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Program Planners' Perspectives of *Promotora* Roles, Recruitment, and Selection

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Abstract

Objective—Program planners work with *promotoras* (the Spanish term for female community health workers) to reduce health disparities among underserved populations. Based on the Role-Outcomes Linkage Evaluation Model for Community Health Workers (ROLES) conceptual model, we explored how program planners conceptualized the *promotora* role and the approaches and strategies they used to recruit, select, and sustain *promotoras.*

Design—We conducted semi-structured, in-depth interviews with a purposive convenience sample of 24 program planners, program coordinators, *promotora* recruiters, research principal investigators, and other individuals who worked closely with *promotoras* on United States-based health programs for Hispanic women (ages 18 and older).

Results—Planners conceptualized the *promotora* role based on their personal experiences and their understanding of the underlying philosophical tenets of the *promotora* approach. Recruitment and selection methods reflected planners' conceptualizations and experiences of *promotoras* as paid staff or volunteers. Participants described a variety of program planning and implementation methods. They focused on sustainability of the programs, the intended health behavior changes or activities, and the individual *promotoras*.

Conclusion—To strengthen health programs employing the *promotora* delivery model, job descriptions should delineate role expectations and boundaries and better guide *promotora* evaluations. We suggest including additional components such as information on funding sources, program type and delivery, and sustainability outcomes to enhance the ROLES conceptual model. The expanded model can be used to guide program planners in the planning, implementing, and evaluating of *promotora* health programs.

Introduction

There is increasing global consensus that social, economic, and environmental conditions contribute to health status, and inequitable distribution of these conditions significantly contribute to persistent and pervasive health disparities between and across populations (Braveman 2006; Commission on the Social Determinants of Health 2008). In the United States (U.S.), racial/ethnic disparities between Whites and Hispanics range from obesity and diabetes to tooth decay (Centers for Disease Control and Prevention 2011). Language barriers, restricted access to care due to lack of health insurance, limited understanding of how to navigate the complex and fragmented healthcare system, and lack of culturally appropriate care contribute to health disparities among Hispanics, the largest U.S. ethnic minority population (Marshall *et al.* 2005). Recent xenophobic legislation aimed at undocumented immigrants has heightened fear of authorities and further restricted the ability of many Hispanic immigrants and their families to access health and social services (Gee and Ford 2011). Due in part to the growing shortage of community-based healthcare providers and the challenges of reaching populations marginalized by language, culture, lack of health insurance, geography, immigration status, and other structural barriers, health program planners from various institutions (e.g. community organizations, academia) have selected to train community health workers (CHWs) to deliver health education and outreach services to underserved populations, particularly racial/ethnic minority groups. (Andrews *et al.* 2004, Ingram *et al.* 2008, Aiken *et al*. 2009).

In the Alma Ata Declaration, the World Health Organization (WHO 1978) acknowledged the value and utility of CHWs as a resource for the delivery of primary healthcare services and implementation of peer-to-peer social learning approaches internationally. The WHO (1989) definition of CHWs is still widely accepted:

> Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (p. 6).

A generic umbrella term referring to a wide variety of paraprofessional health workers in diverse settings and healthcare systems across the globe, CHWs are known by in Spanish as *promotoras*[1] (Lehman & Sanders 2007).

Social networks and community empowerment are two key constructs that inform the CHW delivery model. This model is predicated on enlisting, training, and empowering a community's recognized natural leaders to provide health education and link other community members to existing health services, with the goal of improving and maintaining healthy behaviors (Israel, 1985, Bishop *et al.* 2002). Thus, this healthcare delivery model contributes to community empowerment by building community capacity to plan, organize, and deliver healthcare (Zimmerman 2000).

Depending on the philosophical underpinnings and the community contexts and settings, CHWs perform different types of activities and function at different levels within health programs and systems (Crigler *et al.* 2009). In the U.S., CHW programs tend to focus on a specific health issue. Funded through short-term external grants, these programs are often coordinated through community-based organizations, coalitions, faith-based organizations, hospitals, healthcare clinics, or academic institutions (HRSA, 2009). In some programs

[1]We use the feminine form, *promotora* rather than the masculine *promotor* to reflect the predominantly female community health worker population in the Hispanic-serving programs surveyed in this research.

CHWs volunteer their time but may receive monetary reimbursement for certain activities. In others they function as salaried employees. However, the lack of national recognition of the CHW role as a position reimbursable through federal funding mechanisms compromises the sustainability of CHW positions.

Definitions of CHW roles tend to be general and often limited to brief mentions of CHW relationships with community members and to their roles in linking the community with healthcare resources (Rhodes *et al.* 2007). Examples of CHW role descriptors include being natural helpers, community leaders, and individuals to whom others naturally turn to for information and resources (Bishop *et al.* 2002). Within the contexts of individual programs and across the healthcare system, the lack of clear definitions or delineations of CHWs' roles may contribute to blurred role boundaries and to potential conflicts in role expectations and position-related parameters (Ashforth *et al.* 2000, Brownstein *et al.* 2005). Role boundaries aid in identifying specific tasks and expectations and provide the individual practitioner with a sense of understanding or control within a specific position (Zerubavel 1991). Identified gaps in the CHW research literature include a lack of attention to CHW role conceptualization and the lack of detailed information about CHW recruitment processes (Jackson and Parks 1997, Rhodes *et al.* 2007). O'Brien and colleagues (2009) conducted a systematic review on CHW recruitment, selection, and training, focusing on how selection and training influenced CHW role development. However, they did not examine how CHW role conceptualization influenced the selection process.

There is increasing use of *promotoras* to implement grant-funded community-based programs with the aim of preventing or controlling obesity (Kim *et al.* 2004, Balcazar *et al.* 2006, Keller and Cantue 2008, Baquero *et al.* 2009) among U.S. Hispanic women, a group with one of the highest risks for developing obesity-related diseases such as Type II diabetes and hypertension (Cossrow and Falkner 2004). In these programs, program planners employ *promotoras* as a key way to deliver culturally and linguistically competent interventions; however, the conceptualizations and expectations of *promotoras* often differ across such programs. The goals of this study were to further understand how program planners' *promotora* role conceptualizations influenced 1) the planning process and placement of *promotoras* within the wider healthcare spectrum; 2) the establishment of *promotora* role boundaries and the type and amount of work they perform; and 3) outcome expectations of *promotora*-delivered health programs (Gilson *et al.* 1989, Zerubavel 1991, Ashforth *et al.* 2000, Andrews *et al.* 2004). We based this research on the premise that planners' beliefs, conceptualizations, and expectations of the *promotora* role drive health program components and processes from development through implementation and that the expected role influences the criteria and measures program planners use to evaluate the effectiveness of *promotora*-delivered interventions. Better understanding of how program planners conceptualize and implement *promotora*-delivered health interventions can provide an evidence base for improved utilization of *promotoras* in community health programs. Although this research focused on *promotora*-delivered interventions related to obesity, the findings are applicable to *promotora*-delivered interventions focused on diverse health issues (e.g., asthma, cancer, diabetes).

Purpose and Conceptual Model

Employing a qualitative descriptive research design we sought to explore how planners conceptualized and implemented the role of *promotoras* within obesity prevention, physical activity, and/or nutrition programs designed specifically for U.S. Hispanic women. We used the Role-Outcomes Linkage Evaluation Model for Community Health Workers (ROLES) model (Figure 1; O'Brien *et al.* 2009), one of the most recent models which illustrates how CHWs are first selected and later linked to program outcomes, to construct our in-depth

interview guide for the study. We intended to modify the model if study results revealed disparities between the current model and program planners' perspectives of *promotora*s' roles.

The ROLES model describes a sequential process in which program planners (1) select and (2) train CHWs, who then (3) enact the role through teaching, home visits, community outreach, skill-based actions, and social support. The final step involves the (4) examination of outcomes and effectiveness measured by changes in behavioral, clinical, psychological, educational, systemic, and environmental health-related indicators (O'Brien *et al.* 2009). For this research we focused on program planners' perspectives and experiences, rather than *promotoras*, given planners' responsibilities for creating and managing health programs; organizing *promotora* activities; and recruiting, selecting, and training *promotoras* (Lehman & Sanders, 2007). The University of South Carolina Institutional Review Board approved the research.

Methods

Participant Recruitment, Interview Guide Development, and Data Collection

We recruited a purposive convenience sample of program planners, program coordinators, *promotora* recruiters, researchers, and other individuals working closely with *promotoras.* Inclusion criteria were: 1) the *promotora* program included a focus on obesity prevention, physical activity, and/or nutrition given the high rates of obesity among Hispanic women (Ogden *et al.* 2012); 2) the program was U.S.-based and served primarily Hispanic women (ages 18 and older), although programs may have included family members; and 3) the program planner spoke English. We identified names of potential participants through literature searches, Internet searches of evidence-based *promotora* programs for Hispanic women, and referrals from other program planners. We made initial telephone and/or e-mail contact with 65 individuals, of whom 25 (38%) did not respond. Among the 40 responders, 14 (22%) reported that they did not work on a project that met the inclusion criteria; 2 (3%) declined to participate due to time constraints; and 24 (37%) agreed to participate in an individual telephone interview.

We conducted in-depth, semi-structured telephone interviews to elicit program planners' detailed, reflective descriptions of their experiences planning and implementing *promotora*-led initiatives (Fitzpatrick and Boulton 1994, Maxwell 2005). Based on the ROLES conceptual model (O'Brien *et al.* 2009), we designed a semi-structured interview guide with the aim of exploring program planners' conceptualization of *promotoras*' role, recruitment, selection, and training. We designed open-ended questions and probes (Table 1) to ensure the flow of the conversation, clarify, and elicit further details (Warren 2002). The first author pilot tested the interview guide with a program planner who met the same criteria as those included in the study. Following the pilot test, we revised questions that were unclear or directive (Lindlof and Taylor 2002). The audio-recorded telephone interviews lasted between 30–90 minutes, with an average length of 60 minutes. Personal and program identifiers were not included in the interview transcripts.

We also gathered program-specific information such as the type of organization, geographic location, health focus, and program and training language(s). Recruitment and data collection activities occurred between May and September 2010.

Data Analysis

The purpose of our data analysis was to describe how program planners of obesity-related health programs for Hispanic women conceptualized and operationalized the *promotora* role

as they recruited and trained *promotoras* to implement obesity-related health programs for Hispanic women. The goal of the analysis was to further understanding of how program planners' *promotora* role conceptualization influences the placement of *promotoras* within the wider spectrum of healthcare providers and sets role boundaries that frame the type and amount of *promotoras'* activities and responsibilities.

We used a mix of inductive and deductive qualitative coding and analysis techniques combined with a constant comparison approach (Strauss and Corbin 1998). Three authors independently conducted initial open-coding of the same three interview transcripts, identifying key words and terms (e.g., *in vivo* codes), themes, relationships, questions, patterns, or sequences in the data (Infante *et al.* 2009). We compared these initial codes within and across the three interview transcripts then developed a common coding scheme. The resulting coding scheme was organized into a codebook and entered into ATLAS.ti v6 software program. Using this coding scheme, the first author then reread and coded the entire data set twice, identifying and comparing salient themes and patterns within and across the interviews (Strauss & Corbin, 1998). All authors contributed to the later stages of the analysis, which involved interpretation and representation of the major narrative themes and writing up the results (Huberman & Miles 2002).

Results

Sample

The sample of 24 planners included 21 women and 3 men from 22 distinct programs. Participants' specific roles included program director (n=7), program coordinator (n=4), principal investigator (n=10), co-investigator/consultant (n=1), and *promotora* trainer (n=2). They represented diverse types of organizations including community based organizations (CBOs, n=8), universities (n=5), university-community based organization collaborations (U-CBOs, n=5), federally qualified health centers (FQHC, n=3), hospital-based programs (n=2), and a state government-run program (n=1). Of note, eight of the ten programs sponsored through universities and U-CBO collaborations were research studies.

Geographic representation included the following U.S. regions: Southwest (n=7), West (n=7), Midwest (n=3), Southeast (n=3), and East (n=2). Programs served both rural (n=8) and urban (n=14) populations and focused on Type II diabetes (n=7), obesity/weight management (n=6), family health/wellness (n=4), cardiovascular health (n=3), health literacy (n=1), general women's health (n=1), and osteoporosis (n=1). All program curricula included lessons on physical activity and nutrition for obesity prevention. Eleven programs were bilingual (English-Spanish) and eleven were conducted in Spanish only.

Qualitative Findings

Planners conceptualized *promotora* roles based on personal experiences and understandings of the underlying philosophical tenets of the *promotora* approach. Their conceptualizations of *promotora* roles reflected the individual program definitions of the role, historical role conceptualizations, role expectations, methods of reimbursement, and levels of *promotoras*' involvement. Recruitment and selection methods reflected planners' conceptualizations and experiences of *promotoras* and whether or not *promotoras* were engaged as paid program staff or community volunteers. Planners described a variety of implementation approaches. In focusing on sustainability, they raised concerns and strategies related to continuation of the specific program, the intended health behavior change or activity, and the individual *promotoras*. In the following sections we describe the thematic findings in detail, providing examples and illustrations from the qualitative data.

Role Conceptualization: Local and Global Contexts and History—A common theme was the conceptualization of the *promotora* model as a participatory, community-based approach that naturally incorporated cultural sensitivity and accountability and aimed to further health equity and improves access to care. Program planners also conceptualized this model within the broader context of community engagement, where community leaders and members are involved in pinpointing resources and barriers to care. In the words of one U-CBO participant, *promotoras* were culturally competent and able to "*best engage people* [community members served in these programs] *in the contexts of their lives*." Because *promotoras* often were part of the target population, they understood community members' life circumstances and underlying social determinants of health and health behaviors within the context of the specific program.

Advantages and benefits of the *promotora* model for community health programs included equity and reach, particularly in relation to access to care. Program planners considered the use of *promotoras* as improving equity in access among Hispanic communities. *Promotoras* improved reach, especially among individuals and groups harboring feelings of distrust for U.S. medical providers and the healthcare system. One participant from a U-CBO partnership program described the *promotora* model as a way to empower community members to rely on peers within their social networks to provide health education, link them to health resources, and work with healthcare providers to prevent and treat illnesses.

Program planners described their conceptualization of the *promotora* role within the context and history of local projects, as well as within more global contexts and history. Planners' made decisions regarding *promotora* roles based on factors such as the type of program (e.g., randomized control trial, community program), funding source (e.g., short term grant vs. longer term funding), and type of organization hosting the program, resulting in diverse renditions and variations on the *promotora* model. One university-based participant pointed out the salience of these program dimensions, arguing that they actually influenced the entire *promotora* model and that comparing different models was similar to *"comparing apples and oranges."*

A few participants noted they had first encountered the CHW delivery model in a global context or associated it with immigrants, refugees, or individuals living in rural villages in South and Central American countries. Some identified the *promotora* role with Paulo Freire's (1970) popular education methods, which actively involved learners as leaders of cultural circles or discussion groups with the goal of acquiring skills and knowledge while engaging in critical reflection. Others illustrated their role conceptualization through personal accounts of their involvement with *promotoras* or their personal experiences as *promotoras* in other projects. For example, one participant identified herself as one of the first *promotoras* in the state and described her personal trajectory from *promotora* to director of a *promotora program*.

Defining the Role and Identifying Role Expectations and Level of Involvement —*Promotoras'* roles and duties varied within the context of each specific program. They included educator, health outreach provider, bridge or connector to education or health services, natural helper, participant recruiter, cultural broker, provider of social support, friend, social advocate, problem solver, and role model. Participants attributed *promotoras'* effectiveness in serving as a bridge to connect the community with healthcare resources to their ability to understand the social and environmental influences on a community's health and engage with community members to address their targeted needs:

> They know the environment where they work. They know the services available, and they know the healthcare systems in place. So, they know all of these things,

> and they can put their knowledge to work to better the health of everyone around them because they are leaders within their community and because people will trust them. (CBO)

Because of this level of trust, *promotoras* were effective vehicles for disseminating information on how to access and pay for services.

Promotoras' roles spanned the healthcare continuum from prevention to treatment and included involvement at varying levels in planning, recruitment, enactment, and evaluation stages of health programs. This participant captured the flexibility of the role:

> I see the *promotora* model as the vision of an integrated approach to prevention where the *promotora* is part of that team. If you incorporate them in clinical settings they could begin to be part of that team. If you draw them in from the community, they can begin to do outreach and health education, health promotion, and then you can begin to integrate them into the health infrastructure. (CBO)

Another common theme was the conceptualization of the *promotora* model as an alternative to the dominant medical model of U.S. healthcare. Some participants clearly considered the *promotora* model to be a more effective method of providing healthcare and resources to underserved and hard to reach populations. *Promotoras* worked 'with' people or community members to improve health outcomes, in contrast to the paternalistic medical model approach of working 'on' people.

> The *promotora* model is all about trusting that people can learn and use their own leadership skills to move them up. There is a huge resource in the community that is not being used, and the healthcare system traditionally uses a very paternalistic model, which has not necessarily given us the best results. (U-CBO)

In contrast to a medical provider-directed healthcare experience, the *promotora* peer health education model seeks to empower patients or program participants to make informed health decisions through education on health topics, modeling and teaching skills necessary for personal health management and decision-making.

Situating Role as Volunteer or Paid Employment—Diverse views regarding the issue of economic value and remuneration for *promotoras'* work surfaced in the analysis, focusing on *promotoras* as community volunteers or paid employees. Although participants' views may have reflected the context and finances of specific health programs, those who subscribed to the historically-based model tended to conceptualize the *promotora* role as that of community volunteer engaged in the sole purpose of contributing to social mobility within the community through education and empowerment.

There was wide recognition that this distinction between volunteer and paid employee was not simple, and that the type of work *promotoras* performed, regardless of compensation, involved more than simply showing up to a job. Several participants noted that *promotoras'* work required patience, love, and dedication for the sake of the community. Whether programs involved paid or volunteer *promotoras*, there was consensus that *promotoras* deserved recognition and some type of compensation for their time, energy, efforts and services.

Challenges of Undefined Role Boundaries—Although there was certainly a high degree of agreement around the overall *promotora* model, there was no clear consensus among participants on the specific definition of the *promotora* role. A common theme across the data was the challenge of blurred boundaries of the *promotora* role. Some identified "*promotora*" as a broad umbrella term applied to a wide range of individuals involved in the

provision of health education and services to their communities. For most, the widespread use of the term *promotora* did not reflect a single, functional definition or role description. One participant alluded to the loss of application of a "*correct*" concept and model in practice:

> The word *promotora* or community health worker is so vastly used now. In reality, programs may use the name for this role, but they don't have the correct concept of what a *promotora* is. And, if they don't have the concept they don't have a *promotora* model. (FQHC)

Embedded in the diversity and ambiguity across *promotora* role definitions and expectations was the challenge of evaluating *promotora* effectiveness and impact:

> One of the challenges of the whole community health worker movement is that the roles have varied so widely, and we don't have a lot of good effectiveness data. When we do, it is often with different populations, with different definitions of workers, different definitions of their roles. (University)

As a result, lack of easy access to effectiveness data on *promotora* programs was one of the major challenges for program planners, particularly those engaged in developing funding proposals.

Implementation: Recruitment Processes and Eligibility Criteria—In describing the implementation of the various *promotora* programs, participants again reflected their particular role conceptualizations and expectations. Program planners described a variety of methods to advertise for and recruit potential *promotoras*. One strategy was to ask current or former *promotoras* to identify individuals who possessed leadership qualities and community trust. Some programs implemented more formal recruitment processes, including holding information sessions and disseminating position announcements through different forms of media (e.g., Spanish language radio and newspapers), making announcements at community-based organizations, soliciting referrals from other community leaders, and sending position advertisement messages through community social networks. A common strategy was to employ a variety of recruitment methods to maximize the pool of applicants for the position.

Program planners discussed the importance of both formal and informal *promotora* eligibility and selection criteria. Language and community engagement were the most frequently cited eligibility criteria. Some programs required *promotoras* to be bilingual (English/Spanish); other programs accepted monolingual Spanish speakers. Most planners expected potential *promotoras* to have existing knowledge and relationships with the community; some required or preferred that *promotoras* work and/or live in the target community. Women with wider and more numerous social connections within the target population were well-suited for the promotora role:

> It is important when you select *promotoras* that there is that potential for them to easily share their resources, knowledge, and support with people that are naturally in contact with them. So someone who is very socially isolated… doesn't have contact with people to share information. (FQHC)

Few program planners reported using formal education requirements (e.g., high school, GED, or higher education) or prior experience working in health-related positions as eligibility or selection criteria. In contrast, personal qualities and a willingness to serve the community were consistently identified as a prerequisite:

> I personally do not look for education. I do not look for how many years of community service they have performed or how much they know about nonprofits.

> I look more at their dedication, their loyalty. I look for their compassion, humility, and in my questions and interview strategy, I try to recognize these things. Everything else I can teach them. But I can't teach them how to care for other people. (Hospital)

Although most program planners did not subscribe to a specific formal education requirement, several noted that in future programs they would include a minimal education as a *promotora* qualification. Lack of literacy could impede *promotoras'* effectiveness in programs that involved providing assistance with completion of health-related and program evaluation forms:

> As far as education is concerned, perhaps that should be one of the criteria more strictly adhered to. Some have very minimal ability to read or write in Spanish. We need people who can understand some research protocol and do some documentation. So we need people who are comfortable reading and writing. (University)

Selection, Hiring, and Training Procedures—The selection and hiring procedures organizations used to fill the positions in *promotora*-delivered programs varied widely. At one end of the spectrum were two programs that had no *promotora* selection process. Any individual interested in serving the community could participate in the training and become a volunteer *promotora.* Another format, used by several CBO and U-CBO-based programs, was to hold training sessions for larger cadres of community members, with the dual purpose of providing the community with a free service (e.g., health education) and having an opportunity to observe the communication and leadership potential of potential *promotoras*. During these trainings, which often involved opportunities for role play and enacting other skills such as leading small groups, program planners were able to observe potential *promotoras* in action and judge their fit for the program requirements. Planners tended to consider *promotoras'* willingness to learn and to serve their communities more than educational achievement and prior work experience. One hospital-based participant stated selection criteria included *promotoras'* demonstrated enthusiasm for promoting health in their social networks and the "*fire in their eyes.*" Other desirable characteristics and traits included openness, compassion, empathy, nonjudgmental character, leadership qualities, and ability to relate to others. Program planners extended invitations to individuals they deemed to have the desired characteristics for the position to serve as a *promotora.*

At the other end of the spectrum, in some of the programs with salaried *promotoras,* there was a formal job application process similar to that of any other paid employment (e.g., through the organizational human resources department). Of note, *promotoras* hired in states with CHW certification were required to complete certification training programs before they could work in the community.

Anticipated Outcomes: Sustainability of Program Processes, Results, and Promotoras—In describing their experiences with *promotora*-led programs, participants focused on several long-term outcomes. In programmatic terms, these included maintaining the necessary funding and community engagement necessary to sustain program activities and program agents (e.g., *promotoras*). They also identified the goal of sustaining the intended health behavior change or activity at individual and community levels. Due to the variety of organizational contexts (e.g., grant-funded research projects, hospitals), the express intent to sustain the particular *promotora* programs varied. Program planners associated with CBOs tended to have more concrete plans for sustaining the *promotora* programs, such as building community partnerships, identifying local program champions, and transferring responsibility to predetermined community stakeholders. In contrast,

participants working on grant-funded research projects appeared to be more readily accepting of the fact that there were no contingency plans for program sustainability once funding ended. There were, however, a few reports of spontaneous *promotora*-led initiatives to continue delivering the health education initiative within their communities after the formal program was over.

Program planners envisioned *promotora* sustainability both in terms of maintaining the individual *promotoras* engaged over time and as contributing to their personal social and economic well-being and mobility. Some participants believed policy measures, such as standardizing the role of *promotora*, would create a more sustainable position for *promotoras* in the healthcare system, and their work could then be made reimbursable by government programs such as Medicaid and Medicare. Interestingly, several participants proposed that a desired long-term outcome of *promotora* programs was personal career development and improved social mobility among the individual *promotoras*. Thus, encouraging *promotoras* to build on the knowledge, skills, and connections they acquired through participation in the community health initiative to advance their personal education and career was also seen as contributing to sustainability.

Discussion

This study explored program planners' conceptualizations of *promotoras*' roles in U.S. obesity-related health programs for Hispanic women. *Promotoras* with extensive social networks and who speak the same language and share similar cultural backgrounds with community members are well-suited to deliver health outreach among U.S. Hispanics. Incorporating *promotoras* into community-based health programs is an appropriate strategy for addressing health and healthcare access disparities among Hispanics, while simultaneously building linkages and improving trust with the healthcare system and healthcare professionals. Although not a panacea for the lack of culturally and linguistically appropriate care or discriminatory practices, *promotoras* can make substantial contributions to improving relationships between ethnic minority communities and healthcare providers. Strong social ties, trust, and the ability to move between and across community and healthcare settings allows CHWs to make contacts and connections and bridge gaps (Peretz et al. 2012).

Importantly, participants in this study represented programs administered at local, community levels as opposed to larger-scale, national programs as seen in the international CHW literature (Earth Institute 2011, World Health Organization 2007). Further, our research examined *promotora*-delivered programs focusing on a specific health issue (i.e., obesity) among a specific population group (i.e., U.S. Hispanic women), whereas CHWs working within the contexts of other national health systems have more expanded roles (e.g., provision of primary care services to rural populations). As one program participant commented, making assumptions about such very different CHW programs and models is akin to "comparing apples and oranges." Despite these differences, a common characteristic of the CHW approach is the selection and training of members of the target population to reach marginalized populations with health information and services (Gilson *et al.* 1989; HRSA 2009).

Although Hispanics are the largest ethnic minority in the US, they do not constitute a monolithic ethnic entity. Health status and access to care among Hispanics depends on set of complex interactions, including but not limited to ethnic heritage and background, cultural beliefs, attitudes and practices, nativity, immigration status, language proficiency and utilization, geographic location, and socio-economic resources (Jerant *et al.* 2008).

Therefore, *promotora* interventions need to be tailored to the social, cultural, linguistic, and environmental characteristics and contexts of local Hispanic communities.

Historically, lack of defined roles and activities for CHWs/*promotoras* led to challenges in sustaining community-based CHW-led programs (Earth Institute 2011). In our study, we found wide variation among program planners' descriptions of the *promotoras'* particular roles and activities. *Promotoras'* blurred role boundaries may negatively affect the type and amount of work they perform (e.g., overburdening *promotoras* with too many roles); may be related to work inefficiencies (e.g., oversight of work expectancies); and may provoke difficulties in *promotoras'* work environments (Brownstein *et al.* 2005, O'Brien *et al.* 2009, Swider 2002). Therefore, program planners should set parameters of activity levels and roles for their individual program's *promotoras* to reduce their risk of developing job burnout (Altpeter *et al.* 1999, Bishop *et al.* 2002, Brownstein *et al.* 2005). Having clearly defined role boundaries will also facilitate program planners' evaluation of *promotora* effectiveness (Altpeter *et al.* 1999). Program specific role definitions could assist researchers and practitioners in the development of evaluation criteria for selecting their program's *promotoras.* Such criteria could influence the type of interview questions or skills-based activities used to select future *promotoras.* As part of program evaluation, planners and researchers could interview health program participants to identify which of the *promotoras'* personal traits (e.g., personality characteristics) and more formal traits (e.g., language spoken) made them most effective and qualified to engage their communities to participate in the health program. Researchers could also interview program participants that remained in the study and those who discontinued the program to examine how the *promotora*-participant relationship affected the study or intervention participation. They could also conduct network analyses to measure how these community health workers expanded the healthcare information and outreach within their communities.

The implementation of standardized training programs and formalization of roles and responsibilities can foster sustainability of *promotora* positions within health programs (Earth Institute, 2011). In this study, program planners who advocated for *promotora* certification also saw the creation of role definitions as the first step to making this job a formal and sustainable position within healthcare organizations. This finding is consistent with research that advocates credentialing *promotoras* in order to formally recognize their role as a healthcare provider and, in turn, reimburse their work via government funding programs such as Medicaid and Medicare (Dower *et al.* 2006). Further, *promotora* certification has been linked to *promotora* career advancement, enhanced earning capacity, retention, personal status, and self-worth (Kash *et al.* 2007). Clearer role definitions and expectations in conjunction with recognized certification processes would not only contribute to *promotora* sustainability within specific programs and the broader healthcare system, but enhance individual well-being.

One of the major debates around CHWs revolves around their incorporation into the paid healthcare workforce. Currently, countries across Latin America, Africa, and Asia recognize and remunerate CHWs as members of the formal healthcare workforce (Jong-Wook 2003). The WHO reported an association between lack of monetary compensation and CHW/*promotora* turnover (Lehman and Sanders 2007). Although there is still considerable debate and controversy in the international literature about paying CHWs, there is little evidence of the long-term sustainability of programs utilizing volunteer CHWs (WHO 2007). Our findings indicated a wide range of opinions on the issue of *promotoras* as salaried workers or volunteers. We noted program planners tended to base their role conceptualizations regarding whether or not *promotoras* were treated as paid employees or volunteers on personal philosophies and financial considerations, a pattern consistent with past research (Swider 2002). Another interesting finding was how participants' philosophical approaches

may have influenced *promotora* selection procedures. When the role of *promotoras* was clearly defined as part of the paid multi-disciplinary healthcare team, program planners described more formal recruitment and selection processes, although the specific procedures varied based on program and organizational settings (e.g., university, FQHC, or CBO). In contrast, participants working in programs where the *promotora* role was strictly a volunteer position reported using more informal selection processes and providing small incentives (e.g., reimbursement for gas) for the volunteers. This approach is consistent with past research that concluded that offering multiple types of incentives (e.g., community recognition and reimbursement for expenses) was the best means to recruit and retain *promotoras* and CHWs (Bhattacharyya and Winch 2001).

Interestingly, even in programs where *promotoras* were paid employees, participants often reported selection criteria based on candidates' personal qualities (e.g., respected by the community) and skills (e.g., listening skills) rather than on formal qualifications such as education and experience. Similar to findings reported by O'Brien and colleagues (2009), these planners hired *promotoras* who exhibited "interest in subject material, willingness to learn, and compassion" (p. S264). Of note, there were no reports of *promotora* assessment or evaluation using specific or formal assessment tools, nor were there any reports of systematic assessments of candidates' characteristics or qualities. An important area for program planning and evaluation is the development of criteria to help identify individuals best fit to serve *promotoras* to engage their communities and, further, program evaluation which includes how the *promotora* influenced program outcomes.

Based on these findings, we expanded the ROLES model (Figure 1) to include more specific aspects of *promotora*/CHW role conceptualization (Figure 2). For example, we now include program planners' conceptualization of the role of *promotoras* and the overall CHW delivery model, how they define *promotoras* (Bishop *et al.* 2002), role expectations, whether or not the *promotoras* are paid for their efforts, and the level of involvement they will have within the intervention or program. We suggest the need for program planners to recruit and select *promotoras* based on program-specific role conceptualization and implementation. Role conceptualizations may differ based on intervention size, population served, program health focus, and expected *promotora* activities.

The modified model (Figure 2) also reflects ways in which both program planners and *promotoras* sustain the health program in their communities after the initial program funding has ended. Future researchers could examine and possibly modify program delivery and dissemination procedures and long term outcomes. This expanded model is a framework to guide planning, implementation, and evaluation of health programs. More clearly defined *promotoras* role expectations and boundaries will allow for more specific role evaluation criteria. Further, the use of this model could lead to the development of *promotora* recruitment, selection, and training protocols which would help promote greater encouragement of collaborations with *promotoras* in healthcare programs (O'Brien *et al.* 2009).

It is important to note the limitations of the study. Potential selection bias related to our use of a convenience sample exists; however, we used a purposive sampling technique to ensure a wide variety of planners' perspectives and experiences working with *promotoras.* Although this study provides a variety of planners' perspectives, due to the small sample size and the formative aim of the research study, it is difficult to categorize these programs (e.g., paid versus unpaid, use of formal criteria for *promotora* selection) and link them to program characteristics. Because outcome evaluation data was not available for all programs, we were unable to examine any measures of *promotora* program success or program planner satisfaction with the *promotora* model. Our findings should not be

generalized to the larger population of program planners working with *promotora*-led health programs for U.S. Hispanic women, but may inform the work of other planners and researchers.

Conclusion

This exploratory study examined how planners' *promotora* role conceptualizations are associated with recruitment and selection of *promotoras* among select programs serving U.S. Hispanic women. This is important because *promotoras* serve as the spokespeople of the community-based health programs and often as the bridge between specific populations and access to their country's healthcare system at large. In a global context, *promotoras* provide care to marginalized populations, particularly within countries that struggle with a shortage of healthcare providers (Jong-Wook 2003).

We asked participants for the specific details, criteria, and processes by which they selected *promotoras* for their health programs. Program *promotora* position descriptions differed according to the type of program being held, the program's health focus, program context and environment, and required *promotora* qualifications. The findings suggest that *promotoras'* role descriptions and boundaries may be delineated, negotiated, reviewed, and revised as programs evolve. This is an area for further consideration by researchers and CHW program planners, as role descriptions and parameters influence the type of training *promotoras'* need, the activities they perform, and the degree to which they are integrated into the community and overall health system (Haines *et al*. 2007).

U.S. and international-based *promotora*-led programs have been successful in linking underserved populations and communities to healthcare, thus reducing health disparities (Lehman and Sanders 2007; Ingram *et al.* 2008). The outcomes of this study may apply to health program planners worldwide to demonstrate the need to create program specific *promotora* position descriptions which may, in turn, reduce the ambiguity of *promotoras'* position within the healthcare setting (Lehman and Sanders 2007). It may also guide the development of protocols for recruiting and selecting *promotoras* while also leading to further development of evaluation methods for *promotora* programs (O'Brien *et al.* 2009). Ongoing attention to consistency and congruence across *promotora* role expectations, recruitment and selection criteria, and training, support, and evaluation processes will contribute to enhancing the effectiveness of *promotora*-delivered community health programs and potentially lead to expediency in addressing health disparities. Further, *promotora* program effectiveness data could support the need to integrate this workforce into permanent, sustainable positions into national healthcare systems (Brownstein *et al*., 2005; Lehman and Sanders, 2007).

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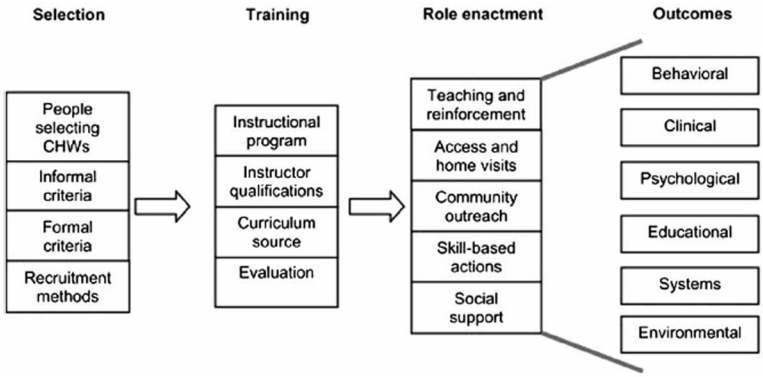

Figure 1.

O'Brien *el al.'s* (2009) Role-Outcomes Linkage Evaluation Model for Community Health Workers.

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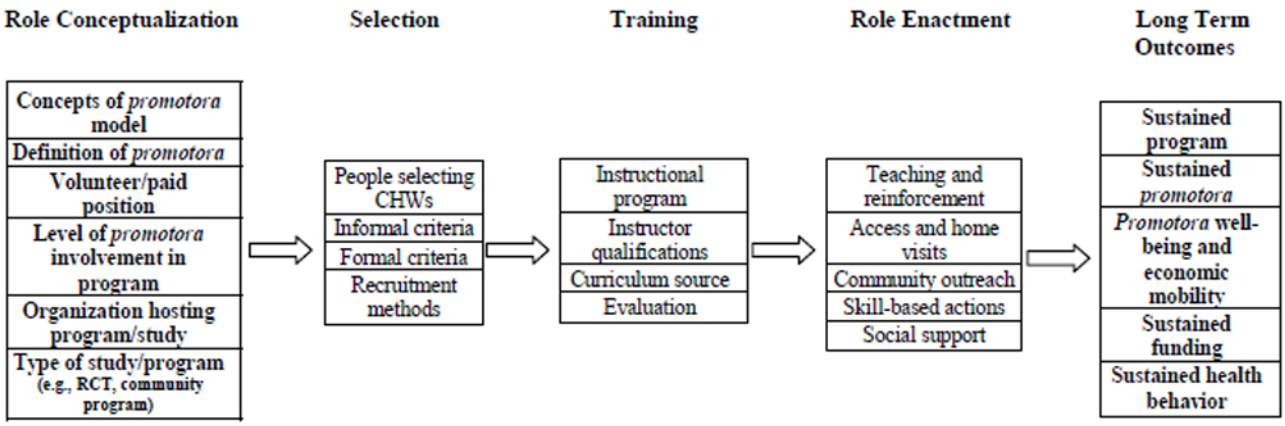

Figure 2.

Linking *Promotora* role conceptualization. preparation, enactment, and outcomes (Adapted and expanded from O'Brien *el al.* (2009) for *Promotoras de Salud).* Components presented in bold font are based on this study's research findings.

Table 1

Example questions and probes from the in-depth interview guide.

In general, what do your program's *promotoras* do?
• What are their specific responsibilities in (name of program)?
• How do their tasks/responsibilities compare to other staff/volunteers?
• What role do they play in participant recruitment?
• In conducting formative research?
• In conducting pre- and post-evaluations?
How did you recruit your *promotoras?*
• How did you advertise the program?
– What informal criteria (e.g.. personality traits) did you look for in your *promotoras*?
– What formal criteria (e.g.. education) did you expect for your *promotoras*?
How did you measure how your *promotoras* delivered the health program?
• How did you evaluate how they taught or led the intervention?
– In what ways did they work with or support the community?
• How did they meet with the community (e.g.. access and home visits)?
• What types of community outreach did they perform?
• Please describe any process evaluation techniques you used to ensure that dose and fidelity of the program being delivered.