**On the Front Lines of Prevention: *Promotores de Salud* and Their Role in Improving Primary Care for Latino Women, Families, and Communities**

**Abstract**

There are thousands of studies that have documented the history and effectiveness of community health workers (CHWs) and their evolving role in population health over the last several decades. However, few published literature reviews have focused on the contributions of Latin/o CHWs (e.g. *promotores*) in developing countries and disadvantaged communities within the United States. This article presents a review of the scholarly literature published in the last decade (2005-2015) and illustrates the important role promotores have played in improving primary care for Latina women, their families and communities. After filtering articles by inclusion criteria, the authors reviewed the final sample of 63 articles. Seven categories emerged from the literature: 1) factors that motivate individuals to become promotora/es; 2) descriptive characteristics of promotores and their settings for practice; 3) health issues most commonly addressed by promotores; 4) the effectiveness of programs involving promotores and lay health models; 5) the impact of lay health work on self-efficacy; 6) the power of promotores as social change agents; and 7) best practices for training and supporting promotores and their integration into health systems. This review provides a snapshot of the evidence and ample support that promotores, in their varied responsibilities and settings, are essential partners to improving primary care for women and medically underserved communities.

Key terms: community health worker; promotores de salud; promotores; lay health worker; primary care

Introduction

Women around the globe, in both developing countries and low income areas of developed countries, face challenges accessing basic health care and primary prevention. In 1970, the World Health Organization (WHO), in response to the failure of the Malaria Eradication Campaign, challenged Western medicine’s emphasis on tertiary care, especially for those in resource-poor areas. In the Alma Ata Declaration of 1978, the WHO emphasized that the delivery of medical care was only a limited part of improving individual and population health (WHO, 2007). Vertical (e.g. “top down”) ideologies soon gave way to a focus on primary prevention involving community and grass roots approaches and focusing on strengthening individual and community capacity. Historically, this paradigm shift led to the formation of many lay health worker (LHW) programs in low income regions of the world such as the “barefoot doctors” in China and the emergence of Promotores de Salud (Spanish for “promoters of health”) in Latin America and Latina/o communities in other parts of the world.

Lay health workers are known by many different names throughout the world, including (but not limited to): *community health worker* (CHW), *Promotores de Salud (*Spanish for “promoters of health”), p*romotora* (Latina female health promoter) or *promotor* (Latino male health promoter)*, or promotores* (Spanish gender neutral term for health advisors); *health advisor*, *health promoter*, *village health worker*, *peer advocate*, and *patient navigator*. The diversity of terms reflects the different typologies and settings for lay health workers: some are volunteers, others are paid; some work in rural settings while others work in urban communities; some are focused solely on navigating individuals to (and through) hospital systems and healthcare, while others may have a broader scope of practice, engaging in more community organization and advocacy work, etc. (WHO, 2007). One of the most common umbrella terms for lay health workers, “community health worker” (CHW), is defined by the World Health Organization as someone who is “trained to carry out one or more functions to healthcare” (WHO, 2007, para 3). However, a CHW is not a health expert such as a doctor, physician assistant, nurse, or allied health professional. A widely used description of CHWs by WHO (2007) is as follows:

“*Community health workers should be members of the communities where they work; should be selected by their 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 should have shorter training than professional workers* (para 4).”

The American Public Health Association expands this definition by acknowledging the broad range of lay health worker responsibilities, outside of just healthcare, including health advocacy:

*“A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy”* (APHA.org).

*Promotores* work primarily in Hispanic/Latino communities and are community health workers who are “respected and visible,” and “share a common identity with the members of their community” ([Hansen et al., 2005](#_ENREF_21)). No matter the term used to describe them, the role lay health promotors play in primary care, community health, and advocacy is similar from country to country: community health workers have proven to be vital contributors to global and population health and are important liaisons between health systems and communities. They are often women who are trusted members of their communities, and who provide culturally relevant health education and outreach to an array of audiences, but especially to groups underserved and/or marginalized.

The history of lay health workers spans decades and includes a vast body of research. A search by the authors for articles relative to lay health workers and CHWs in CINAHL, Ovid, PubMed, and Medline retrieved more than 4,000 articles published just within the last three decades (Figure 1). However, what has been written specifically about *promotores* and their contributions to Latin communities over the last ten years? What contributions have they made to population health and primary care for women? The focus of this critical review of the literature is to provide a snapshot of promotores and their contributions, globally, to improving the health of Latina women, their families, and their communities. Guiding questions for this review include the following:

* *What motivates individuals to become promotores?*
* *What are demographic characteristics of promotores?*
* *What are practice settings and health issues most commonly addressed by promotores?*
* *What are the factors that keep promotores engaged in this work?*
* *Are health promotion programs involving promotores effective in terms of improving health outcomes and cost?*
* *What can we learn from the literature about required training or certification of promotores globally?*
* *How does working as or with promotores impact self-efficacy, feelings of social connectedness, and community engagement?*
* *What barriers do promotores face in their practice that impact retention and their integration into national health systems?*

**Methodology**

The authors examined literature relating to the work and role of promotores over a four month period using four search engines: CINAHL, PubMed, Ovid and Medline. The search terms used were ‘Promotoras de Salud,” “Promotores de Salud,” ‘promotoras,” “promotor,” “promotores,” and “Latina CHW.” Most often, the term “CHW” was synonymous with those search terms, but only articles that used the term “CHW” to describe Latina/o CHWs or promotores were included in the sample. Search terms were explicitly mentioned in the article abstract and/or title. A total of 210 articles were retrieved from this initial search. The articles in this original sample were filtered further to only include articles written in English, published within the last decade (2005 – 2015), and to those which had undergone the process of peer review. The authors did not exclude studies where promotores provided services to women and their families, too. For instance, articles that discussed promotores’ involvement with cardiac disease prevention programs were included in the sample since heart disease is a leading chronic killer for both women and men. The search excluded articles which solely focused on the curriculum development process for promotores (e.g. selecting materials; pilot testing), although this is definitely a topic worthy of another literature review.

After extracting articles that fell outside of the search criteria (Figure 1), the sample was reduced to 87 articles. These included Cochrane systematic reviews. After reading the abstracts and skimming through all 87 articles, an additional 24 articles were excluded from the sample because they did not meet inclusion criteria. This narrowed the final sample to 63 (Figure 1). Characteristics of these studies were then organized into a literature matrix to compare descriptive information about the sample, study outcomes, and topics relative to the guiding questions. The full matrix was not included as a table in this article due to its size (it spanned 18 pages). However, the references listed in this article reflect the breadth of the sample and include both empirical and non-empirical peer reviewed articles published within the last decade (2005 – 2015).

[Insert Figure 1 here]

**Results and Discussion**

By examining the literature in the study sample (n = 63), we gained valuable insight on the guiding research questions and seven categories emerged relating to the work of promotores: 1) factors that motivate individuals to become promotora/es; 2) descriptive characteristics of promotores and their settings for practice; 3) health issues most commonly addressed by promotores; 4) the effectiveness of programs involving promotores and lay health models; 5) the impact of lay health work on self-efficacy; 6) the power of promotores as social change agents; 7) best practices for training and supporting promotores and their integration into health systems.

1. **Factors that motivate individuals to become promotoras/es**

Only a few published, peer-reviewed studies have explicitly examined motivating factors for becoming promotoras/es (Alfaro-Trujillo, Valles-Medina & Vargas-Ojeda, 2012; Hanson et al. 2005; [Ruano, Hernandez, Dahlblom, Hurtig, & Sebastian, 2012](#_ENREF_50); Sherrill et al., 2005; Squires & O’Brien, 2012). Ramirez Valles (1998) first provide a compelling historical overview of the CHW role and its place within various societies and cautioned that the relationship between promotores/CHWs and their employers (or host organizations) could replicate colonial and oppressive power relationships. Hansen et al. (2005) examined motivating factors of promotoras in Guatemala, and found that many promotoras reported a desire to become a health professional. When funds for schooling were limited or non-existent, or proximity to a medical school posed a barrier, becoming a promotora was the next best option ([Hansen et al., 2005](#_ENREF_21)). Or, as Squires and O’Brien (2012) found in their qualitative study, some promotoras were led to serve in the role because they had immigrated and could not practice in their profession in their new country. Altruism, social recognition and gaining additional knowledge on health-related issues were other motivating factors mentioned in the research (Alfaro-Trujillo, et al., 2012; [Hansen, et al., 2005](#_ENREF_21); [Sherrill et al., 2005](#_ENREF_53)).

A number of studies indicated that promotores describe their work as a “service” to their community ([Albarran, Heilemann, & Koniak-Griffin, 2014](#_ENREF_1); Alfara-Trujillo, Valles-Medina, & Vargas-Ojeda, 2012; [Ingram, et al., 2008](#_ENREF_22); [Keller et al., 2012](#_ENREF_27); [Reinschmidt, et al., 2006](#_ENREF_49); [Sabo et al., 2013](#_ENREF_51); [St John, Johnson, Sharkey, Dean, & Arandia, 2013](#_ENREF_56); Squires & O'Brien, 2012; [Tran et al., 2014](#_ENREF_58)). The intrinsic rewards that come from serving in the role of a promotor/a, and a deep the desire to help others was a strong theme throughout the literature. Squires and O’Brien (2012) reported that the initial reasons promotores gave for participating as a CHW were “It’s an interesting project” and “Ayudar a los demos”—to help others (p. 463).

Additionally, promotores in the studies reviewed often expressed a desire to assume an active leadership role in their communities (Ruano et al., 2012) or to achieve social recognition (Glenton, et al., 2013). As one promotora explains, “*I want more light in my life and to give this to others as well. To do something more…*. “ (Squires & O’Brien, 2012, p. 463). The work of being a promotor/a is often viewed by the promotores as transformative not only for the communities they serve, but for the individual (Alfaro-Trujillo, Valles-Medina & Vargas-Ojeda, 2012; Hanson et al. 2005; Sherrill et al., 2005; Squires & O’Brien, 2012; Wiggins et al., 2009).

One compelling example of this is provided by a promotora in a study by Squires and O’Brien (2012):

*“I am reminded we can make the decision to take control of our own lives, and above all, to feel happy as women, knowing that we are our own bosses…..You must take control of yourself…know your body, know your mind, know your soul, know you –as a human being and woman” (p. 464).*

Financial compensation *did not* emerge as a *primary* reason in the published literature for becoming a promotor/a ([Glenton et al., 2013](#_ENREF_20)). Alfaro-Truillo et al. (2012) reported that the pay for most promotores was often in the form of travel reimbursement, food, medication, or cash (Alfaro-Truillo et al., 2012). As mentioned earlier in this article, service and “wanting to help” was the leading factor often cited. However, this does not mean compensation was not a consideration at all. For example, in a 2012 study examining profiles, perceptions, and motivations of promotores working with NGOs on the US-Mexico border (Alfaro-Trujillo et al., 2012), promotores reported that they had to reduce their involvement with NGOs and participation in lay health promotion activities “due to lack of economic compensation for their community participation” (p. 588). In the same study, the average monthly income for a CHW near Tijuana was $400 USD. Promotores often work and volunteer with organizations that are are operating with very limited funding. Promotores may attrite or reduce their involvement in search of other sources of income (Alfaro-Trujiollo et al., 2015). Furthermore, Ingram, Sabo, Rothers, Wennerstrom & de Zapien (2008) found that promotores who were full-time employees outside of their promotor/a role, received a stipend, or who were paid hourly by an employer for non-related promotor/a work, were more likely to express that their primary motivation they took up the role of the promotor/a as a way to give back to their communities ([Ingram, Sabo, Rothers, Wennerstrom, & de Zapien, 2008](#_ENREF_22); [Stacciarini et al., 2012](#_ENREF_57); [Wasserman et al., 2006](#_ENREF_60)) compared to promotores that did not work full-time and who derved in more economically marginalized communities where jobs were scarce.

Throughout the literature examined, there was a tension between the idea of promotores as “volunteers” versus “health workers.” One notion can be viewed in direct opposition to the other. Some view the emerging “profession” of promotor/as new opportunities for employment and empowerment, while others view the institutionalization of the CHW role as “altering the core elements that could help them develop quality relationships with members” (Arvey & Fernandez, p. 1636). Arvey and Fernandez (2012), quoting seminal work from Witmer et al. (1995), offered this view:

“*Although such support can offer financial and other securities, it can also threaten what makes CHWs unique and effective*” (p. 1635).

The conflicting views about compensation are also evident in literature relating to the broader scope of CHWs, not just those working within Latin communities. For example, in a recent study by Schwartz and Colvin (2015), CHWs in Khayelitsha, a township near Cape Town, South Africa, with high rates of poverty, unemployment, and ill health, the intrinsic motivation to volunteer was often privileged over the extrinsic, which was seen as some in the community, or other CHWs to be a “threat to moral principles” (p. 145). However, reasons for emphasis on the intrinsic are complex and rooted in issues of power, culture, social status, and gender; women are typically serving in CHW roles, and may be portrayed in society as being less concerned with social status and economic reward (Schwartz & Colvin, 2015).

In addition, the literature in the study sample also indicated that previous familiarity with promotores and their work was an additional motivating factor, especially when a person’s family member (such as a mother, grandmother, aunt, uncle or brother) had served in this role (Ingram et al., 2011; Ruano et al., 2012; Squires & O’Brien, 2012).

1. **Characteristics of promotores and their settings for practice**

Most promotores, as reported in the literature, are from the communities they serve (Balcazar et al., 2006; Forster-Cox, et al., 2007; Glenton et al., 2013). They shared language (Spanish primarily), ethnic and cultural backgrounds (e.g., Latino heritage), and sometimes shared occupational experiences (e.g. agricultural work). Much of the published studies relating to CHWs within Latino/Hispanic communities highlighted the work of *promotoras* since the literature indicates that the majority of lay health workers in Latin and Spanish-speaking communities are females. However, studies relating to male *promotors* are emerging ([Arredondo et al., 2013](#_ENREF_4); Brown, Malca, Zumaran, & Miranda, 2006; [Moralez, Rao, Livaudais, & Thompson, 2012](#_ENREF_42)). Brown et al. (2006), for example, explored the role of the community health worker in rural Peru, and found that most of the 171 CHWs were male (76%) and participated on a voluntary basis. Reasons given were related to culture and ascribed gender-roles: a majority of the men believe that CHW training and necessary travel (for home visits) would take women away from their families at night (Brown et al., 2006). The CHW role in this study was also perceived as a leadership role and one that held esteem in the community. This was an outlying case example, however; as most of the promotores in the studies reviewed for this article were women over 35 who had significant life experience and were respected in the communities they served. However, younger promotoras (18-34) were most commonly involved with post-partum or substance abuse programs (Ingram et al., 2008). The

While demographic information specifically on promotores globally is scattered and incomplete, Ingram et al. (2012) published one of the first “profiles” of CHWs in the U.S. In this study, the National Community Health Advocacy Survey (NCHWAS) was used to collect descriptive, benchmark data that would provide a general profile of CHWs in the U.S. In their sample of 371 CHWs, 72.8% identified themselves as Hispanic/Latino. Most CHWs/promotores in the sample also reported that they primarily served Hispanic/Latino communities (85.1%) which closely matched CHW workforce estimates from the Bureau of Health Professions of 77.9% (Ingram et al., 2012). In this same study, Ingram and co-authors also found that the majority of CHWs/promotores in their sample, worked with non-profits, grassroots organizations, and community based clinics (63.9%); reported more than a high school education (70%); were female (92 %); and addressed a range of health issues, with chronic disease, prevention, maternal/child health, and health access being some of the most common.

Arvey and Fernandez (2012) also reported that promotores work in an array of settings, Promotores may work with community health agencies and departments: hospitals and clinics; community health centers; government; schools; non-profits; churches; factories; and corporations. They can work in and outside of formal institutions, often interacting with people within the community at people’s homes, churches, and work settings.

Most promotores in the studies included in this review (n = 63) had at least some high school education, while a smaller number of studies reported samples that included promotores with additional certifications and degrees such as a certified nurse assistant ([Arcury, Marin, Snively, Hernandez-Pelletier, & Quandt, 2009](#_ENREF_3);  [Forster-Cox, Mangadu, Jacquez, & Fullerton, 2010](#_ENREF_19); [Ingram et al., 2007](#_ENREF_23); [Livaudais et al., 2010](#_ENREF_36); [Reinschmidt et al., 2006](#_ENREF_49); [Ruano, et al., 2012](#_ENREF_50); [Sherrill, et al., 2005](#_ENREF_53); [Wasserman, et al., 2006](#_ENREF_60)).

1. **Health topics most commonly addressed by promotores**

The range of health issues addressed by promotores can be classified into three broad categories: *disease and injury prevention, disease management, and environmental health & occupational safety.*

*Disease and injury prevention*. Promotores conduct a wide range of activities to reduce the burden of disease and injury within communities. They create awareness about a particular disease; educate the community about prevention measures; encourage screening; and promote healthy behaviors. Promotores also provide referrals and connect individuals to local social services which include access to health care, food, counseling, and job training ([Arredondo, et al., 2013](#_ENREF_4); [Marsh, Derose, Rios, & Cohen, 2015](#_ENREF_39)).

Promotores in the sample of literature for this article commonly worked to promote women’s and family health in a number of ways, but the most common activities pertaining to prevention noted were: providing health education, distributing health information, organizing events, referring people to community resources and making home visits (Alfaro-Trujillo et al., 2012).

The health topics mentioned in the literature that were the most frequently addressed by promotores included: **breast, cervical and/or colorectal cancer** (Hansen et al., 2005; Larkey et al., 2006; Larkey et al., 2012; Livaudais, Coronado, Espinoza, Islas, Ibarra, & Thompson, 2010; Marshall, Curran, Koerner, Kroll, Hickman, & Garcia, 2014; Moralez, Rao, Livaudais & Thompson, 2012; Smith, Wilson, Orians, & Byrd, 2013; Wasserman, Bender, Lee, Morrissey, Mouw & Norton, 2006); **cardiovascular health** (Albarran, Heilemann, & Koniak-Griffin, 2014; Alfaro-Truillo et al., 2012; Ayon, 2014; Koniak-Griffin, Brecht, Takayangi, Villegas, Melendrez & Balcazar, 2015; Ingram et al., 2012; Lewin, et al., 2006)**; diet, nutrition and obesity prevention** (Bacquero, et al., 2009; Bustillos, John, Sharkey, & Castillo, 2013; Faucher, 2008; St. John, Johnson, Sharkey, Dean & Arandia, 2013; [Stacciarini, et al., 2012](#_ENREF_57); [Tran, et al., 2014](#_ENREF_58)); **diabetes** (Cherrington et al., 2008; Ingram, Torres, Redondo, Bradford, Wang & O’Toole, 2007; Lujan, Ostwald & Ortiz, 2007; McEwen, Pasvogel, Gallegos & Barrera, 2010; Rothschild, Martin, Swider, Tumalalan, Janssen, Avery, & Powell, 2014; Salant et al., 2013; Spinner & Alvarado, 2012); **HIV/AIDS and HPV** ([Fernandez et al., 2009](#_ENREF_17); Ingram et al., 2012; [Ramos, Green, & Shulman, 2009](#_ENREF_48)); **maternal, reproductive and sexual health** (Betancourt, Colarossi & Perez, 2013; Bonilla, Morrison, Norsigian, & Rosero, 2012; Blanco; 2011; Glenton et al., 2013; Ingram et al., 2012; Lewin et al., 2010 Prue, Hammer & Flores, 2010); **domestic violence** (Alfaro-Trujillo et al., 2012; Ingram et al., 2012) and **health screenings** (Fernandez et al., 2009; Hansen et al., 2005; Reinschmidt, Hunter, Fernandez, Lacy-Martinez, Guernsey de Zapien, & Meister, 2006; Ingram et al., 2012).

Additionally, studies provided insight on promotor/a-led educational programs for **asthma and air quality** (Ingram et al., 2012; Lucio, Zuniga, Seol, Garza, Mier & Trevino, 2012); **alcohol and substance abuse** (Ayon et al., 2006; [Ingram, et al., 2008](#_ENREF_22)), **mental health and stress management** ([Lucio et al., 2012](#_ENREF_37); Stacciarini, Rosa, Ortiz, Munari, Uicab, & Balam, 2012; Tran et al., 2014; Waitzkin, Getrich, Heying, Rodriguez, Parmar, Willging, et al., 2011), and **dental health** (Ingram et al., 2012).

*Disease management*. Promotores in the literature were also frequently tasked to help individuals manage chronic illnesses, such as diabetes ([Balcazar et al., 2006](#_ENREF_7); [Faucher, 2008](#_ENREF_16); Ingram et al., 2012; [St John, et al., 2013](#_ENREF_56)); and cancer, including survivorship and co-survivorship ([Borges & Ostwald, 2008](#_ENREF_12); [Cherrington, et al., 2008](#_ENREF_14); Hansen, et al., 2005; Ingram et al., 2012; [Koniak-Griffin et al., 2015](#_ENREF_28); Larkey, 2006; [Lujan, Ostwald, & Ortiz, 2007](#_ENREF_38); [Marshall et al., 2014](#_ENREF_40)).

*Environment* *health & occupational safety.* The study sample also revealed that promotores commonly participate in programs that address environmental health and occupational safety. They have championed efforts to create better and safer built environments such as walking trails and parks ([Albarran, et al., 2014](#_ENREF_1)); prevent pesticide exposure and teach pesticide safety ([Betancourt, Colarossi, & Perez, 2013](#_ENREF_9); [Forster-Cox, Mangadu, Jacquez, & Corona, 2007](#_ENREF_18)); and promote disaster planning and preparedness (Eisenman, et al., 2009).

1. **The effectiveness of programs involving promotores**

Many published studies report positive outcomes for prevention programs involving promotores compared to control groups (Arcury, et al., 2009; Balcazar, et al., 2009; Borges, 2008; Fernandez, McCurdy, Arvey, Tyson, Moreles-Campos, Flores et al., 2009; Forster-Cox et al., 2007; Ingram et al., 2007; Larkey et al., 2006; Lewin et al., 2010; Lujan, 2008; Ramos, Green, & Shulman, 2009; Reinschmidt et al., 2006). Researchers reported that positive outcomes were related to increased awareness, improved disease management skills (e.g. monitoring blood sugar levels), and better retention within health education or rehabilitation programs (Albarran et al., 2014, Arcury et al., 2009; [Baquero et al., 2009](#_ENREF_8), Bustillos, John, Sharkey & Castillo, 2013, Forster-Cox et al., 2010; Ramos et al., 2009, Waitzkin et al., 2011). Participants in programs led by or involving promotores, reported increased awareness and behavior change pertaining to physical activity ([Arcury, et al., 2009](#_ENREF_3), [Forster-Cox, et al., 2010](#_ENREF_19)), depression ([Albarran, et al., 2014](#_ENREF_1)), nutrition and diet (Bacquero et al., 2009; Bustillos, John, Sharkey & Castillo, 2013), and maternal and child health ([Albarran, et al., 2014](#_ENREF_1); Glenton, et al., 2013; Lewin et al., 2010). What is still questionable, however, is whether CHW/promotor/a-led programs are better than other health education programs and prevention models; recent reviews have reported limited impact on health outcomes when comparing lay health models to other interventions (Viswnathan, Kraschnewski, Nishikawa, Morgan, Thieda, Honeycut, et al., 2012). However, most of these studies had very low sample sizes, lacked control groups, and used volunteer or convenience samples. More rigorous research designs are warranted. Regardless, there is still strong evidence to underscore promotores’ impact on social measures, such as social support, self-efficacy, social connectedness and trust, which are valid theoretical constructs of behavior change.

One of the few randomized control trials published (Koniak-Griffin et al., 2013) explored the effectiveness of a promotor/a-led lifestyle behavior program on cardiovascular disease risk factors (e.g. body mass index, waist circumference, blood pressure, lipids and glucose) among low-income, adult Latina/os, and provided strong evidence to support the hypothesis that prevention programs in Latino communities that are led by promotores are more effective than lifestyle programs without them. At the end of the six month intervention (that included 8 classes followed up by 4 months of individual coaching by promotores), those in the intervention group had more significant improvements in risk measures than those in the control group. In addition, those in the experimental (promotora-led) group had higher rates of attendance and participation than those in the control group. This study yielded important evidence to support lay health program models, specifically within Hispanic/Latino communities. Additional randomized control trials are warranted.

In both qualitative and quantitative studies, a key variable associated with positive outcomes was social support. Waitzkin et al. (2011) in a mixed method study, explored the effectiveness of promotores as mental health promoters in primary care. Although the quantitative results of the study did not yield significant results, the authors noted that for many program participants, the change in reported depressive behaviors was due to emotional bonding and the perceived social support received from promotores. Participants in the study reported that working with a promotor/a fostered companionship (compa~nerismo), that the promotor/a was a comadre (friend), a buena profesora (good teacher), and a cultural mediator and/or a role model ([Waitzkin et al., 2011](#_ENREF_59)). Additionally, multiple examples from the literature illustrate the positive impact of promotora-led interventions and increased social support on screening rates: female participants opted for screening of a disease or condition after they were contacted by a promotora; specifically for screening relative to diseases such as cervical cancer ([Albarran, et al., 2014](#_ENREF_1)) colorectal cancer ([Smith, et al., 2013](#_ENREF_54)), and HIV  [(Ramos, et al., 2009](#_ENREF_48)). Although the focus of this particular review of literature is on the contributions of promotores to women’s health, it’s important to note that men, teens, seniors, and a variety of other populations have also benefitted from programs involving promotores ([Arvey, et al., 2012](#_ENREF_5); [Borges & Ostwald, 2008](#_ENREF_12); [Lewin et al., 2010](#_ENREF_35)). The evidence is clear that promotores and lay health promotion programs play an effective role in primary prevention for everyone.

**5. The impact of promotor/a work on self-efficacy**

Self-efficacy, the belief a person has that they have the ability to accomplish or perform a particular task, influences a person’s health decision making and is an important concept for planning health education and training for promotores ([Keller, et al., 2012](#_ENREF_27)). Multiple studies included in this review indicated that serving as lay health promoter increased one’s self-efficacy as well as the self-efficacy of others. Promotores in the literature examined reported that their involvement in their communities and as lay health promoters strengthened their ability to make decisions about their own health (Ayon, 2014; Glenton, et al., 2013; Kash et al., 2007; Koniak-Griffien et al., 2015; Reinschmidt et al., 2006). Kash et al. (2007) also observed that promotores helped women in the study access to health information and social services, and their efforts were especially beneficial to women whose travel was restricted or for those who could not go unaccompanied to see a health professional.

The positive outcome of increased self-efficacy is seen in studies involving a variety of topics and audiences. In a study by Balcazar et al. (2009), lower income, middle-aged Mexican adults living near the Mexico-Texas border participated in a promotora-led cardiovascular health program called, ‘Your Heart, Your Life.” Participants who worked with the *Promotoras de Salud Contra la Hipertension* (Community Health Workers Against Hypertension) over a 9-week period achieved improved measures of sodium, fat, and cholesterol and higher self-efficacy scores on performing heart healthy behaviors. In another study, Ayon et al. (2006) explored promotora led adolescent substance abuse prevention programs, and found that by working with the promotoras (all who were mothers), Latino parents increased their knowledge of substance abuse and increased their ability to identify if their children exhibited signs of substance abuse.

Koniak-Griffin and colleagues (2015) found that involvement of promotoras as health coaches in a lifestyle and behavior intervention for low-income Latina women living in Los Angeles (*Healthy Women Prepared for Life*) led to more positive outcomes and increased self-confidence among participants. Participants in the intervention group also achieved improved measures on risk factors such as body mass index, weight, blood pressure, glucose and had higher retention rates than those not matched with a promotora.

There is also evidence that health promotion programs involving promotores improve participants’ feelings of self-efficacy relating to breast and cervical cancer screening (Hanseon et al., 2005; Larkey, 2006; [Reinschmidt, et al., 2006](#_ENREF_49); Wasserman, et al., 2006).

In addition, participating as a promotor/a can increase feelings of self-efficacy for the promotor/a. Otiniano, Carroll-Scott, Toy, and Wallace (2012) presented a case where promotores participated in a research-capacity building course relative to community assessment and then hosted their own workshop to train others on community assessment skills. Although there were a number of challenges for the promotores involved in the study, including the need for tailored training materials, the majority of the promotores reported a greater sense of self-confidence, improved presentation skills, and a better understanding of the community assessment process after participating in the pilot.

Furthermore, Lucio et al. (2012) also provided a case for including promotores in the research process. Promotores in the study were not merely a linguistic bridge but could help to frame the research and provide guidance on working with the community in the process. This, the authors noted, led to better data collection and ultimately improves research ([Lucio, et al., 2012](#_ENREF_37)).

[Insert Photo 1 here]

Caption for Photo 1: Promotoras de salud of Familias Unidas in Snohomish County, WA, celebrating after a breast health event. Photo by Sandra Solano-Huber. Used with permission.

1. **Promotores as social change agents**

A number of studies provide evidence that promotores can serve as powerful community advocates and catalysts for social change. For example, Sabo and colleagues (2013) surveyed a U.S. sample of 371 CHWs (53% Latina/o) and found that over 75% of them were participating in some form of advocacy, ranging from promoting change within their organizations (77%) to participating in civic efforts (57%) to engaging in political advocacy (46%). The authors also reported that more than half of the sample of CHWs in the study provided some sort of advocacy story. For example, one CHW contributed the following:

“*In the workplace, we worked hard for the last 5 years to prove the community health worker concept and benefits to having them in a clinical setting. In a clinical setting, we advocate for those who are underserved and uninsured. We are well received now, and are counted as part of the care delivery team”* (Sabo et al., 2013, p. e4).

Studies have also provided evidence that promotores can create positive change to improve environmental health and safety, especially in low resourced and impoverished border regions where communities are challenged with poor sanitation and daily exposure to environmental pollutants. Forster-Cox et al. (2010) demonstrated how promotoras living in *colonias,* rural, impoverished areas near the U.S.-Mexico border led environmental safety assessments of homes, installed smoke detectors, and educated community members about home and safety issues. Similarly, Lucio, Zuniga, Seol, Garza, Mier, and Trevino (2012) reported that promotoras in their study, also living in border colonias, took action to make positive changes to their households to improve indoor air quality after undergoing an asthma and healthy homes training. In another study by Forster-Cox and coauthors (2007), promotoras provided education to Latino immigrant families on the Texas-Mexico border to reduce pesticide exposure.

Studies also noted a gradual change in focus from individuals and families to community among promotores over time. Alfaro-Truillo, Valles-Medina, and Vargas-Ojeda (2012) examined characteristics of promotores serving communities on the Texas-Mexico border, and through mixed methods, observed a “transformation” and shift from their initial focus on individual and family health to concerns for the larger community. Strengthening promotores’ “collective efficacy” (e.g. ability to achieve a task or goal as a group), in addition to self-efficacy, can improve lay health workers’ ability to initiative change within their communities.

For example, Farquhar and co-authors (2008) found that using a community-engaged (e.g. popular education) approach to health promotion increased the number of promotores who participated at community events, the number holding leadership positions, promotores’ sense of community solidarity. Many of the studies examined in this review of literature underscored the value promotores and CHWs place on advocacy, and their civic and community involvement; however, advocacy was also mentioned as an area where more promotores felt they lacked sufficient training (Alvillar et al., 2011; Ingram et al., 2008; Ingram et al., 2012).

It’s also important to recognize that because of the differing roles and settings for promotores, advocacy is not always a required part of their practice. This also highlights the need, globally, to identify “core elements” of effective training programs that seek to improve not only health and wellness of individuals and populations, but also health equity within communities (Arvey & Fernandez, 2012).

1. **Training and supporting promotores**

At the time of this literature review, except for the Indian Health Service’s training for Community Health Representatives, there were no standardized, global training programs or certifications for promotores which was also noted by Larkey et al. (2012) and Moralez et al. (2012). Training for promotores can vary not only from country to country, but by province to province or state to state. For example, in the U.S., training in California to become a CHW in may differ from state requirements in North Carolina; requirements for a lay health worker in Brazil differs from those in Cuba. One does not necessarily need to have professional certification to practice as promotora or promotor. However a strong theme throughout much of the literature is that training, coaching and ongoing mentoring from other health professionals and/or senior promotores is a key ingredient for program success and retention of promotores ([Murray & Ziegler, 2015](#_ENREF_43)). Providing CHW certification opportunities for promotores was found to enhance their retention in lay health promotion programs ([Arvey, et al., 2012](#_ENREF_5)). Ingram et al., (2008) recommend that promotores should be provided with basic outreach training as well as with ongoing professional development, and leadership training and advocacy skill building ([Ingram, et al., 2008](#_ENREF_22)).

Additionally, lay health worker training materials must be suited to match the language, culture and reading level of promotores. Instead of medical books, training through hands-on exercises, interactive discussion, role-play, or informal one-on-one training are more effective alternatives ([Wasserman, et al., 2006](#_ENREF_60)). Ayon (2014) underscored the need for providing training materials in Spanish as well as in English, including vibrant colors and culturally appropriate images in the design, and for materials to be written at a reading level of 10 or lower. The training material must be culturally sensitive to the community being served ([Cherrington, et al., 2008](#_ENREF_14)). Hi-tech training material (such as mobile aps) may be appropriate for some educational strategies and audiences, but Koskan and co-authors (2013) found that low tech materials, such as flipcharts, are still commonly used among promotoras so they can control the pace of training and work in most rural and low income communities ([Koskan, Friedman, Brandt, Walsemann, & Messias, 2013](#_ENREF_29)).

As mentioned earlier in this paper, lack of financial incentives may lead to attrition and burn-out. Although studies show that altruism is the most common reason promotores give for working with communities, providing financial incentives helps to retain promotores (Albarran, et al., 2014; Bonilla, Morrison, Norsigian & Rosero, 2012; [Moralez, et al., 2012](#_ENREF_42)).

Bonilla, Morrison, Norsigian & Rosero (2012) reported that providing both certification and financial compensation enhanced retention of promotores. Promotores in this same study reported that completing a certification program generates strong feelings of self-worth ([Bonilla, Morrison, Norsigian, & Rosero, 2012](#_ENREF_11)). In some training programs, promotores were paid through a third party such as Medicaid ([Albarran, et al., 2014](#_ENREF_1)) and had opportunities for paid employment which improved retention.

In addition to financial support and certification opportunities, promotores need teaching tools and resources that best serve their audience. For instance, in a study that addressed the effectiveness of a lifestyle behavior intervention emphasizing physical activity, promotores and participants were provided with pedometers ([Kash, May, & Tai-Seale, 2007](#_ENREF_25)). In another study, promotores leading a physical activity program for post-partum women, needed equipment such as strollers to increase participation ([Albarran, et al., 2014](#_ENREF_1)).

Occupational stressors, such as long hours, unmanageable workload, physical demands, and poor organizational communication can also impact satisfaction and retention among promotores. Henriques-Camelo (2012) explored work-related illnesses reported among Brazilian CHWs, and found that long hours and exhaustion were often physical side effects reported by Latina/o CHWs as side effects to their work. Spinner and Alvarado (2012) suggest that organizations that work with promotores should have a clear program plan, with clear objectives and role assignments, to help balance work among team members and unify all involved toward a common goal. Regular “check-ins” between supervisors and promotores to adjust task assignments and workload as needed can also help to improve teamwork and reduce turnover as well.

Poor communication within organizations can also lead to increased stress and frustration among promotoras (Alvillar et al., 2011). When a promotor/a’s role is unclear to them, or to other staff members on the team, it can spark conflict. Maintaining open communication about the promotor/a’s assigned responsibilities and having regular “check-ins” can help to reduce the miscommunication and confusion. Also, facilitating and encouraging communication among promotores will help build social connectedness and aid with keeping everyone informed. Some organizations have developed professional networks and use multiple channels of communication channels such as social media (e.g. Facebook pages), email listservs, and/or text messaging to keep communication flowing ([Alvillar, et al., 2011](#_ENREF_2)).

Furthermore, creating opportunities for inter-professional education as part of certification programs, or CHW trainings in partnership with medical schools, hospitals, clinics, and community health centers, will help to enhance the integration of promotores into eam-based care in areas of the world where this is emerging. This approach will also other health professionals to gain more understanding about the important role that CHWs/promotores play in primary care. A study in Brazil performed a survey of people served by a promotora program, where promotora provided primary health care along with health awareness. The study conducted a baseline survey, followed by a follow-up survey after two years of promotora services. The results indicated that the rating for “overall performance of the CHW was satisfactory to maintain your and your family’s health” increased significantly ([Kawasaki et al., 2015](#_ENREF_26)). Although this study sets an example, in order to blend promotora services in healthcare networks, more studies are necessary.

Studies have increasingly advocated for financial and managerial support for lay promotor/a-led health promotion programs ([Lewin, et al., 2010](#_ENREF_35); [Otiniano, Carroll-Scott, Toy, & Wallace, 2012](#_ENREF_44)). Promotores who are working in low resourced and vulnerable communities often come from those same communities; hence, providing promotores with suitable means of transport such as a bicycle, bus pass, or reimbursement for gas and equipment (e.g. helmet; flip charts; gloves) is essential for their success. In addition, promotoras have noted that their work often leads to physical fatigue ([Glenton, et al., 2013](#_ENREF_20)) and their work environment may confined to areas such as garages, churches, or no dedicated space at all (Ruano et al., 2012). Improved logistical support can reduce physical fatigue, feelings of overload, inefficiencies that lead to frustration and turn-over.

Studies also show that promotores are also seeking professional development opportunities beyond just CHW certification. Health-related, culturally tailored trainings were identified to be of highest need (Alfaro-Trujillo et al., 2012; Alvillar, et al., 2011; Ingram et al., 2008). In addition, pomotores may require training about confidentiality as their clients may be sharing sensitive and personal information ([Reinschmidt, et al., 2006](#_ENREF_49)).

Despite of the barriers mentioned in the literature, most promotor/a-led programs in the literature report positive outcomes. One could surmise this is tied to promotores’ commonly reported intrinsic commitment to community and to the people they serve. However, there is a need to further explore the needs and occupational stressors promotores experience, their ideas about career advancement, and organizational and work-related factors that reduce burn-out. When promotores are well cared by organizations and systems, they can extend better care to individuals and to the communities they serve.

**Limitations**

This review of the literature was limited by a multiple factors. A primary weakness is that only articles published in English were included. This likely accounts for why there were so many more U.S.-based studies in the final sample. Future reviews should focus on the research published in Spanish and English and disseminate the findings in both languages to broaden the audience and contribute to the body of scholarly literature. Also, this review is cross-sectional, focusing on studies published only within in the last decade (2005 – 2015). The findings of this review are further limited by the search terms and databases used in the inclusion criteria (Fig. 1). Articles in the sample were also limited to peer-reviewed works that were available in full text within the databases searched or retrieved through inter-library loan. So the final sample is not representative of all published works relative to promotores.

**Conclusion**

Lay health workers have served on the front lines of prevention for decades. There are thousands of studies that have documented the history of CHWs and their evolving role in population health. However, this article focused specifically on the contributions of *promotores de salud* and their contributions to improving the health of Latina women, their families, and their communities. As reflected in the literature, there is ample evidence to support the claim that lay health models that include promotores, can achieve positive results. Preventative education and early screenings improve health outcomes, expenditures, and quality of life, and educating women about these issues creates a huge ripple effect within their families and communities. As the famous adage goes, “If you educate a man, you educate an individual. If you educate a woman, you educate a nation (Anzia, 2007).” Hence, promotores increase social capital within Latino communities. Eng (1996) wrote, “lay health workers are a source of health that is internal to a community” (p.28). Trust, cultural congruence, gender and perceived social support are all important factors when designing health programs and services, and promotores play a key role in addressing them.

Efforts to clarify the role/s of promotores and CHWs, including standardization of training and certification, continue to be debated on a global scale. Are promotores navigators to health systems and services? Are they role models and facilitators? Health advocates and activists? A mix of all of these? And is a “one-size fits all” approach to training and certification appropriate? Future studies should explore the impact of “institutionalizing” the role of promotores/CHWs into formal health systems in places where this has already occurred (such as Brazil). Health reform, in countries such as the United States, is pushing prevention to the forefront. How does the integration of lay health workers as members of a primary care team “disrupt” existing models of medical education and social services training? What are the benefits and negative effects of transforming a “lay,” and (historically voluntary) role into one that may be deemed “professional” and “legitimate” by institutions that are often run by the dominant majority? There are still many questions that remain, but one thing is clear: improving the health of Latina women, their families and communities, calls for an increased focus on primary care, cultural humility and an expanded team-based approach, of which promotores are essential partners.

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**Abbreviations**

CHW. Community Health Worker

CINAHL Cumulative Index to Nursing and Allied Health Literature.

LHW. Lay Health Worker

**Databases Searched:** CINAHL, PubMed, Medline

**Terms used:** *CHW, promotora, promotora de salud, promotores de salud, promotores, Latina CHW*

**= 210 articles**

**Databases Searched**: CINAHL, PubMed, and Medline

**Terms Used:** *Community Health Worker, CHW, lay health worker, lay health promoter, lay health promotion, village health worker, health navigator, peer health advisor, peer health advocate, volunteer health worker, promotora, promotor, promotoras de salud, promoteres de salud, promotores*

**= 4,000 (+) articles**

**Filtered by search criteria:**

* Peer reviewed
* Publication date between 2005 – 2015
* Written in English
* Used terms *promotores, promotors, promotoras, or promotores de salud or Latina/o CHW* in title or abstract
* Excluded articles soley about a particular training or curriculum development for promotores

**= 87 articles**

**Final study sample n = 63**

Authors reviewed all **87 articles and abstracts**

**7 were duplicate articles**

**17 did not meet inclusion criteria**

**-24**

**Figure 1. Flow diagram of review process for identifying articles that met inclusion criteria**



Photo 1: Championing health for women and communities: Promotores de salud of Familias Unidas in Snohomish County, WA, celebrating after a breast health event. Photo by Sandra Solano-Huber. Used with permission.

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