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Engaging Men as Promotores de Salud: Perceptions of Community Health Workers among Latino Men in North Carolina*

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Abstract

The *promotor de salud*, or community health worker (CHW) role, is highly feminized and little is known about how men view their participation in CHW programs. We conducted in-depth interviews with Latino men in North Carolina to explore this gap. We used systematic coding and display procedures informed by Grounded Theory to analyze the data. Men described their communities as lacking cohesion, making integration of Latino immigrants difficult. Most did not consider themselves leaders or feel they had leaders in their communities. Their perceptions of the feminized CHW role as well as the volunteer or low-paid nature of CHW work conflicted with men's provider role. They also did not think they could perform the CHW role because they lacked education, skills, and broad networks. Efforts to increase male participation in CHW programs in new Latino immigrant destinations will need to understand and address these gender and migration-related dynamics in order to engage both women and men in improving the health of their communities.

Keywords

Community health workers; Men; Latinos; Community participation; Immigrants

Introduction

The use of *promotores de salud*, or community health workers (CHW), has been adopted as a culturally and linguistically appropriate health promotion strategy to address the unique health needs of the Latino population in the United States. In a recent nationwide study, 35% of CHW were Latinos, two times the percent of the US population that are Latino (17%) (1) and 76% of the CHW programs targeted Latino populations (2).

Recent US policies to reduce health disparities have encouraged the use of CHW approaches. In 2010, President Barack Obama signed the Affordable Care Act (ACA), which formally recognizes and provides funding for CHW-based programs (3).

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Additionally, in 2011, the US Department of Health and Human Services (HHS) launched the Action Plan to Reduce Racial and Ethnic Health Disparities. The Plan includes a Promotores de Salud Initiative to "promote the participation in health education, behavioral health education, prevention, and health insurance programs" of the Latino population (4). Given the institutionalization of the CHW role and availability of resources for CHW programs, it is essential to ensure that such programs and interventions are effective, sustainable and responsive to the needs of the populations they are intended to serve.

The public health literature highlights several key characteristics of CHW. First, CHW are considered natural leaders and advocates for the health and other rights of their communities, through community organization, mobilization and empowerment activities (5–8). They are bridges and cultural mediators between communities and the formal health care system by facilitating access to health care, providing health care system navigation, and conducting outreach and/or enrollment in services (9; 10). CHW provide culturally appropriate information through health promotion activities within their own communities, as well as counseling and social support (6; 9). More recently, CHW have also been incorporated into community-based participatory research projects (7; 11–13). Second, CHW are usually members of their target communities and, thus, are considered knowledgeable and aware of the community's needs (14). Finally, since most CHW are unpaid or low paid "volunteers", they are considered a low-cost and potentially sustainable way to assist underserved communities (4; 6; 15–17). Another characteristic of most CHW is that they are women; in the US, the CHW population is over 80% female.[2] The CHW profession has gone through a process of feminization since its initial phases in the early 1960s (6; 9; 18; 19). One explanation for the feminization of CHW is that women were often the principal target audience of maternal and child health education and promotion activities (18). Women were, and still are, considered responsible for the health of their families, which translated into a responsibility for the health and wellbeing of their communities (18; 20). Other explanations emphasize the relative ease of recruiting women who did not work and wanted to do other activities beyond their household duties (19–21).

One question that has not been addressed thoroughly, though, is the reasons why Latino men are less engaged than women in CHW initiatives (22; 23). There are a few examples of programs that have engaged Latino men as CHW and little research to better understand Latino male involvement in CHW activities. One exception is the HOMBRES and HOLA programs developed by Rhodes et al, in which Latino men have been successfully recruited to promote sexual health, including the use of condoms, among their peers (24; 25).

Given the institutionalization of CHW within the ACA policy and HHS agenda for health equity, CHW there is a growing interest and need to identify ways to engage men more actively as CHW in health promotion efforts to engage broader sectors of the population. We aim to understand how Latino men living in North Carolina (NC) perceive the role and characteristics of *promotores* in their communities and reflect on how and if men can be engaged as active participants in CHW programs.

Methods

Study setting

In 2000, Latinos in NC made up only 3% of the state population. After 2000, NC became a preferred destination for new immigrant populations coming from Latin American countries, as well as Latinos coming from other states in the United States (26). Currently, the Latino population comprises 9.0% of the NC population, and they are mostly young, unmarried foreign-born men (27). An estimated 42% lack any form of authorized migration status (28). The NC state government has responded to this demographic change by implementing state-level restrictions that limit immigrants' rights in an effort to stem immigration trends. Despite this unwelcoming context, the high costs and dangers of travelling back to their countries of origin and the relatively stable economy of the region has resulted in the continuing reunification and settlement of Latino families in NC (26; 28).

Study approach

We used an inductive qualitative approach (29). We chose qualitative methods because we anticipated that men's perspectives and experiences related to CHW programs would require in-depth conversations to explore the intersections of culture, migration, poverty, and gendered constructions of health (30). Through our iterative fieldwork process, we listened to men's lived experiences and discourses around health and gender, probed to obtain a richer understanding, and adjusted questions as needed throughout the course of the study.

Our approach was also informed by community-based participatory research principles (31). The study objective to explore men's attitudes towards CHW programs was conceived of by Latina promotoras in a photo-voice project in which they identified a lack of male health promoters as a barrier to health promotion in their communities (32). We developed the recruitment strategy together with the promotoras, received their input on the interview guides, and held interactive feedback sessions throughout the data collection and analysis processes.

Sample

Our recruitment criteria was being male, at least 18-years-old, self-identified as a Spanish-speaking Latino, and living in one of 4 NC counties for at least 1 year. We recruited men through various mechanisms including churches, community clinics, local organizations, referrals from promotoras, local day labor sites, the regional Mexican consulate, and participant referrals. Our final study population included 15 men. We stopped recruiting when we reached saturation of key themes related to our study aim, for example, men's uses of time and participation in community health-related activities (33).

Data collection

We conducted interviews between June and September 2012. Informed by the literature about the CHW role and input from community members and promotoras, we explored men's perceptions of their time and time constraints, sources of health information, leadership, male responsibility, and community participation (15; 21; 22). While we selected these topics *a priori*, we used open-ended questions and extensive probing to obtain

participant's perspectives on these topics and generate new understanding of their meaning (29).

All participants provided verbal consent and received a $20 gift card for their participation. Except for one, all interviews were conducted in Spanish. A female graduate student trained in qualitative methods and a native of Mexico conducted all interviews, with exception of one (conducted by another female graduate student). The Office of Human Research Ethics at our institutions approved this study.

Data analysis

We used an inductive approach to analysis informed by the principles of Grounded Theory (29). The interviews were audio-recorded and transcribed verbatim by a professional transcription service and reviewed for quality by our team. We used Atlas.ti7 software to assist with data management and coding (34).

After an initial round of reading transcripts and memoing to identify key themes, we conduced line-byline coding. Next, we moved to focused coding, where we aimed to synthesize and explain larger segments of data.[29] Through this process, we generated a smaller number of codes that we grouped into 7 major categories: 'community'; 'time'; 'masculinity'; 'migration'; 'health'; 'sexual and reproductive health'; and 'work'. After that, we created visual depictions of the data including matrices and clustering, to clarify our understanding of the central ideas (29). We wrote analytic memos throughout each of these steps, which formed the foundation for this paper.

Results

Results are presented in 4 sections. We first describe the general characteristics of the study population to provide context for the interpretation of our findings. In the next three sections, we present key themes related to characteristics of CHW as described in the introduction including: 1) men's descriptions of their communities; 2) men and volunteerism; 3) men's community leadership and participation as *promotores de salud*. Throughout these three sections, we aims to show how the lived experiences of Latino men are far removed from the expected characteristics of CHW, which, we argue, results in the lack of men's identification with the CHW role and their minimal participation in community-based health activities.

General characteristics

All men were born outside the US, the vast majority in Mexico (Table 1). Participants were between 21 to 53 years old. Three men were single, two divorced, and the rest were married; among married men, all but two lived with their families in NC. Ten out of the 15 men had at least one child. Time living in the US varied from 6 to 24 years. All men were literate in Spanish, although levels of formal education varied between second grade of elementary school to technical degrees and some university-level training. Almost all men were either employed or day laborers and most of them have been in their current job for over a year. Types of employment included farming, painting houses, gardening, working in restaurants and grocery stores, construction, managing apartment complexes, and electrician. A couple

of men were seasonal migrants but had been coming to work to NC for more than 4 years for periods between 4 to 9 months each year.

Men's descriptions of their communities—Participants provided mixed opinions about the Latino communities in which they lived. Men who had been living in NC longer described the visibly greater presence of Latinos, compared to when they first arrived, and greater access to many material goods and services in Spanish. Due to the 2008 financial crisis and recent migration restrictions, however, some men felt that it was more difficult for Latinos arriving to NC more recently to find jobs and affordable housing, access health services, and get a driver's license. Some participants described that the harsh immigration environment has created fear among Latinos due to the legal consequences of living without documents.

According to some men, discrimination and racial profiling of the Latino community also contributed to the current climate of fear. Participant 3, a 21-year-old who had spent most of his life in the US, mentioned observing this racism in situations when some of his Latino friends did not speak English:

> "I feel like the majority of my friends that are Latino arrived 5 or 10 years ago, they haven't been here long and they're just starting to master English and are trying to understand how to speak it, how not to speak it. (…) It's definitely a barrier here because I feel like there's some racism. Like, for example, I have some family in [(a bigger city in the West Coast of the United States]) and there I feel like they are more excited to speak with other Latinos than here. I feel like it's more closed-minded here."

With regard to community dynamics among Latinos, some men did not feel the Latino community was cohesive or organized. Participant 8 felt the Mexican community in particular was less organized than people from other countries, "(…) *especially us Mexicans, we are very disorganized. Others are more united, for example, the Hondurans, the Salvadorians are more united*." He also believed that due to the violence and discrimination experienced by Central Americans when crossing through Mexico on their way to the US, they dislike Mexicans and tend to form their own country-specific groups. In addition to this ethnic-segregation, participants also described discrimination, racism, and classism within the Latino community that limits community cohesion. For example, participant 8, who migrated from a big city in Mexico to the US, only spent time with his family and American-born friends because he did not identify with less educated Mexican migrants from rural areas. When describing the challenges of working with the Latino community, some participants used derogatory words to describe "other" Latino men, including "stupid", "lazy", "small-minded", and "uneducated".

Another barrier to engaging with the community described by some of the participants was social isolation. As participant 1 expressed "(…) *I feel trapped at my house…I mean, I tell them [that] here I have it all, but really, I have nothing, I don't have anyone. But, I'm not talking about my daughters or my wife, but rather, as I said, regular people, people you can call friends or pals.*" Although participant's 1 wife and children lived with him in NC, he lacked a cohesive social network with whom to share other activities.

Men and volunteerism—Some men indicated that they were not interested in volunteering their time for community health activities; they felt their responsibility as immigrant men was to have a job and make money to support their families (both in the US and in their country of origin). Participants reported that they spent most of their time working, looking for a job, talking about their jobs, or thinking about not having enough work. Work, and the time spent at work, was the most important thing for these men.

Work was also important because making money and being able to save money was the main motivation for migrating to the US. Participant 2, for example, derived satisfaction from being able "*to bring something back home*" every day. Participant 5, a temporary worker, said "*I came to the United States to work and earn money because in Mexico, well, there isn't any.*" He kept his focus on work and earning money so that he could return to his family in Mexico after having met his financial expectations.

Besides the economic value of working, some participants also expressed cultural appraisal for work. Participant 10 shared a very strong belief that Latino men work harder than non-Latino men in the US, "*work is something that you like, and it is fulfilling. It is a way of life*." For him, working hard was part of his identity both as a man and as a Mexican. Importantly for considerations of CHW, participant 10 did not consider 'volunteering' within his definition of work and therefore not part of his "way of life". Additionally, participant 7 sharply pointed out that Latino men already contributed to their communities, whether it is recognized as such or not:

> "(…) when [men are] asked much other than what they are already doing, which is hard enough work on its own. (…) building houses, working hard labor, you know, and that's all… in my opinion, that's already service enough and besides that, I doubt they [men] would be willing to lend a hand in the community."

Participant 7 reflects the tension around the fact that the contribution of Latino workers to US society and the economy is not sufficiently recognized. This not only engenders disinterest among Latino men to engage in volunteer work, but also could contribute to divisions between the Latino men and the community at large.

Work also helped some men buffer the stress caused by economic responsibilities, family and personal problems, and immigration-related issues. Men often recounted that working allowed them to avoid feelings of anxiety or despair due to life stressors. For this reason, most men also kept themselves busy at home, doing home improvements or preparing their things for the next work day. Some of them also reported helping with the domestic chores, although this was less frequent. Work and keeping busy were also strategies to make time pass more quickly, especially for those that hoped to go back to their country of origin once they had met their financial needs.

Men's community leadership and participation as health promoters—An important characteristic of CHW is their willingness and desire to take on leadership roles in their communities. When we asked men to identify leaders in their communities, they mentioned doctors, local government authorities or owners of Latino-oriented businesses. Only three participants identified themselves as community leaders based on the fact that

they shared information about health and immigration issues through a radio program, provided information to people that have recently immigrated to NC, or organized community activities (e.g. soccer matches and religious celebrations).

While some men described taking on occasional community leadership roles and activities, when we asked about taking a leadership role by becoming CHW, men were not certain about what that role would entail. Some men correctly guessed about what CHW do, saying phrases such as “they promote health” or “they give out health-related information”, while others simply responded that they did not know what a CHW did. After the interviewers briefly explained to men some of the activities CHW do, the men mentioned that women are better prepared than men to be CHW. Some of the reasons were that women have more free time, have more energy to do various activities during the day, and are more concerned about the health of the family. The testimony of one of the men interviewed (number 7) is a good summary of what men thought about women’s engagement in health-related issues.

> Participant *“(…) women are more…they’re more occupied with housework, activities with the kids, in the schools…and these are things that a man wouldn’t call work. But, in reality, the woman works…works a lot! And she doesn’t get any sort of economic payment.*
>
> Interviewer: *What do you think motivates them [women] or makes them take time for these activities?*
>
> Participant: *Well, honestly, I don’t know how they do it, but they have time for everything! Yeah, well, there are women that are very interested in health, mostly for their kids. I think that they do it with the future in mind to be able to get some sort of help sometime and know where to turn, where to go, where you can get health services or things like that.”*

Men also believed that women needed more health information because women’s bodies are more “delicate” and “require more attention”. In contrast, men acknowledged that they themselves avoided seeking health services because they were afraid to know if they were sick and it was easier to just avoid preventive health screening. Men also stated that women have more contact with health services because of their pregnancies and reproductive health needs, whereas men have to actively seek them.

Likewise, men thought that it was easier for women to talk about health with other people, particularly other women, because they have ties with people in their communities that they form and reinforce regularly when they drop kids at school or when they use social services for the wellbeing of the family. In contrast, men are frequently absent from those spaces or they only take part when their presence is required. The perception that women have a natural ability to talk about health also contributed to men’s opinions on why women are better CHW.

When we asked men about their perceived ability to be a CHW, nearly all men reported that they did not think they could become CHW or health leaders. They expressed that even though they had considered attending certain activities, they did not feel the confidence to just show up and start participating in community health programs and they were

embarrassed to speak in public. They also thought they lacked the necessary education to perform the CHW role appropriately, especially their lack of clinical training to identify diseases or prescribe medicines. Others reported feeling tired after work and lacking the motivation to leave their homes after the workday. Yet others said they would only go if the activities were held in the same town or neighborhood where they lived because they did not want to drive far. Lastly, men were not confident that they were able to talk about health with women, and questioned if it was the "correct" thing to do. Providing health-related information was seen as something that should be done by women and people with specific training and, therefore, participants did not identify with the CHW role.

Discussion

Through our analysis of men's descriptions of their communities and perceptions of CHW, we identified a mismatch between the characteristics of CHW reported in the literature and the realities of Latino immigrant men in NC. We found that Latino immigrant men's lack of participation in CHW-based programs in NC is shaped by traditional gender roles, migration experiences, and the nature of their communities. We identified men's reflections of the process of feminization of the CHW role, particularly the conflict between the CHW role and their economic provider role. Additionally, we also found that the engagement in CHW programs is inhibited by their experiences as migrants living in communities that lack cohesion.

Participants highlighted the distinct roles and responsibilities of men and women in their community, which contributed to their perceptions that women are inherently better at being CHW. We observed through our interviews that some men have adopted very distinct roles from women in terms of economic responsibilities, health, and community engagement. Most of these men fully ascribed to the role of economic providers, which, in combination with their migrant identity, translates into an urgent and continuous need for paid jobs (35–37). Nevertheless, these arrangements are not static. Other authors have observed that the migration process requires that men and women continuously negotiate and adapt their roles (38). For example, when men's income is not sufficient, women get incorporated into the labor force, which was the case for several of our participants' wives (35; 36; 38). Yet, we did not observe that men readily considered taking on non-traditional male roles related to health and community engagement. And, even if they wanted to do so, they felt they lacked the social capital, knowledge and skills that women have. All of the above contributed to the somewhat static nature of the role arrangements observed among Latino men and women in relation to health and community participation.

We also found a mismatch between men's sense of purpose and identity as paid workers and providers and the definition of CHW as volunteers or low-wage workers. We found that this conflict holds even when men do have the time for community activities -in low season or when unemployed -since the real problem is not absolute time, but rather a lack of identification with the volunteer nature of the CHW role. In the case of *promotores* programs, women have been the ones bearing the costs of the "low-cost" initiatives, particularly women that are either unemployed or underemployed (16; 17). Moreover, men

did not see the other possible benefits of participating in community programs, such as the network building and social capital.

We also found that men perceive their community to be lacking cohesion and leadership. Even though the area where we conducted the research has one of the highest concentrations of Latinos in the state of NC, some men perceived a non-cohesive Latino community. During our fieldwork and through the interviews, we witnessed that men (and their families) live far from each other and their movement is constrained by the lack of public transportation, disperse suburban neighborhoods, and the restriction to get driver's licenses. Viruell-Fuentes and colleagues similarly described how limited access to transportation, economic demands, and lack of documentation prevented recently immigrated Latinos from expanding and diversifying their ties and networks in Chicago (39). Another study recently conducted with immigrant men in a similar location to our study (e.g. new settlement area, medium population density) showed that Latino men thought one of promotores' main activities should be to help to the development of trust and familiarity among community members, and connect them with the broader community (40). Taken together, these findings highlight the need to strengthen community ties and increase men's networks in order to create a context that is favorable for male involvement in CHW programs.

Other perceived barrier to engaging in CHW programs were men's self-assessments of their own education level and ability to engage in health-related conversations with other men and women in their communities. This shows another mismatch between the discourses about CHW's low education characteristic and natural leadership and men's lack of identification with those characteristics, presenting a real deterrent for men to embrace the CHW role. The lack of formal health-related education as a perceived barrier has been documented in other CHW programs, and it has been overcome through long-term investments in continuous training, including leadership training (6; 21). If programs want to include men as CHW they need to reassure them by emphasizing that the process of knowledge building and community recognition requires time but will develop.

Most men did not self-identify as leaders themselves nor could they identify Latino male leaders in their communities. This is an important finding because studies among *promotores* have shown that the ability of CHW to successfully carry out community advocacy and community mobilization activities depended on their belief that they were leaders and that they could influence community decisions (8; 15). Among the men we interviewed, the lack of community leaders and the lack of self-perception as leaders highlight that the idea of "natural" leaders or helpers may not be that natural. Leadership needs to be built and fostered via a sustainable investment that aims to empower the community as a whole. This requires thinking beyond the individual-level interventions that aim to modify specific health behaviors, and instead design interventions that look at community empowerment and community-level systems. Building the community capacity to organize and facilitate the creation of healthy social environments should become one of the objectives of CHW programs (40).

Conclusions

Latino men's lack of engagement in CHW programs is facilitated by traditional gender roles, challenges faced by Latino men's immigration status and migrant identity, as well as by the characteristics of the Latino community at large in NC. Latino immigrant men in NC are also concerned with economic production to support their transnational families and do not feel they can engage in unpaid work. Efforts to increase male participation in CHW programs in new Latino immigrant destinations will need to understand and address these gender and migration-related dynamics in order to engage both women and men in improving the health of their communities.

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Table 1

General characteristics of men interviewed

Participants	Age	Place of Birth	Time living in the US	Time working in the same place	Education level	Marital Status	Number of children
1	42	South America	7 years	5 years	Technical college	Married	2
2	49	Mexico	18 years	18 years	Incomplete middle school	Married	2
3	21	Mexico	17 years	Student, does not work	Senior College	Single	0
4	24	Mexico	6 years	4 weeks	Middle school	Married	0
5	49	Mexico	12 years	12 years (seasonal worker)	High school	Married (family living in the place of origin)	4
6	38	Mexico	4 years	4 years (seasonal worker)	Incomplete primary school	Married (family living in the place of origin)	3
7	N/A	Mexico	16 years	Does not work or study	Some college education	Single	0
8	47	Mexico	24 years	18 years	Some college education	Divorced	2
9	32	Mexico	14 years	11 years	Incomplete middle school	Married	4
10	43	Mexico	+ 20 years	9 years	Technical college, and some college education	Married	2
11	45	Mexico	20 years	6 years	Primary school	Married	3
12	52	Mexico	13 years	4 months	Some college education	Married	2
13	36	México	17 years	8 years	Middle school	Single	0
14	34	Mexico	13 years	6 years	Incomplete primary school	Married	2
15	48	Mexico	14 years	14 years	Technical degree	Divorced	0

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