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Becoming a Promotora: A Transformative Process for Female Community Health Workers

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Abstract

Drawing from role theory, this study sought to explore the effects of assuming a new role on Latina community health workers (CHW) participating in a cervical cancer prevention program in a new Latino immigrant community located on the East Coast of the United States. Through a series of in-depth, Spanish language interviews with the 4 participants, the researchers explored the process and effects of assuming and enacting the CHW role through a narrative analysis approach. Themes that emerged from the analysis included "Reasons for becoming a promotora," "Vision and reality of the role," "Structuring interactions: The hierarchy of knowledge transmission," and "Transforming identities." Findings showed that assuming the CHW role had transformative effects on the participants that, in the end, allowed them to reconcile disparate aspects of their own immigrant identities. The findings have multiple implications for designing prevention programs employing CHWs and immigrant community strengthening.

Keywords

community health workers, promotoras, qualitative research, narrative analysis, roles, health promotion, prevention programs

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Over the past 50 years, community health workers (CHWs) have had many names and worked in myriad roles in the health care sector. The CHW role is most commonly employed in underserved communities in both developed and developing countries that lack access to health care services because of cultural, geographic, or economic isolation. Researchers and community health practitioners have charged CHWs with a wide variety of health promotion and disease-prevention activities, ranging from simple health education programs to complex interventions involving chronic disease management (Earp et al., 2002; Fox et al., 2007; Hill et al., 2003). Intervention studies generally show mixed results with regard to the efficacy of CHWs (Anderson et al., 2000; Campbell et al., 2004; Gary et al., 2003; Thompson, Horton, & Flores, 2007). Globally, policy makers increasingly view CHWs as a potential solution to help address health care workforce shortages since CHWs often provide the majority of primary health care in some countries (Kuehn, 2007).

Despite numerous studies worldwide only a few studies have examined the experiences of CHWs working in the role (Paquet, Deslauriers, & Sarrazin, 1996; Plescia, Groblewski, & Chavis, 2008; Ramirez Valles, 1998; Roman, Lindsay, Moore, & Shoemaker, 1999), thus leaving many unanswered questions about the process of assuming this role and developing an occupational identity. For example, what do individuals gain from assuming the CHW role and participating in these programs? Does the role change them as individuals throughout the process? If so, how does this change occur? And finally, in the case of immigrant communities, does assuming the CHW role affect the immigrant experience and, if so, how?

Answers to these questions are central to addressing community health workforce development, and determining how to make CHWs most effective in their roles. This study sought to gain answers to some of these questions by examining the role-development experience of new promotoras[1] working in a community-based, cervical cancer prevention program in an urban, East Coast city in the United States with a new immigrant Latino population. Role theory provided the theoretical grounding for the study.

Background

Roles constitute social categories describing a collective set of behaviors related to a social situation or set of interactions (Simon, 1997). Most people are familiar with roles related to their position in families, social groups, and work places. Individuals assign meaning to their roles through the following processes: enacting the role, developing an individual sense of self-identity,

honing core values and beliefs, and interpreting the meaning of interactions experienced in their role-based identity (Simon, 1997).

Role theory, meanwhile, incorporates identity formation, culture, behavior, and cognition to help explain how roles evolve in societies or how people perform in them (Lynch, 2007; Morgeson, Delaney-Klinger, & Hemingway, 2005; Simpson & Carroll, 2008). Among the schools of thought influencing role theory, the functionalist perspective views roles as a collection of universally agreed upon behaviors, whereas the interactionist perspective defines roles as a mutable set of constantly negotiated, anticipatory, and cognitive-behavioral responses to social processes (Lynch, 2007). Over time, Lynch (2007) posits that some role-based behaviors become socially ingrained through cognitive processing from positive and negative feedback received in the role. For example, Simon (1997) found that perceptions of role-based stress in adults were the result of a complex set of interactions between an individual's work-based and family-based identities. Feedback received in each of the roles, combined with their sense of personal identity, affected perceptions and experiences of stress. Therefore, as individuals act in different roles, the feedback they receive during role performance will affect their perception of the role and its relationship to their own identity.

In the case of the individual who chooses to become a CHW, role theory suggests that the identity, culture, behavior, and cognitive processes will then influence the CHW's efficacy in their role. Competing familial roles would also influence role efficacy as a CHW. Becoming a promotora, therefore, is a process of assuming and integrating a new role with culture, behavior, and cognition influencing the end result.

Research examining the adoption of the CHW role is scant. Ramirez Valles (1998) first provided an excellent historical overview of the evolution of the CHW role and its use in various societies. His analysis cautions researchers to consider how the relationship between CHWs and their supervising group can replicate colonial and gender-based oppression dynamics because of prevailing power differentials. Gilkey, Cochran, and Rush (2011) observed that as attempts to standardize training and roles for CHWs occur, they draw their role identity formation more from experiences when compared to their health educator counterparts who have more formal education. Their study suggests that the tenets of role theory could serve as an excellent theoretical foundation for studying the role-development process among CHWs.

More recently, a systematic review of the domestic CHW intervention literature by O'Brien et al. (O'Brien, Squires, Bixby, & Larson, 2009) helped define the nature of the CHW role, constituting either one or some combination

of the following elements: teaching and reinforcement of health information, facilitating access to services or performing home visits, community outreach activities, skill-based actions such as taking vital signs, and providing social support to individuals identified as high risk for mental health pathologies. A limitation of their findings, however, is that neither did they incorporate the international literature nor did they discuss the behavioral elements required to act correctly and safely within their scope of practice. They did discuss behaviors or desirable personal characteristics as part of selection criteria for the role.

Finally, while focusing on the effects of roles on individual identities, three articles explored the multifaceted nature of role development as a CHW. Plescia and colleagues (2008) reported that CHWs internalized much of the health information they were responsible for communicating and altered their own health behaviors as a result. Roman et al. (1999), meanwhile, found that the CHW role contributed overwhelmingly positive feelings about the individual's self-identity and ability to access health information. Yet in that study, stressors related to feeling inadequate or confronting limitations of the CHW role itself were also present. Familial demands and added stress from integrating another role into their already multifaceted identities challenged most CHWs' self-perceived effectiveness in their new role. All of these studies supported interactionist-based role theories and suggest that for studies involving female CHWs, this theory may provide the best grounding for research studies. In addition, because the majority of CHWs are women (U.S. Department of Health and Human Services, 2007)—and because many women often balance multiple roles in their lives—role theory serves as an important foundation for research that examines women adopting, integrating, and enacting a new role (Hall, 2003).

Method

Since the existing CHW literature has largely neglected studying the experiences of the workers themselves in the CHW role, this study presents an opportunity to contribute to the literature by analyzing the CHW experience through the lens of role theory. We propose that understanding the role-assumption process of these lay health workers becomes a critical factor in promoting CHW retention, intervention efficacy, and program success.

The promotora role analysis presented here served as part of a larger cervical cancer prevention program in an urban Latino community (O'Brien, Halbert, Bixby, Pimenter, & Shea, 2010). The prevention intervention took place in an East Coast city in the United States that has experienced a substantial growth in its Latino population since 2000 (U.S. Census Bureau, n.d.).

Cancer-prevention efforts became a concern of local community leaders given the extremely high regional incidence of cervical cancer in Latin America (Pan American Health Organization, 2006). The promotoras who implemented the intervention completed 24 hr of training that covered relevant medical content, research skills, and professional boundaries prior to program implementation. The selection and training processes for developing this group of promotoras was described in detail elsewhere (O'Brien et al., 2009). The research protocols for the intervention and qualitative study were both approved by the University of Pennsylvania institutional review board.

Each of the promotoras in this study will be referred to by the first initial of their first names. Promotora I was 36 years old and had emigrated from Mexico, where she had completed the equivalent of a seventh-grade education in the United States. She had never previously worked outside the home either in Mexico or in the United States. Promotora B was 29 years old and had an identical educational and work history as Promotora I. Promotora B's country of origin was Ecuador. Promotora G was 55 years old and came from Mexico, where she had professional training, but experience as a teacher. Promotora C was 42 years old at the beginning of this study. Like Promotora G, she also had professional training and work experience as a nurse before emigrating from Colombia. Both identified strongly with their previous work-related roles as a nurse and a teacher (Promotoras C and G, respectively). All four promotoras had resided in the United States for less than 5 years.

To study the role evolution of the promotoras who implemented this intervention, an independent researcher (A.S.) conducted a series of in-depth, semistructured interviews with the promotoras in Spanish before training and after they implemented the intervention. In the first interview, participants were asked to describe why they decided to participate in the program. Based on the identity of each one, the interview progressed. The second interview asked participants to reflect on their experiences implementing their roles as promotoras, the barriers, and facilitators. A.S. had no contact with the promotoras between interviews. Each interview, conducted separately with each promotora at a local community center, was digitally recorded by the interviewer and professionally transcribed in Spanish. The study team's notes about the implementation process and promotora feedback were also incorporated into the data analysis.

For interview coding, the research team used an axial coding technique, beginning with line-by-line analysis of the interview transcripts and ending with a synthesis of key themes and categories. Data coders included the bilingual principal investigator (PI), the physician team member, and a native Spanish-speaking research assistant. To mediate the challenges related to

analyst identities and the cross-linguistic nature of the research, the native English-speaking PI and physician conducted the coding of the transcripts in English, while the native Spanish speaker did so in Spanish. The coders then compared how the coding process matched both technically and thematically between the two languages for consistency and credibility in the analysis. This process was intended to decrease the risk of conceptual drift resulting from translation, as recommended by Squires (2008). The coders then reviewed the resulting themes to explore similarities and differences between the English and Spanish coding. This process generated productive discussions about what contributed to the observed differences, including the coders' own cultural and linguistic backgrounds. This interactive exchange enhanced the quality of the coding and analysis processes and reduced the risk of translation-related conceptual drift. A total of eight in-depth, Spanish language interviews lasting 30 to 60 min each time resulted from the exploration of the promotoras' evolving experiences in their new roles throughout the course of the 2-year parent study.

Results

The findings from our qualitative analysis indicate that the process of becoming and actualizing the promotora role was transformative for the participants in two different ways. For the promotoras with professional education, this work allowed them to feel more complete as individuals, creating a new role that drew on their previous career experience in their home countries. The role seemed to facilitate a blending of two separate identities into a single one.

The promotoras without previous professional experience described individual changes that affected interactions with their families and communities and influenced their self-concept in profound and unexpected ways. The analysis revealed that assuming the promotora role had a significant, positive impact on how the women interacted with their environments and the individuals around them.

Reasons for Becoming a Promotora

The participants' reasons for joining this community health education program began with abstract descriptions about the importance of the project to the community using very general language. The initial reasons for participation were described through the phrases "it's an interesting project" to describe

why they wanted to participate and emphasized the importance of their work for the community: "Ayudar a los demas"—to help others.

When the promotoras further expanded on their reasons for participating through interviewer probes, the depth and scope of their commitment emerged, reflecting a strong desire to develop as individuals and serve their community as advocates. Promotora I's, a woman in her mid-30s with two teenagers, description of her reasons summarizes this finding nicely:

> I have realized that the Latina women who are immigrants in this country do not have any way to access information about how to prevent certain common illnesses that can be detected early just by taking a simple test like Papanicolau. So this is something new for me and it is also very interesting to be able to explain to people who I know, to women, how they can do it, where to go and who to see and I learn who it appeals to and how to let other people know about the steps to follow.

Promotoras C and G, who both had professional backgrounds in their home countries, conveyed their frustrations about what they perceived to be a deficit in health knowledge and health literacy in their community. They linked this lack of health knowledge to cultural norms and systemic factors in their home countries that result in poor provider–patient communication. To illustrate, they explained that health care providers from their home countries "don't tell you anything during medical encounters" and that "women are kept in the dark about their health." Their interactions with the medical community, both in the United States and their home countries, provided a strong motivation for assuming the promotora role.

Promotora B also noted the lack of teaching from health care providers as a barrier to health knowledge in her community. She described her own ignorance about women's health issues, having had bad health care experiences in her home country, and her desire to make something more of herself were motivating factors for becoming a promotora. She described wanting to

> put more light in my life and give this to others as well. To do something more, instead of working . . . or . . . I want to try to advance a bit more, and not just to stagnate in one place with my head down, cleaning, without helping anyone, just being there.

The darkness–light metaphor used by Promotora B pervaded the discussion of why all four promotoras chose this new role. They described

knowledge-based action was a way to "drive out the darkness" that poor health-related knowledge imposes on individuals and communities.

Promotora I also described growing up in a small rural village, where educational opportunities were few and where overworked health care providers had little time for teaching patients during their limited encounters. Her migration experience to the United States with her family had, as she described, "opened my eyes to other things about health and education." An action-oriented individual, she saw the promotora role as an opportunity to channel her activist energies for the benefit of her adopted Latino community in the United States.

Vision and Reality of the Role

Enacting a role requires a vision to guide interactions with the environment and the actors within it. The promotoras' vision for enacting this new role revolved largely around imparting knowledge to their fellow community members. Secondary aspects of the role included providing social support and serving as trusted advisors to community members. Promotora G seemed to sense a growing empowerment from her participation in the project:

> I am reminded we can make the decision to take control of our own lives and, above all, feel happy as women, knowing that we are our own bosses. In our Mexican culture, we believe that the simple act of being with a man means that they can take control of all the different areas of our lives. I don't agree because women have the right to say "here and no further," and that "I am in control, I am my own boss, I can make my own decisions and I can do it if I want to." You must take control of yourself, you are you and no one can interfere with that, know you, know your body, your mind, your soul, you as a human being and as a woman.

A blending of native and immigrant identity also began to emerge for several promotoras. For Promotoras G and C, there was clear excitement about the prospect of assuming this role in their adopted community. They both described how this new role would allow them to fulfill professional ambitions that they had realized previously in their home countries. Both middle-aged women, Promotora G was an adult education teacher in her home country, and Promotora C was an intensive care nurse who could not work as a nurse in the United States because of the language barrier. The two saw the promotora role as a way for them to use the skills, education, and experiences they had in their home countries for the benefit of their new

community. They described feeling "lost" and "not useful" since arriving in the United States 5 years before. Consequently, Promotora G was so emotional about even the prospects of the promotora position that she began to cry during the first interview stating that she was "so relieved for the opportunity to be myself again."

Consistent with role theory, the promotoras' vision of their role was directly related to their previous experiences and identities from their native countries and also influenced by their interaction with other Latinos in their new country. Promotoras C and G conveyed a professional perspective on how poor health-related knowledge affected their families and communities. Promotoras B and I expressed a more inward perspective that reflected how a lack of health knowledge had shaped their personal experiences. All 4 promotoras believed that their new role would allow them to address these important deficits in health knowledge.

Structuring Interactions: The Hierarchy of Knowledge Transmission

In the initial interviews, the promotoras revealed that their reasons for assuming this role created a framework for their interactions with the community. A key revelation was an unconscious, hierarchical ordering of the knowledge transmission process they would implement within the community: family, friends, country members, and other Latinas.

Family members would receive the information first so they could address their immediate concerns about their family members' health as mothers or daughters. This fulfilled their priority to educate their families, which is consistent with the prevailing Latino culture's focus on family (i.e., familismo) and their social role expectations. Friends came next because of the importance of reinforcing social networking ties. Fellow country members came last for knowledge transmission. That finding revealed that their sense of national identity prior to assuming the promotora role initially superseded their connection with other Latinos as a collective whole in their new community. They also expressed concern about the effectiveness of their health education efforts with Latinos from countries other than their own. This unconscious ordering of their planned interactions in the role gave the team clues as to how the promotoras might initially approach implementation.

Transforming Identities

A transformation occurred among the promotoras, both collectively and individually.

The most striking finding from this part of the analysis emerged during the final interviews when all of the promotoras appeared to convey a new sense of collective identity as Latinas. They described their awareness of the sociocultural disconnect they collectively shared as new immigrants in the United States. This collective bond served as a common starting point to establish credibility and transmit knowledge through the promotora role. Each promotora expressed the importance of doing this work within a shared culture where women's health issues often "remain in the darkness." The promotoras also spoke proudly about how they were able to successfully deliver information about cervical cancer to the program participants, regardless of their countries of origin. They also described a multiplicative effect attributable to community social networks, where the knowledge imparted during the classes reached a wider audience than the participants who directly received the educational program. The phenomenon is best illustrated through this quote from Promotora I:

> I have noticed we have all experienced an extraordinary change, not just personally but in the community too because the women of our community now see us as promotoras, who are associated with health care, and now they ask us about health questions if they have any doubts or other things that concern them. Once they know you as a friend or a friendly person, as a neighbor, as a promotora, they come to you seeking information.

Transformations at the individual level were deeply rooted in each promotora's personal history. For Promotoras C and G, their ability to reinvent previous professional identities through this project brought immense personal satisfaction and also improved their relationships at home. Promotoras C and G described family members' reactions to their current work as positive, with some extended family members commenting that they had "returned to the person [they] were before." The changes they experienced from assuming the promotora role, therefore, could be described best as reclaiming and reinventing their previous professional identities.

For Promotoras I and B, the promotora experience produced both internal and external changes, with notable differences in their physical appearances between the first and final interviews. Promotora I described the promotora role as a productive channel for her self-described "activist energies," helping her engage community members in new ways and develop ideas for new projects to promote the health of her adopted community. She felt she could effectively use the skills she developed as a promotora in a project designed

to raise awareness about adolescent health issues, which she had begun working on at that time.

The most dramatic personal transformation occurred in Promotora B. In the first interview, Promotora B was a timid, quiet interviewee who seemed to pay little attention to her physical appearance. She mentioned repeatedly how she needed to get permission from her husband to work as a promotora or even leave the house. Her physical appearance and demeanor suggested the possibility of an underlying depression, a common condition in newer immigrants. Yet by the second interview, after she had worked as a promotora for approximately 1 year, Promotora B was a transformed woman. Brimming with a newfound self-confidence, Promotora B appeared so different at the second interview that the interviewer (A.S.) did not recognize her. Her hair was highlighted and styled, and her manner of dress reflected someone who paid careful attention to her appearance. She exuded confidence, smiled, and made jokes during the interview. She described how the promotora role transformed her life and how it was the main source of her personal transformation. She explained that she knew her work as a promtora had made a visible difference in her community, which prompted her to feel useful in a way she never had before. Promotora B was also excited to report that she had established a new level of trust with her husband when he witnessed the effects of the program on community members and had the chance to meet the study PI himself. As a result, she no longer had to seek permission from her husband to participate in promotora activities or to leave the house. She expressed satisfaction and gratitude for her newfound independence and autonomy, stating that "working in the [promotora] role gave me the confidence that I could do something for others and be useful."

Discussion

The transformative changes experienced by the promotoras in this study illustrate the positive individual effects that becoming a promotora in an immigrant community can foster. Particularly striking was the case of Promotora B and the personal empowerment she derived from her work in the role. The process of enacting the promotora role brought about profound changes in this group of women, causing some to reinvent their previous professional identities and others to discover the benefit and satisfaction that accompany assuming a professional identity for the first time. The self-actualization experienced by all of the promotoras also created an effective team of community leaders that continues to evolve. Social networks developed through the program resulted from the community's

rapid identification of our promotoras as reliable sources of health information. A separate study reports their efficacy in increasing Pap smear screening rates among study participants (O'Brien et al., 2010). The promotoras' ability to develop new ideas for health interventions also demonstrates that their new professional experience enhanced their critical thinking skills and empowered them to confront other community-based health challenges. For example, Promotora I worked with the team to develop a sex education program for U.S-born Latina adolescents in the same community, who often face cultural barriers to discussing sex with their mothers. This group's long-term effectiveness in promoting community health will depend on navigating the politics of the local community, diversifying their knowledge base, and enhancing their ties to local health care resources to sustain their work.

For researchers, health care providers, policy makers, and local leaders seeking to enhance the use of promotoras in community-based health promotion, this study offers key insights into promotora role development and enhancing program success. First, effective promotoras do not necessarily have to have completed professional education or demonstrated previous leadership experience prior to their selection. Promotora I is the informal leader of the group and is widely recognized as such in the community. Our quantitative measurements of participant satisfaction have also been roughly equivalent between promotoras and have not varied by their educational background or work history. This experience suggests that previous educational attainment or professional experience should not be the primary criteria for selecting promotoras. Personal qualities that facilitated the role have been previously reported by our group (O'Brien et al., 2009) and others (Reinschmidt et al., 2006; Viswanathan et al., 2009).

Second, a structured training program with very specific role expectations and performance guidelines helped provide the novice promotora with appropriate guidance necessary to enact the role. Balancing their training with their innate cultural knowledge of the community presents an inevitable tension that promotoras will face. CHW program developers, especially when they are not members of the target community, should include CHWs in program design and encourage creative thinking to tailor medical messages for the target community and its prevailing culture.

Finally, the hierarchical structuring of the language used to convey the knowledge transmission process offered insights into socioculturally ascribed behaviors that would shape their role enactment process. For researchers, this may help with research study design when they include an educational

intervention because they will be able to structure training programs which anticipate this hierarchy of knowledge transmission.

The findings of this study also reinforce the tenets of role theory, mainly the interactionist perspective. Clearly, as they enacted their roles, the promotoras drew from multiple versions of their own identities and were shaped by their interactions within the community. How they interpreted the meanings of these interactions in relation to their identities and experiences influenced their role-enactment process.

Overall, we attribute the largely positive nature of our findings to the quality of the infrastructure and support provided to the promotoras during the initial training program and intervention implementation. We believe that contributed to the nature of the promotora's responses and their feelings of security in implementing the intervention, even when faced with the common obstacles of assuming a new role. With adequate infrastructure, the study could focus on the experiences of the promotoras and isolate them from the implementation challenges that accompany any intervention study. Research or program teams that seek to use a similar model should consider the strength of their program infrastructure as a factor that could create both positive and negative effects on worker experiences and program outcomes.

This study has several limitations. First, while the bilingual coding method described above helped to ensure the transferability and dependability of any translated concepts, any translation effort presents some risk for conceptual drift that threatens the validity of the data (Squires, 2008). The current study's urban location and its setting in a new immigrant Latino community might limit the generalizability of the findings to more established immigrant communities and rural settings. We also caution readers about the applicability of the findings to settings where CHWs come from local communities and are not immigrants. The immigrant Latino experience is distinct from that of Latinos in established communities, which may influence promotoras' experiences in role development. Another consideration is that the women's health focus of the promotoras' work in this study likely had a significant impact on our findings, thereby limiting generalizability to other programs. Finally, as this study included only Spanish-speaking Latin American immigrants, the applicability of the findings to non-Latino immigrant groups may also be limited.

In conclusion, our study captured a unique process that has received scant attention in the CHW literature and presents preliminary evidence of how assuming this role may promote both the personal and professional development of the individuals who do so. At the same time, our findings also reveal the limitations inherent to the promotora role and suggest some potential

boundaries for how to create formal structures for them to improve the recruitment and retention processes. The significant personal and professional satisfaction that our promotoras experienced during the course of this study may have played an important role in the program's efficacy (O'Brien et al., 2010). Future research should evaluate the impact of such personal and professional transformations on the outcomes of promotoras' work. Understanding the process of becoming a promotora may help new groups assume this role more effectively and may cause existing promotora groups to evaluate ongoing personal and professional transformations that could influence their work. We anticipate that this study and others focusing on promotoras' occupational development will help uncover important factors that promote the success of such programs. Developing an experienced promotora workforce may not only help improve health outcomes locally but also serve as a culturally appropriate model for reducing Latino health disparities nationwide.

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Authors' Note

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Note

1. In Latino communities, CHWs are often called *promotoras*. Throughout this manuscript, the terms *community health worker* and *promotora* are used interchangeably.

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