHR to do finger pricks for diabetes screening, even though the resident nurses were too busy to do them. As a result, there were no diabetes screening clinics held in the community for an entire year (Jacklin, 2007).

Paraprofessionals do not simply act in an extender role, performing tasks delegated by professionals (Mackenzie, 2006), but also apply their own unique knowledge, including cross-cultural awareness (Musser-Granski & Garrillo, 1997; Owen & English, 2005).



The nature of their work often requires extensive interaction with clients, so they are able to establish supportive relationships (Jack *et al.*, 2002), and advocate for (Ahmed *et al.*, 2006) or empower them (Schoenberg *et al.*, 2001), while “providing concrete services” (Walter & Petr, 2006, p. 468). A Cochrane review of 43 studies on lay health workers found they were effective in delivering specific preventive and health promotion programs (Lewin *et al.*, 2005).

Paraprofessionals are widely used in developing countries to facilitate access to care (Haq & Hafeez, 2009) or to respond to specific health risks (Swart *et al.*, 2008), as well as to reach populations within developed countries that are marginalized by poverty (Swider, 2002) or ethnicity (Walkup *et al.*, 2009), often related to particular diseases (Hoy *et al.*, 2005; Simmons *et al.*, 2008). However, practice environments change, requiring or allowing adjustments in the roles played (Witmer, 1995). With exceptions (Simon *et al.*, 2009), there are few documented instances of role revision such as that occurring in the First Nation communities of Canada.

Objectives

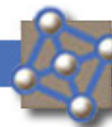
The healthcare system in Canada’s First Nation communities could not function without Indigenous health workers. Indeed, there has been a proliferation in the categories of specialized community health workers (e.g. Diabetes Workers), generally linked to funding for specific country-wide initiatives. This paper undertakes to:

1. examine the evolving role of First Nation health workers in Canada, taking into account their practice environments, educational issues and the factors promoting change; and
2. discuss a proposed national strategy for competency-based standards for their education, certification and regulation.

Methods

Although observations in this concept paper apply to all categories of Indigenous health workers in Canada, for purposes of illustration we focus on Community Health Representatives (CHRs). This is the first group created and likely the most numerous, although exact figures are not known (McCulla, 2004). Our paper is based on several studies conducted over a 14-year period in First Nation communities across Ontario, a province which is home to about 20 percent of the country’s Aboriginal population (Statistics Canada, 2008) and where the preparation and roles of Indigenous paraprofessionals reflect the national norm (Hammond, 2006). The following research informed this paper:

1. Kinch *et al.*, 1994: A study of factors affecting the retention of Indigenous health workers. Telephone interviews were done with 48 community health workers, of whom 30 were CHRs, by an Oji-Cree/English speaking interviewer. The questions were open-ended (e.g. “Since becoming a CHR, did your relationship with your community change? If so, how?”).
2. Boone *et al.*, 1997: A study of professional/paraprofessional interactions during crisis intervention situations. Based on in-depth unstructured interviews with all front-line workers, both professional and paraprofessional, who dealt with a series of suicide attempts in an isolated Cree community.
3. Minore & Boone, 2002; Minore *et al.*, 2004: A study of continuity in the delivery of care in three First Nation communities. Involved a systematic review of 135 clinical charts and in-person English/Oji-Cree interviews with 15 professionals and 15 paraprofessionals, asking open-ended questions about their roles.



4. Jacklin & Warry, 2005; Warry & Jacklin, 2004: Two evaluations of band-delivered health services on Manitoulin Island reserves. The research included focus groups with, respectively, 37 and 36 health centre staff, key informant interviews (4 and 29), participant observation, client exit surveys and analysis of hospital separation data and in-house statistics.
5. Jacklin, 2007; Jacklin & Kinoshameg, 2008; Jacklin, 2009: An investigation of factors influencing community health and healing at the Wikwemikong Unceded Indian Reserve, involving participant observation over a two-year period, in-depth interviews with 13 health centre staff and semi-structured interviews with 350 community members.
6. Minore *et al.*, 2008: An Ontario-wide health human resources survey, consisting of closed and open-ended questions, completed by health program staff for 101 of Ontario's 134 First Nations. The survey explored recruitment and retention of both professional and paraprofessional workers, especially those of First Nations heritage.

Findings

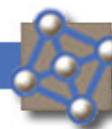
Practice environment: Because of their diversity – large and small, readily accessible and remote, adequately resourced and underserved – the sites in Ontario where the research was conducted encompass the range of conditions affecting health delivery in the majority of First Nation communities in Canada. The relative health of residents in all of them fails to match that generally enjoyed by Canadians, as is true in First Nations across the country (Young, 2003; Frohlich *et al.*, 2006). But this health status gap is narrowing (Romanow, 2002), in part because of the shift to Aboriginal governance (Health Canada, 2006).

Although the Canadian federal government is generally thought to be responsible for the health of individuals residing in First Nations communities, in fact, the majority of services are delivered by organizations operating under local authority. Since 1989, more than 80 percent of eligible communities have taken over management, either fully or to a significant extent, through a Transfer of Health Programs agreement. Beyond providing essential public health programs, they are free to plan and deliver services that address local needs and preferences.

First Nation paraprofessionals in practice: The Canadian Royal Commission on Aboriginal Peoples (Canada, 1996) concluded that the CHR program was a significant success story. Introduced by the federal government in 1962 to augment the health services available to First Nations and Inuit people, especially in places where access to routine care was restricted, CHRs quickly became an integral part of the healthcare system and, in some cases, the principal on-site providers.

From the outset, the CHR job description was vague, but intended to focus on health promotion and disease prevention along, in the early days, with some direct care of patients, including the delivery of babies. CHRs were only supposed to initiate clinical interventions when forced to manage an emergency. Doing so, however, became a routine practice, although never officially sanctioned. Narrowing the scope of practice to educational home visits and other prevention and promotion activities has caused consternation among community members, some of whom want paraprofessionals to continue offering hands-on treatment.

Because many nurses and doctors working in First Nation communities are there for comparatively brief stints – a few weeks or months – they often do not understand the roles of Indigenous health workers (Purden, 2005), or lack confidence in their training and skills (Boone *et al.*, 1997). As a result, these professionals fail to acknowledge paraprofessionals as colleagues with separate but equal knowledge who can make a valuable contribution to the team (DuBois *et al.*, 1991). Nurses, doctors and others with longer First Nations work histories recognize that sometimes paraprofessionals are their strongest link to community members.



First Nation paraprofessionals' preparation for practice: Of necessity, CHRs frequently work for a period of time without extensive preparation. The need to fill positions with responsible people simply outstrips the system's capacity to provide prior training. Most CHRs eventually do have formal instruction, but that can take many forms, from short certificate courses to two-year diplomas. The curricula tend to focus on generic skills: communications; counseling; case management; advocacy; program development; and delivery. Ideally, the course content is informed by the needs of communities in a program's catchment area, so issues of particular local relevance are addressed (Jacklin & Warry, 2005). For example, the curriculum for a course offered by the Oshki-Pimache-O-Win Education and Training Institute in Northwestern Ontario was developed with input from a First Nations advisory board and the organization mandated by the region's chiefs to represent their communities' health and educational interests to other levels of government.

There is a need for continuing health education for paraprofessionals, not only to update information and skills, but also to make them feel supported in their jobs. This same education can be used to help create career ladders. Some articulated education programs do exist, although none that are CHR-specific. For example, after one year in the First Nations Partnership Program in British Columbia, students are eligible for a certificate in Early Childhood Education; those who continue for a second year achieve a diploma in Child and Youth Care. Upon completing two more years of study in the University of Victoria-based program, they will receive a degree in Child and Youth Care. This "step on-step off" educational model accommodates changes in people's personal and work situations; progression from paraprofessional to professional levels may be interrupted, but the transitions are seamless (Ball & Pence, 2001).

Discussion

Factors promoting change in First Nation paraprofessionals' practice: The questions of liability that are challenging and redefining long existent paraprofessional roles come from two sources. On the one hand, "many nurses and physicians are second-guessing the roles of CHRs because of regulations and legislation" (McCulla, 2004, p. 44). Specifically, the legislation regulating health professionals only permits them to delegate controlled acts, such as giving sub-coetaneous injections to other professionals deemed competent to perform them. This concern exists, despite exemptions that allow unregulated individuals to perform such "acts of daily living" as giving insulin injections. On the other hand, First Nation Chiefs and Councilors, in their capacity as employers, are anxious about their liability for the actions of their health paraprofessional employees - an anxiety doubtlessly reinforced by their insurance carriers.

Professionals may be held accountable for breeches in the behavior of paraprofessionals working under their supervision, but they have little or no disciplinary authority. That rests primarily with the employers or, in other words, with community leaders. These leaders, in most cases, do not have backgrounds in health, so they are unfamiliar with acceptable procedures. In sum, professionals are concerned about answering to their own regulatory bodies, while employers face accountability for things that may seem ill-defined and indistinct to them.

A strategy for adjusting to change in First Nation paraprofessionals' practice: The ill-defined roles of paraprofessionals are being redefined, more by happenstance than plan, while they struggle to meet sometimes unrealistic and often conflicting expectations. The National Indian and Inuit Community Health Representatives Organization (NIICHO) has proposed a detailed strategy to rectify this situation. It would involve five steps: development of clear job descriptions; standardization of training; accreditation of educational programs; certification of graduates; and regulation of practitioners. These elements interlink with one another. Without agreed upon scopes of practice, it is difficult to establish a set of competencies that can form the basis for



educational curricula, as well as practice standards. Without such standards, it is hard to monitor people's practices in ways that are fair and justifiable.

As a start, NIICHRO led a multi-stage consultation with stakeholders to identify a core set of competencies. The result was a list of twenty-two that fall within seven domains: 1) Aboriginal and primary health care; 2) empowerment, community relations and cultural competence; 3) prevention, promotion and protection; 4) emergency care; 5) communications; 6) ethics, leadership and teamwork; and 7) administration (Hammond & Collins, 2007). Job descriptions for specific categories of workers must still be set, appropriate curricula developed and mechanisms established that would enable accreditation, certification and regulation. NIICHRO proposes that the latter three tasks could be done by provincial/territorial branches of a national association, since education and the regulation of health workers are subject to provincial or territorial jurisdiction in Canada. The approach mirrors the model in place for professionals; but practical and conceptual considerations will affect how – or if – it is implemented.

For instance, in practical terms, some individuals already in the CHR role, although they have considerable interpersonal skills and valuable local knowledge, may not have sufficient formal education to succeed in rigorous competency-based training or upgrading programs. However, in most cases, their experiential learning would likely justify their being “grand-parented” into the role, and thus continuing on the job.

Conceptually, the idea of national standards is at odds with the equally important notion that local autonomy must be upheld. Indeed, a structured, standard approach would take away much of the flexibility that allows paraprofessionals to respond to changing local circumstances, a hallmark of their success (Witmer *et al.*, 1995). Consequently, any system of accreditation or regulation that is established must explicitly recognize that First Nation communities have a right to not adopt or enforce the requirements locally. To help ensure that such decisions are fully informed continuous education is required. This should be directed toward community members as well as to the leaders, and emphasize the benefits for client safety that derive from standardization. As well, governance of the system should involve individuals who are representative of the population served.

Conclusion

Combining professionals' clinical knowledge with paraprofessionals' cultural and community awareness is the only workable means of delivering essential health services in most First Nation communities. However, because of uncertainty about the part they can and should play, and of concerns about liability and accountability, paraprofessionals are underutilized and somewhat marginalized within the care team. This situation is unacceptable, given the health needs of the people and the shortage of health human resources in most of their communities. The solution, in part, requires the determination of appropriate scopes of practice and expected competencies for paraprofessionals, on which standards for accredited educational programs and certification can be based.

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References

- Ahmed, N., Fort, J., Micab, T., Dickerson, P., & Belay, Y. (2006). Changes needed in the healthcare system: Perspectives of lay health workers. *Journal of Ambulatory Care Management*, 29, 17-23.
- Ball, J., & Pence, A. (2001). *Constructing knowledge and training curricula about early childhood care and development in Canadian Aboriginal communities*. Toronto: Caledon Institute of Social Policy.
- Boone, M., Minore, B., Katt, M., & Kinch P. (1997). Strength through sharing: Interdisciplinary teamwork in providing health and social services to northern native communities. *Canadian Journal of Community Mental Health*, 16, 15-28.
- Canada (1996). *Final report of the Royal Commission on Aboriginal peoples: Gathering strength*. Ottawa: Indian and Northern Affairs Canada.
- DuBois, J., Nugent, K., & Broder, E. (1991). Psychiatric consultation with children in underserved areas: Lessons from experiences in northern Ontario. *Canadian Journal of Psychiatry*, 36, 456-461.
- Frohlich, K., Ross N., & Richmond C. (2006). Health disparities in Canada today: Some evidence and a theoretical framework. *Health Policy*, 79, 132-143.
- Hammond, M. (2006). *Road to competency: CHR's and the need for national competency-based training and credible career paths for Inuit, Métis and First Nations health and wellness workers*. National Indian & Inuit Community Health Representatives Organization (NIICHO).
- Hammond, M., & Collins, R. (2007). *Moving further down the road to competency: Final report of the 2006/07 core competencies project for wellness and primary health care providers*. National Indian & Inuit Community Health Representatives Organization (NIICHO).
- Haq, Z., & Hafeez, A. (2009). Knowledge and communication needs assessment of community health workers in a developing country: A qualitative study. *Human Resources for Health*, 7, 59, 1-13.
- Health Canada. (2006). *The evaluation of the First Nations and Inuit health transfer policy: Final report*. Lavoie, J., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel, C., & McNeil, D. Centre for Aboriginal Health Research. 3 vols. Ottawa: Health Canada.
- Hoy, W., Kondalsamy-Chennakesavan, S., Scheppingen, J., Sharma, S., & Katz, I. (2005). A chronic disease outreach program for Aboriginal communities. *Kidney International*, 68, S76-S82.
- Jack, S., DiCenso, A., & Lohfeld, L. (2002). Opening doors: Factors influencing the establishment of a working relationship between paraprofessional home visitors and at-risk families. *Canadian Journal of Nursing Research*, 34, 59-69.
- Jacklin, K. (2007). *Strength in adversity: Community health and healing in Wikwemikong*. Ph.D. Dissertation, Department of Anthropology, McMaster University, Hamilton, ON.
- Jacklin, K. (2009). Diversity within: Deconstructing Aboriginal health. *Social Science and Medicine*, 68, 980-989.
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- Jacklin, K., & Kinoshameg, P. (2008) Developing a participatory Aboriginal health research project: "Only if it's going to mean something." *Journal of Empirical Research of Human Research Ethics*, 3, 53-68.
- Jacklin, K., & Warry, W. (2005). *Mnaamodzawin Health Services health transfer evaluation report*. Prepared for Mnaamodzawin Health Services Health Board. Aundeck Omni Kaning: unpublished document held at Mnaamodzawin Health Services.
- Kinch, P., Katt, M., Boone, M., & Minore, B. (1994). On being everything and nothing: The retention of native health care workers in northern communities. *Arctic Medical Research*, 53, Suppl. 2, 92-97.
- Lewin, S., Dick, J., Pound, P., Zwarenstein, M., Aja, G., van Wyk, B., et al. (2005). Lay health workers in primary and community health care. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.:CD004015.
- Mackenzie, M. (2006). Benefit or burden: Introducing paraprofessional support staff to health visiting teams: The case of Starting Well. *Health & Social Care in the Community*, 14, 523-531.
- McCulla, K. (2004). *A comparative review of community health representatives' scope of practice in international Indigenous communities*. National Indian & Inuit Community Health Representatives Organization (NIICHRO).
- Minore, B., & Boone, M. (2002). Realizing potential: Improving interdisciplinary professional /paraprofessional health care teams in Canada's northern aboriginal communities through education. *Journal of Interprofessional Care*, 16, 139-147.
- Minore, B., Boone, M., Katt, M., Kinch, P., & Birch, S. (2004). Addressing the realities of health care in northern aboriginal communities through participatory action research. *Journal of Interprofessional Care*, 18, 360-368.
- Minore, B., Hill, M., Kuzik, R., Macdonald, C., & Rantala, M. (2008). *Aboriginal health human resources in Ontario: A current snapshot*. Health Canada: Government of Canada. Catalogue No. H34-200/208E
- Musser-Granski, J., & Carrillo D. (1997). The use of bilingual, bicultural paraprofessionals in mental health services: Issues for hiring, training and supervision. *Community Mental Health Journal*, 33, 51-60.
- National Aboriginal Health Organization (2003). Analysis of Aboriginal health careers: Education and training opportunities. Retrieved July 25, 2009, from <http://www.naho.ca/english/>
- Owen, C., & English, M. (2005). Working together as culture brokers by building trusting alliances with bilingual and bicultural newcomer paraprofessionals. *Child Welfare*, 84, 669-688.
- Purden, M. (2005). Cultural considerations in interprofessional education and practice. *Journal of Interprofessional Care*, Suppl 1, 224-234.
- Romanow, R. (2002). *Building on values: The future of health care in Canada*. Ottawa: Health Canada, Commission on the Future of Health Care in Canada.



Schoenberg, N., Campbell, K., Garrity, J., Sneider, L., & Main, K. (2001). The Kentucky Homeplace project: Family health care advisers in underserved rural communities. *Journal of Rural Health, 17*, 179-186.

Simmons, D., Rush, E., & Crook, N. (2008). Te Wai o Rona Diabetes Prevention Strategy Team: Development and piloting of a community health worker-based intervention for the prevention of diabetes among New Zealand Maori. *Public Health Nutrition, 11*, 1318-1325.

Simon, S, Chu, K., Frieden, M., Candrinho, B., Ford, N., Schneider, H., et al. (2009). An integrated approach of community health worker support for HIV/AIDS and TB care in Mozambique. *BMC International Health and Human Rights, 9*, 1-20.

Statistics Canada. (2008). Aboriginal population profile, 2006 census of Canada. Retrieved August 29, 2008, from <http://www12.statcan.ca/english/census06/data/profiles/aboriginal/>

Swart, L., van Niekerk, A., Seedat, M., & Jordaan, E. (2008). Paraprofessional home visitation program to prevent childhood unintentional injuries in low-income communities: A cluster randomized controlled trial. *Injury Prevention, 14*, 164-169.

Swider, S. (2002). Outcome effectiveness of community health workers: An integrative literature review. *Public Health Nursing, 19*, 11-20.

Walkup, J., Barlow, A., Mullany, B., Pan, W., Goklish, N., Hasting, R., et al. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*, 591-601.

Walter, U., & Petr, C. (2006). Lessons from the research on paraprofessionals for attendant care in children's mental health. *Community Mental Health Journal, 42*, 459-475.

Warry, W., & Jacklin, K. (2004). *Wikwemikong Unceded First Nation health transfer evaluation report*. Northwind Consultants, prepared for the Wikwemikong Health Board. Wikwemikong: unpublished document held at the Wikwemikong Health Centre.

Witmer, A., Seifer, S., Finocchio, L., Leslie, J., & O'Neil, E. (1995). Community health workers: Integral members of the health care work force. *American Journal of Public Health, 85*, 1055-1058.

Young, T. K. (2003). Review of research on Aboriginal populations in Canada: Relevance to their health needs. *British Medical Journal, 327*, 419-422.