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Editorial

Role of Public Health Education in Addressing Intimate Partner Violence Against Women: A Global Crisis

Priya Banerjee, Ph.D., *The College at Brockport, State University of New York*

Globally, the overall health status of women has improved over the last few decades, albeit inconsistently in different parts of the world, and in different health priority areas. In fact, Skolnik (2016) indicates that "being born female can be dangerous to your health, especially in low and middle income countries" (p. 232). Though alarming, the statement is data-driven. To corroborate: in low to middle income countries, a combination of biological factors, poor access to accurate health-related information and preventive services, and lack of social power work together to diminish women's quality of health (World Health Organization [WHO], 2013). The WHO estimates that adolescent girls are more at risk for sexual abuse and new HIV infection than boys and are more likely to die from self-inflicted injuries, road traffic injuries, and drowning. Women in their reproductive years, worldwide, are disproportionately affected by HIV/AIDS, and in low to middle income countries, maternal deaths are more prevalent than in any other parts of the world (WHO, 2013). These facts are a significant cause for concern in the field of public health, especially because women make up approximately half the world's population. The World Bank (2015) estimates that in 2014, the female population, as a percentage of each countries' total population, ranged between 26.3% (United Arab Emirates), to 53.8% (Ukraine).

Time and again, the world has witnessed the power of women as "agents of the common good," and female-focused health promotion results in rapid progress in a country's "economic growth, health, food security and nutrition, democracy, peace and security" (InterAction, 2013, p. 1). It is in this spirit that Ban Ki-Moon, Secretary-General of the United Nations, stated, "female energy, talent, strength represent humankind's most valuable untapped resource" (United Nations, 2012, para 6). On International Women's Day in

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Priya Banerjee is an associate professor in the Department of Public Health & Health Education at the College at Brockport, State University of New York. Please send correspondences to pbanerje@brockport.edu.

2012, he called for governments to recognize the importance of empowering women as a necessary condition for success of society in all of its aspects. In fact, the progress made in the world regarding women's health is documented in the 2015 WHO's Commission on Information and Accountability report indicating that 30 countries show an increase in the implementation of maternal death surveillance and vital statistics (WHO, 2015), and reports from the Millennium Development Goals Project point to a decrease in maternal deaths, poverty, and increased access to education, sanitation and safe drinking water (United Nations, 2015).

Further, the theme for International Women's Day in 2016 was, "Planet 50-50 by 2030: Step It Up for Gender Equality"—the call to "step it up" speaks directly to energizing and accelerating the implementation of items on the 2030 agenda of the Sustainable Development Goals Project pertaining to women's health, specifically goals 4: Ensure inclusive and quality education for all and promote lifelong learning and 5: "Achieve gender equality and empower all women and girls (UN Women, 2015).

The collection of research presented in the special supplement of the *Global Journal of Health Education and Promotion* addresses the empowerment of women by women in various settings, as women and girls often suffer from health issues of cultural origins and need creative and grassroots solutions. Research included in the special supplement also showcases community health interventions designed with a focus and sensitivity to social and cultural norms.

In keeping with the theme of Intimate Partner Violence (IPV), a qualitative study, *Health Worker Attitudes to Intimate Partner Violence on the Tibetan Plateau: A Qualitative Assessment of Cultural and Material Factors behind Non-Interventionist Attitudes* delved into cultural attitudes toward Intimate Partner Violence (IPV) as barriers to the development and delivery of appropriate community health education interventions related to IPV. The findings of this study can be extrapolated to different communities in the world where similar attitudes and beliefs toward IPV exist.

The research on the *Pregnancy-Related Experiences of Bangladeshi Immigrant women in the U.S.* is another qualitative study describing the experiences of Bangladeshi women in terms of their assimilation into a new culture. Key findings of the study pointed to critical gaps in the delivery of health services in the U.S. healthcare system in terms of cultural sensitivity, particularly communication issues due to language barriers and even in some cases a sense of discrimination.

On the Front Lines of Prevention: Promotores de Salud and Their Role in Improving Primary Care for Latino Women, Families, and Communities is a review of literature documenting the history and effectiveness of community health workers (CHWs) on primary health care in a community setting. The study, possibly the first of its kind describes the typical “profile” of a CHW–the motivations to become one, and provides evidence from 63 articles about the important role played by them in community health education efforts in underserved communities in the U.S. and abroad.

We know that the research in this special issue will add to the body of literature on the subject of women’s health and hope that we have presented information that is not only interesting but useful to our general readership from all fields of public health education and promotion. I would like to thank the contributors for their in-depth research and expertise. In addition, I want to acknowledge and praise the work of our chief editors, Dr. Miguel Perez and Dr. Deborah Fortune, and thank the expert reviewers for their contributions.

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Pregnancy-Related Experiences of Bangladeshi Immigrant Women in the U.S.

Kamrun N. Mustafa, *University of Southern Mississippi*
Mark J. Kittleson, *The College at Brockport, SUNY*

Abstract

This study explored the pregnancy-related experiences of 10 immigrant Bangladeshi American mothers living in New York City. This qualitative research done through interviews and participant observations has revealed that the women faced several problems, including financial instability, isolation, loss of social status, and loss of their identity as (Bangladeshi) Muslims. The study also found that initial settlement challenges adversely affected their psychosocial and physical well-being, which in turn affected their prenatal health.

Keywords

culture; ethnic minority; Bangladeshi immigrants; immigration; women; pregnancy

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Kamrun N. Mustafa is a visiting assistant professor for the Department of Health at the University of Southern Mississippi. **Mark J. Kittleson** is the dean for the School of Health & Human Performance at The College at Brockport, State University of New York. Please send author correspondence to kamrun.mustafa@usm.edu.

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Pregnancy can be a joyful time as well as a critical stage in every mother's life. However, research suggests that becoming a mother is a trying time filled with many challenges (Canuso, 2003; Liamputtong & Naksook, 2003; Liem, 1999). Little is known about the lives of immigrant women, in particular those living in the United States who go through pregnancy while trying to adapt to another culture. Much of the research on migration addresses this stressful process, outlining various stages of adjustment patterns for immigrants coping with cultural changes (Akhtar, 1999; Ibrahim, Ohnishi, & Sandhu, 1997; D. Sue & Sue, 1987; S. Sue, 1988).

According to Liamputtong and Naksook (2003), not only is the migration experience associated with stress, but it is also often accompanied with the loss of a support system of family relationships (Al-Issa & Tousignant, 1997; Rice, 1999). But immigrants' confrontation with significant changes in many areas of their lives, their interpretation of these changes, and their perceptions of societal perspectives about immigration impose severe pressures on them (Espino, 1991). For women, immigration-related stress could be more complex in nature. Living as an immigrant is a struggle by itself as "migrant women struggle to find a comfort zone between their cultural traditions and the culture of their new land" (Liamputtong & Naksook, 2003, p. 664). not in ref list

Research examining the experiences of South and Southeast Asian immigrant pregnant women is scant and studies on Bangladeshi women's pregnancy experiences in the United States as new immigrants are nonexistent. This cultural group needs exploration because it is ill-adapted to an American setting. Bangladeshi immigrants inherit a culture influenced by conservative social mores and religion. Their value system, which is heavily influenced by their religion, discourages them from exposing themselves to the U.S. mainstream lifestyle (Nazroo, 1998). They tend to retain these values even after living in the United States for a considerable time. Yet little is known about how these cultural characteristics affect Bangladeshi immigrant women's ability to experience a successful pregnancy. To expand research on Southeast Asian women's pregnancy experience in the United States, this study will explore the pregnancy experiences of 10 Bangladeshi women living in a major U.S. metropolitan area. This study also focuses on their physical, mental, emotional, social, and environmental health.

Review of Literature

According to the 2010 U.S. Census Bureau, an estimated 3.9 million South Asians live in the United States, the third largest group within the Asian American and Pacific Islander category. Between 2000 and 2010, the Asian population in the United States increased by 45.6%, and Bangladeshis alone were the fastest growing group, registering a 156.6% increase. Although Bangladeshis have migrated to different regions in the United States, New York

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City has the highest population of Bangladeshis in the country (Gany, Shah, & Changrani, 2006). Yet their experiences remain largely unchronicled.

An understanding of immigrant women's cultural backgrounds can enhance their chance for a successful pregnancy in the context of the U.S. health care system. However, physicians and other health service providers are not always able or willing to adjust their practices to a culturally diverse population (Adeniran et al., 2008). Substantial disparities in health care coverage remain for certain ethnic minorities (Healthy People, 2010).

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U.S. Department of Health and Human Services, 2010?

A small body of research suggests that Bangladeshi women are in a weak position to empower themselves in matters related to pregnancy because of religious beliefs, practices, and family structure. According to Rozario (2007), a woman's only social status is a wife and a mother. She is responsible for raising children and for anything that pertains to household matters. In the South Asian culture, a woman is represented as "educated, demure, chaste, modest, submissive, self-sacrificing, kind, patient, and devoted to family—a symbol of her nation, culture, and religion" (Deepak, 2005). Naturally, pregnancy and childbirth are considered sacred activities for women (Jones, Hughes, & Bond, 1999).

Bangladeshis often live in extended families, and the presence of extended family members can constrain health choices by women. In some cases, the religious beliefs of family members can delay mothers in seeking care outside the home. For example, the sociocultural norm of wearing the veil, known as a hijab or purdah, is not meant to create a barrier. But in many cases, hijabs or purdahs can be construed as a barrier for a variety of religious or social implications. Reinforced by a patriarchal society, a woman who wears the purdah is generally not allowed to have contact with males, including male physicians (Rashid, Hadi, Afsana, & Begum, 2001). Adamu, Salihu, Sathiakumar, and Alexander (2003) reported that Muslim women must ask their husband's permission to use health services. Few Bangladeshi men are present at the delivery room and are generally unaware of the physical, mental, and emotional pain the women go through, yet they make critical decisions about pregnancy-related treatment and childbirth (Sapkota, Kobayashi, & Takase, 2011). On the contrary, research also suggests that American physicians and other health care providers tend to react negatively toward patients who wear the purdah (Stewart, Parker, Chakraborty, & Begum, 1993). Stewart et al. (1993) also noted that these purdah restrictions act as barriers to women's use of a hospital during the baby birthing process.

Theoretical Framework

The theoretical framework used in this study is the PEN-3 model developed by Airhihenbuwa (1995). This model is particularly relevant to this study because it is a culture-centered model. It builds on the cultural criticism of the existing models of health communication by viewing health beyond mere biological factors and emphasizes the sociocultural context in which to analyze how health behavior is shaped, enabled, and empowered (Dutta, 2007). With the sociocultural context in mind, this study is prompted by one overarching research question (RQ): What are the experiences of immigrant women from Bangladesh living in a large U.S. metropolitan area during pregnancy?

Method

Sample Selection and Recruitment

Prior to data collection, approval to conduct research was obtained from the Southern Illinois University Carbondale Human Subjects Committee. Initially, 30 Bangladeshi women were recruited to participate in the study using the snowball technique of the nonprobability sampling method (Gubrium & Holstein, 2003). However, the interviewing process ended after the 10th participant was interviewed because data had reached a point of saturation (Guest, Bunce, & Johnson, 2006). To participate in the study, the women had to have completed their first successful pregnancy in the United States between 1 month and 1 year prior to the date of the interview. All interviews were conducted in Bengali by the author. The first four participants were recruited through the researcher's personal network, and the remaining six were referred by participants. All lived in the New York metropolitan area.

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Three of the 10 participants had been living in the United States for 2 years, six participants between 3 and 6 years, and one participant for 9 years. The participants ranged in age from 22 to 39. Half of the participants had a high school diploma, and the other half also had a college education. Only two women were working, and they along with their husbands had blue-collar jobs. Family income was between $1,200 and $2,400/month. Five participants shared apartments with their extended families.

Data Collection and Interview and Setting

Three data collection methods were used in this study for triangulation purposes: interviews, observations, and hospital documentation. Triangulation is the use of multiple data sources (Schwandt, 1997) to support themes or the theories that are being built or confirmed and also for validating the accuracy of the data gathered in the data collection process (Lincoln & Guba, 1985; Patton, 1990). The data collection for this qualitative study involved in-depth, open-ended, semistructured interviews. Most of the interviews were held in the participants' homes while their husbands were away.

Observations

The author observed interviewees' home environment, their interaction with other family members, their neighborhood, and the hospital prenatal care units they went to. The author also accompanied one participant in her labor room. Participant observation was used as a method of data collection, to produce a rich and thick description of social interactions within their natural settings (Geertz, 1973). The author conducted two observation sessions in the prenatal care outpatient unit in one of the hospitals for approximately 6 hr. The scope of observation was narrowed to patients of Bangladeshi origin. During the observation, field notes were taken on how they came to the clinic, how they reported to the reception/information desk, who was accompanying them, how they were dressed, how they were communicating with the health care professionals, and what kind of treatment they received from the health care providers, including their verbal and nonverbal communication patterns.

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Instrument Development and Data Analysis

For the purpose of this study, the PEN-3 model guided the design of the interview instrument to ensure that all questions covered the various aspects of the project. Interviews were audiotaped and transcribed verbatim in Bengali and then translated into English. Two independent bilingual researchers checked the translation for accuracy. Data were analyzed using thematic categories. The constant comparison method was employed to identify relevant themes and categories that emerged from the transcribed interviews, following the suggestions of Strauss and Corbin (1988). The study received ethical approval from the Southern Illinois University Carbondale Human Subjects Committee.

Findings

Transition

Most of the study participants perceived the process of transition from Bangladesh to American society to be a rocky experience featuring major challenges. Many of them saw physical relocation as an uprooting from the traditional families, coupled with changes in the societal value system, environment, and culture significantly affecting their life, livelihood, and well-being. A majority of the participants said pregnancy became an additional source of stress because they were struggling physically, mentally, emotionally, and above all financially at the initial stage of resettlement. After coming to America, most participants could not relate to the American way of life and wondered where they belonged. One participant illustrated her frustration by saying, "Who am I? A Bangladeshi or an American? Where do I fit in?" Another reported, "I was no less excited when I got the news of our possibility of immigration to the U.S. But, believe me, I never ever think of calling America my home. So, I really don't know where I belong." Despite the hardships, some participants felt proud of settling in the United States. Coming to America with more opportunities for them and better education for their children was like a dream.

A couple of participants felt good about their pregnancy, but most women felt they had lost social status by leaving a comfortable lifestyle in Bangladesh, typical of the middle and upper class. With the loss of social status came a sense of shame and guilt. After the baby was born, they were still struggling for survival with their husbands working long hours in low-paying jobs and living in substandard housing environments. One respondent said,

> Can you imagine, my father is an investment banker and here I am in this ghetto? During the first few days, I did not even call my parents in Bangladesh. How could I tell them that my husband is a construction worker?

For most participants, coming to America came not only with social costs, but also with financial ones. For them, "America was like a dream gone bad." Almost all respondents complained about the high cost of living in New York City and how it made their life difficult. One respondent from the Bronx said, "My husband made about $2,400 per month as a framer at an art gallery. We lived in a joint family of 13 people in a three-bedroom apartment."

Culture

Participants in this study put high emphasis on living in close proximity to other Bangladeshis and adhering to their traditional practices. They described a number of issues that mattered to them: (a) re-creating Bangladesh in New York, (b) clustered living, (c) preference for family setup, (d) traditional practices, (e) value systems, (f) religious issues, and (g) food habits. The neighborhoods where the participants lived became a home away from home. Narrating her experience, one respondent expressed, "Here we talk in Bengali, eat Bangladeshi food, wear our traditional dresses, enjoy Bangladeshi TV channels and observe common religious and community festivals and national holidays of Bangladesh, and we raise our children in the Bangladeshi cultural environment." Pregnant women especially preferred clustered living. It helped them develop a network of strong bonds with other new or would-be mothers. They also relied on the elderly women in the neighborhood as a substitute for their mothers in Bangladesh for guidance and advice. One study participant said, "After I had a baby, my extended family members, friends, and neighbors visited me both in the hospital and home, brought me foods and clothes for the baby. Some of them became part of my family." Most of the participants were generally happy about their cultural environment, and one participant from

Brooklyn said that she wears the hijab and keeps her face covered when she goes out. It gives her pride and respect. But in other neighborhoods, people would take it as a strange way of dressing.

Participants who lived in joint family households were even happier. One of them said,

> We share a three-bedroom apartment, the kitchen and household chores, and spend our leisure time together. If someone gets sick or otherwise busy some of us take her place and do the job. During my pregnancy it was really helpful.

A few participants expressed their frustration about the role and attitudes of their husbands toward their pregnancy. Those who did not get their husbands' support during the pregnancy felt that in a new land the husband should be the most important individual for a woman to lean on, to confide in, and with whom to have intimate exchanges.

One of the most common concerns shared by the participants was whether they would get a female doctor for their prenatal checkups, delivery, and postpartum care. Some of the respondents said their religious outlook and cultural upbringing discouraged them from seeing a male doctor unless it was life threatening. One participant said, "I do not even feel comfortable talking to a man about what I am going through. Being checked by a male doctor is out of the question. That's how I grew up as a Muslim girl."

Food habits surrounding the pregnancy were an important issue among the participants and were also a cause of concern for the health care professionals. Bangladeshi women insisted on their particular way of food preparation and consumption and generally did not follow the dietary guidelines recommended by their doctors and nutritionists. Some participants and their newborn babies suffered from malnutrition and other medical conditions. Two of the participants said that their babies were born with severe dehydration and cracked skin. The food guide provided by the health care professionals did not carry any useful message to many of the Bangladeshi women, and as one participant put it, "I could not understand anything nor could I relate the guide to the food we are used to. I threw the food guide into the trash can. It was written in English with hard-to-understand Bengali subtitles." Beyond malnutrition issues, other physical health issues included hypertension, physical weakness, and dehydration.

Some of the study participants were at a high risk for gestational diabetes and were advised by their physicians and nutritionists to take six meals a day spread equally over the course of the day. However, none of the high-risk participants followed these instructions. Instead, they waited until their husbands returned from work to have a meal, which often meant eating dinner late at night. The participants and their husbands opposed the changes advocated by the physicians because they considered their dieting style an integral part of their life, which they were unwilling to change.

Experiences With Health Care Services

Participants had to deal with health care services issues such as (a) the lack of health care professionals' cultural sensitivity, (b) unequal health care treatment, (c) quality of services, (d) help (level of care) from professionals, (e) communication issues, and (f) language barriers. All the participants experienced the American health care system for the first time during their pregnancy and were critical of the overall health care delivery system.

Cultural sensitivity. Participants had mixed feelings about the attitudes of the health care professionals. They reported that physicians and nurses were not attentive enough to their pregnancy issues and were not culturally sensitive and cooperative. One participant described the problem as "American physicians and nurses expected me to behave as any other American woman. Hey, I am not an American, I am a Bangladeshi. Try to understand me. Ask me what I want to eat. Ask me how I feel." Another respondent provided similar feedback: "There were so many issues I could not express properly to my physicians or nurses. I was sure that any Bangladeshi physician could easily understand my problem. It's a cultural thing."

Unequal treatment. Several participants perceived unfair treatment by physicians and hospital personnel during their pregnancy due to their traditional attire. A participant believed that she was a victim of discriminatory treatment, stating,

> I was not treated with respect and care. Their faces changed as soon as they saw me in long dress and "hijab." I did not fully understand their conversation but I could figure it out what they were talking about. They used to ask me why I wear such a dress. They made fun of it.

Quality of health services. Some of the participants were dissatisfied with health care services in the hospitals. The issues included a long waiting time, rude treatment from health care professionals, inefficient recordkeeping, lack of facilities, lack of physicians, lack of support staff, lack of coordination in scheduling, and a crowded and unhygienic environment. One participant described her hospital visit experience for a prenatal checkup as a nightmare, when she had to wait for hours and had to come back on many occasions without even having seen the doctor.

Help from professionals. Six of the study participants illustrated their positive experience with their physicians' attitudes as loving, caring, and helpful. To some participants, the service provided by American physicians was much better than that of physicians in Bangladesh. One respondent recalled that her primary care physician was kind to her and her gynecologist congratulated her and her husband on their first baby and gave them a red rose. She also added that the ultrasound technician showed her baby's movement in her womb and then the tech started dancing in joy.

Communication issues. All participants talked about the difficulty of communicating with physicians, nurses, or hospital personnel during their pregnancy. For some of the participants, the patient–physician gap was more a cultural issue than a lack of English language proficiency. Most of the time, patients' feelings and concerns did not make any sense to their American physicians and hospital staff members.

When the researcher talked to some of the hospital staff members regarding their impressions about Bangladeshi clients, their views varied. The dietitian of one of the hospitals was critical of the Bangladeshi patient population. She angrily said, "Bangladeshi patients are the toughest ones. They are very rigid about their behavior and have attitudes." In contrast, the director of the Department of Obstetrics & Gynecology of a hospital in New York was positive about Bangladeshi patients. He said, "Health care is a complex system. The Bangladeshi population is very nice. They know how to appreciate. Bangladeshis have very good family support. I wish I knew their culture to serve them better."

Language barriers. The participants and health care providers agreed that language was a major problem for the Bangladeshi population. Some of them used body language to communicate with their health care providers, losing important information in the process. One participant said, "My physician was very caring, but I did not understand her words, because she spoke too fast." Sometimes, participants brought their neighbors or distant relatives to the hospital, who helped them fill out the paperwork and doubled as interpreters. However, three of the 10 participants expressed their satisfaction about the free professional interpreter services offered by the major hospitals in New York City.

During the informal interview with the hospital officials, the author was given copies of "Patient Guide," "Nutrition Guide for Pregnant Women," "Guide to Breastfeeding," and "Diabetes Booklet." The "Patient Guide" was written in English, Spanish, and Chinese, and the other books were written in English only. She was also given a Bengali version of the "Patient's Bill of Rights." The version was poorly drafted, had many typographic errors, and seemed difficult to understand for the average Bangladeshi mother.

Discussion

This study investigated Bangladeshi women's pregnancy experiences in the United States, including their physical, mental, emotional, social, and environmental health. Interview responses in relation to field observations and health documentation revealed three important findings about their pregnancy experiences in relation to their immigration experiences.

The first finding supports earlier findings exploring the traumatic experience of settling in a new culture (Liem, 1999; Rice, 1999). This trauma was caused by a major gap between Bangaldeshi women's expectations about American culture and their experiential reality. Some of the hard realities encountered by the participants included financial hardship due to unemployment or underemployment, loss of social status, lack of social support, substandard living, and conceiving amid the fear of an uncertain financial future.

The second finding revealed the interaction between culture, religion, and pregnancy. Religion and culture are so embedded in Bangladeshi life that it is hard to separate one from the other. Participants' cultural practices and religious beliefs significantly influenced their health behaviors, including the decision-making process in accessing quality health care. Because of their religious and cultural upbringing and their gendered approach to health care, they could not take full advantage of pregnancy-related health services.

Participants who were brought up in a patriarchal and conservative society showed a significant lack of power over their own health and health care decisions. In a single family setup, the husband was the decision maker, whereas in a joint family setup, the in-laws were more likely to make decisions. These latter findings support Bloom, Tsui, Plotkin, and Bassett's (2000) and Singh, Bloom, and Tsui's (1998) work in India, which revealed that although men knew little about pregnancy and complications associated with childbearing, they made the critical decisions about the mother to be. This lack of agency, combined with physical, mental, and emotional weakness, low self-esteem, and feelings of depression and isolation, rendered the participants vulnerable to physical/mental breakdown during pregnancy.

The third finding was the lack of English language proficiency, which hampered efficient interactions between the participants and their physicians. Most of the participants spoke little to no English. Few health care providers had interpreter services. For this reason, the participants could not express their problems properly and did not understand what their physicians meant. Hyman (2001) observed that women's difficult immigration experiences were often aggravated by weak English language skills and limited social opportunities to improve them.

Conversely, many of the health care professionals lacked the knowledge, skills, and motivation to address the cultural differences of their clients. In support of existing research on the disrespectful treatment of ethnic minorities because of their race or lack of English speaking skills (Blendon et al., 2007), this study also reports a lack of satisfaction with the health care experience during pregnancy (David & Rhee, 1998). Shaffer (2002) reminds that health care providers' understanding of another culture is an important factor that influences access to prenatal care.

Recommendation and Conclusion

Immigration and issues of pregnant women will continue to be a major concern for American health care services. The complexity of the issue will grow further with the changing demographic mosaic of the American population. This issue needs to be addressed from multifarious perspectives. Steps should be taken to deliver health care services in a culturally appropriate manner. Course curriculum and/or training materials should be developed for health educators, physicians, and other professionals to ensure access to quality care for ethnic minorities. In the development of further research initiatives focusing on immigrant pregnant women, much can be done in the areas of cultural sensitivity, health programs, policy development, and health education.

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Health Worker Attitudes to Intimate Partner Violence on the Tibetan Plateau: A Qualitative Assessment of Cultural and Material Factors Behind Non-Interventionist Attitudes

Hamsa Rajan, *University of Oxford, United Kingdom*
Ligia Kiss, *London School of Hygiene and Tropical Medicine*
Karen Devries, *London School of Hygiene and Tropical Medicine*
Cathy Zimmerman, *London School of Hygiene and Tropical Medicine*

Abstract

Qualitative interviews with a small number of health care providers and nongovernmental organization (NGO) staff members were conducted to understand providers' attitudes to intimate partner violence (IPV) on the Tibetan plateau and the link between these attitudes and prevalent social norms. NGO members have received gender awareness training and tended to consider prevalent gender norms and roles to blame for IPV. Health care providers, on the other hand, tended to endorse these norms. Providers did not appear to conceptually separate abusive and nonabusive conflict, giving rise to perceptions that abuse is commonplace and without traumatic effects. In general, providers did not consider that assisting cases of IPV was part of their professional responsibility. When asked what type of help victims need, health workers focused on reconciliation with perpetrators or emotional support. Providers said they would advise victims to avoid conflict and react to perpetrators with less anger. Respondents also expressed beliefs that victims are sometimes the guilty party responsible for conflict. Respondents felt separation from an abusive partner is generally not an option, because divorce is considered to cause concerns for children, difficult financial circumstances, and a negative reputation for wom-

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Hamsa Rajan is a PhD candidate in the Department of Social Policy and Intervention, University of Oxford. **Ligia Kiss** is a Lecturer in Social Epidemiology at the London School of Hygiene and Tropical Medicine. **Karen Devries** is a Senior Lecturer in Social Epidemiology at the London School of Hygiene and Tropical Medicine. **Cathy Zimmerman** is a Reader in Migration, Health, Vulnerable Migrants, Human Trafficking, Labour Exploitation, and Gender-Based Violence at the London School of Hygiene and Tropical Medicine. Please send author correspondence to hamsa.rajan@spi.ox.ac.uk.

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en following divorce. Perceptions that divorce is usually the worst option for women and lack of awareness regarding the difference between abusive and nonabusive conflict should be addressed in health worker training programs and community interventions. Our findings are relevant to other regions of the world in which IPV is not considered extraordinary or serious and in which heavy social and material constraints can act as a barrier to divorce for women.

Keywords

domestic violence; intimate partner violence; gender violence; gender-based violence; health worker; health care; doctor; nurse; health professional; Tibet; China; Asia; gender; women

Intimate partner violence (IPV) in heterosexual relationships has been defined as a process by which a man uses physical violence as well as psychological, emotional, and financial abuse in a malicious attempt to assert power and control over his female partner (Gilchrist & Kebbell, 2004; Kilpatrick, 2004; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Pence & Paymar, 1993; Stark, 2007). Stark (2007), for example, argued that domestic violence is more accurately termed coercive control and draws parallels between tactics used by abusive men to control heterosexual partners and capture crimes, such as kidnapping, the taking of hostages, or the internment of prisoners of war. This bears similarities to the argument of Sloan-Lynch (2012), who asserted that domestic abuse is not a series of "isolated acts of violence" but is instead "a source of brutal oppression" and characterized by "a miasma of fear" (p. 787). As Stark explained, victims often have a sense that perpetrators' excessive anger and violence are possible at any moment and unpredictable, regardless of what the victim says or does. Abusers regulate and restrict victims' daily activities; often engage in stalking and surveillance of their partners' belongings, phone calls, and activities; work to deprive victims of "money, food, access to communication or transportation"; and work to cut victims off from social support, such as family and friends (Stark, 2007, p. 5). IPV is usually distinguished from nonpartner violence in surveys (Fulu, Jewkes, Roselli, & Garcia-Moreno, 2013; Jewkes, Fulu, Roselli, & Garcia-Moreno, 2013) and measured separately.

A large body of evidence lists adverse health effects associated with IPV (Black et al., 2011; Campbell, Abrahams, & Martin, 2008; Dillon, Hussain, Loxton, & Rahman, 2013; Stockl et al., 2013; Woods, Hall, Campbell, & Angott, 2008; World Health Organization, 2013). Studies show that survivors use health services more often than the general population (World Health Organization, 2012), and researchers have noted the importance of health care settings for identifying and responding to IPV survivors. Survivors often do not approach police or legal services and are therefore likely to be left without institutional support unless identified in the health care setting (Colombini, Mayhew, & Watts, 2008; Odero et al., 2014). Investigators have likewise noted that because health workers[1] are often the first professionals approached by survivors, they can play a key role in intervening and providing support (Husso et al., 2012; Morrison, Ellsberg, & Bott, 2007). However, research suggests that health care providers in many settings are often ill-equipped and/or unwilling to address IPV (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012; Colombini, Mayhew, Ali, Shuib, & Watts, 2013; Kirst et al., 2012; Roelens, Verstraelen, Van Egmond, & Temmerman, 2006). For health workers who learn of or suspect abuse, research has suggested they may minimize survivors' experiences, ignore the abuse, or blame the victim as responsible for the perpetrator's actions (Beynon et al., 2012; Colombini et al., 2013; Corbally, 2001; Haggblom, Hallberg, & Moller, 2005; Kim & Motsei, 2002; Odero et al., 2014; Rodriguez, Bauer, Flores-Ortiz, & Szkupinski-Quiroga, 1998; Rodriguez, Quiroga, & Bauer, 1996). This negative response can cause survivors to lose faith in health care providers, to feel that their relationships with providers have deteriorated, or to believe that services provided in health care settings have lost much of their value (Hathaway, Willis, & Zimmer, 2002; Rodriguez et al., 1998; Rodriguez et al., 1996).

IPV is a common occurrence in China, with studies indicating between 17% and 30% prevalence of gender-based violence in families or of IPV (Human Rights in China, 2006; Jolly & Ying, 2003; Merry, 2005; Parish, Wang, Laumann, Pan, & Luo, 2004; Tam et al., 2015). However, there is a dearth of information on health worker attitudes and practices toward IPV on the Chinese mainland (Kamimura et al., 2015). In addition, evidence regarding violence against women among Tibetan populations, in particular in Tibetan regions of China, is scarce. Most important, a clear gap in the public health literature exists with regard to a deeper probing of why and how providers adhere to non-interventionist, minimizing, and victim-blaming attitudes (Colombini et

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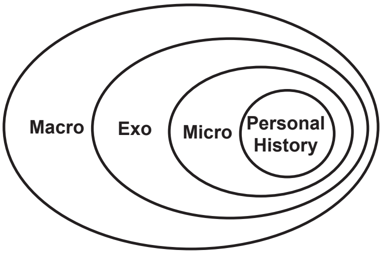
[1] Health workers/health care providers are defined here as current or former full-time staff members of hospitals or clinics as well as those who have completed a medical internship. The length of work experience among providers interviewed in this study ranged from 3 to 19 years. In the study region, many rural and remote areas have a village clinic located relatively near residents' homes. Village clinics, however, often provide only very basic services; care needs beyond this level usually require travel to the nearest town or city. Recent studies have found the coverage rate of rural medical institutions in Western China is high, but lower than the coverage found in Eastern and Central China (Wang et al., 2015). One study found there are approximately 23 health workers per 1,000 people in rural areas of the study region, but noted that township and village health care workers were responsible for residents of much larger areas of land than was found in eastern parts of the country (Han et al., 2012).

al., 2008; Cronholm, Singh, Fogarty, & Ambuel, 2014; Goicolea et al., 2015; Morrison et al., 2007).

This study was an analysis of interviews with health workers and nongovernmental organization (NGO) staff members residing on the Tibetan plateau. This was an exploratory study of health worker attitudes and practices to IPV and of the cultural and societal context affecting IPV response. Similar to findings from other low and middle income country settings, such as parts of sub-Saharan Africa, Latin America, and Asia (Colombini et al., 2008; Mitchell, Parekh, Russ, Forget, & Wright, 2013; Odero et al., 2014), this study also revealed a lack of workplace protocols or regulations on IPV, a tendency among providers to ignore abuse to focus on treating physical ailments alone, and provider attitudes generally disparate from supportive or positive interventionist responses. The attitudes and practices of health workers in one part of the Tibetan plateau, as revealed by our findings, present a valuable case study for two reasons. First, this is one of the poorest regions of China with consistently low human development indicators (Li & Wei, 2010; Liu & Griffiths, 2011) and a region in which household farming and animal husbandry make up a large proportion of economic activity (Fang, 2013; "Tibetan nomads," 2009). The study area is a region with important similarities to many other low and middle income country settings. Second, and primarily, this study looked closely at the cultural and material factors and rationales behind providers' attitudes. Such an investigation is necessary if training programs for health workers are to be effective.

Theoretical Framework

This study used Heise's (1998) ecological model of IPV, in which violence is seen "as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors." This model relies on a "notion of embedded levels of causality" (pp. 263–264), in which personal history factors are embedded within a microsystem environment. The microsystem level, in turn, is embedded within the exosystem, which is embedded within the macrosystem (see Figure 1). The individual level encompasses "those features of an individual's developmental experience or personality that shape his or her response to microsystem and exosystem stressors" (Heise, 1998, p. 266) and can include elements such as witnessing marital violence as a child, being abused as a child, and having an absent or rejecting father. The microsystem encompasses situational factors and "refers to those interactions in which a person directly engages with others as well as to the subjective meanings assigned to those interactions" (Heise, 1998, p. 269). This level can include male dominance in the family, male control of wealth in the family, frequency of marital conflict, and use of alcohol. The exosystem encompasses the immediate social environment of individuals and includes elements such as unemployment or low socioeco-



Personal History

- Witnessing marital violence as a child
- Being abused oneself as a child
- Absent or rejecting father

Microsystem

- Male dominance in the family
- Male control of wealth in the family
- Use of alcohol
- Marital or verbal conflict

Exosystem

- Low socioeconomic status
- Isolation of women and family
- Delinquent peer associations

Macrosystem

- Male entitlement or ownership of women
- Masculinity linked to aggression and dominance
- Rigid gender roles
- Acceptance of interpersonal violence
- Acceptance of physical chastisement

Figure 1. Heise's ecological model. From "Violence Against Women: An Integrated, Ecological Framework," by L. L. Heise, 1998, *Violence Against Women, 4,* p. 265.

nomic status, a woman's or family's social isolation, and male peer groups that encourage gender-based violence. Finally, the macrosystem encompasses "the broad set of cultural values and beliefs that permeate and inform the other three layers of the social ecology" (Heise, 1998, p. 277). In this study, by looking at survivors' interactions with health care workers, and by exploring broader gender norms as they affect IPV, we focused on the exosystem and macrosystem levels.

This study additionally drew on Esser and Kroneberg's (2015) theory of behavioral motivation. Pulling together evidence from experimental and theoretical work in psychology, neuroscience, sociology, and economics, Esser and Kroneberg proposed a theory of individual action that accords with the contention of IPV scholars that perpetrators' actions often derive from prevalent and readily accessible social scripts. Stark (2007), for example, described how perpetrators draw heavily on readily accessible and gendered social scripts when they abuse female partners. He described, for example, that perpetrators sometimes use social scripts associating the feminine with emotionality to decry their female partners as crazy and associating the masculine with rationality or femininity with moral degradation to show disdain for female partners. Esser and Kroneberg likewise described humans' choice of actions and responses as a matter of first defining a situation. If the situation in question resonates with strongly held norms and mentally held conceptions of prototypical scenarios believed to warrant a particular response, a response is automatically enacted.

If the response involves high stakes and potentially severe consequences, a more deliberative response ensues in which an actor first weighs the pros and cons of different actions prior to responding. This model of frame selection asserts that social norms are highly salient factors in individual behavior. Rather than being endowed with absolute power, however, these norms are tempered by the situations an actor encounters (Esser & Kroneberg, 2015).

This theoretical background led to our focus on social norms, definitions, and conceptions of abuse. Our theoretical framework also gave rise to our interest in investigating the attitudes and practices of health providers, as this is an important component of the broader environment described in Heise's ecological model.

Study Purpose

As there is no literature on the attitudes and responses of health workers toward IPV and IPV survivors in the study region, this study aimed to fill a gap in the literature. Specifically, this study aimed to fulfill four purposes:

1. Explore health care providers' knowledge and beliefs regarding the nature and causes of IPV, IPV's effect on health, prevalence of IPV, and severity of the problem in the study region.
2. Explain whether providers have come into contact with IPV survivors through their contact with patients, family, or friends; explain how providers learned of the IPV and the manner in which providers responded to these cases.
3. Gain from providers a description of common or prevalent responses by the community and the authorities to incidences of IPV; understand whether providers' own responses reinforce those of the community.
4. To further understand whether providers' responses reinforce or counteract those of the community, obtain from NGO staff a description of community and authority responses to IPV as well as the gender norms, roles, and relationships that may give rise to IPV; NGO staff members should be individuals who have received gender awareness training and who work on social problems affecting women.

Method

Health care providers' knowledge and beliefs about IPV as well as their contact with IPV through patients, friends, or family were explored through qualitative, semistructured interviews conducted in April 2009 in a region of Western China located on the Tibetan plateau. Providers were also asked to discuss their impressions of community and authority responses. Qualitative, semistructured interviews were conducted on similar topics with staff (current or previous) of NGOs (see Appendix for a partial list of interview questions).

Most of the NGO staff members have received gender awareness training and have worked on projects related to women's health or women's needs. NGO members' gender awareness training included discussion of IPV and rape; gender stereotypes; gendered opportunities and constraints found in education, professional areas, and the family; representations of gender in local religious practices; and prominence of women in contemporary society as well as within histories and hagiographies. In their professional work, NGO members have worked to improve women's health in the areas of family planning and sexually transmitted infections. NGO members have also worked to reduce the household labor burden of women and to change common gender-unequal community opinions.

In their professional work, NGO staff members have traveled to remote villages and nomadic settlements to assess and deal with local needs. Health care providers, on the other hand, were based in clinics or hospitals in cities or small towns. NGO members' professional work and gender awareness training, including their awareness of rural women's struggles, meant NGO members were likely to have a more comprehensive understanding of local gender norms and of community responses to IPV, including responses among the large proportion of the population living in rural areas. NGO interviews thus complemented the health provider interviews by offering a wider contextual understanding of IPV in this region.

The interview topic guide was developed based on a literature review of provider attitudes to IPV in China and worldwide, the principal researcher's personal knowledge of local culture and practices, previous qualitative research with IPV survivors in Cambodia (Zimmerman, 1995), and the World Health Organization (2005) Multi-Country Study on Women's Health and Domestic Violence Against Women.

Questions and informed consent forms were translated from the original English into Chinese and Tibetan. Translations were cross-checked to ensure clarity and accuracy of meaning. Some questions were modified after the first interviews, making the interview process iterative. The majority of interviews lasted for approximately 1 hour 20 min and were conducted in Tibetan, Chinese, or English, according to the participant's preference. Interviews were tape-recorded and were either fully transcribed or partially transcribed to capture all statements related directly or indirectly to the subject of IPV. Partial transcription was at times conducted because some recordings included content unrelated to IPV and therefore did not constitute data requiring analysis. Two individuals refused to be tape-recorded. Notes taken by hand during these two interviews were typed and elaborated upon within 48 hr of interview completion. When conducting data analysis, we employed thematic analysis, a process by which recurrent themes and links between respondent statements are assessed (Green & Thorogood, 2005; Miles & Huberman, 1994).

Participants were a convenience sample introduced via the principal investigator's local contacts. Five health care providers were interviewed including nurses, doctors, and individuals not currently working in a clinical capacity but who have completed a medical internship. Most worked in obstetrics, gynecology, or family planning. Providers were all female. NGO staff members were identified through a similar process. Four individuals who have worked in a significant capacity on nonprofit development or health projects were interviewed. As noted, all of the NGO participants have worked on activities that included a focus on women's health or women's issues. The majority have also received gender awareness training. All NGO members were also female. Unfortunately, further details on respondent work activities and characteristics cannot be provided because of the small sample size and confidentiality concerns. Health care providers were between 25 and 45 years old, and NGO staff members were between 20 and 30 years old.

Many of the ethical concerns common to IPV research projects, such as worries for victims' safety in the event that the perpetrator discovers the victim has been speaking to researchers about abuse, did not apply to this study, because we did not seek to interview victims directly or ask respondents about their own experiences of violence. As only five health care providers and four NGO staff members were interviewed, neither the respondents' names or work locations nor the specific site of interviews is listed here because of ethical concerns. Ethical approval was obtained prior to conducting interviews through the London School of Hygiene and Tropical Medicine, and local ethical review was conducted by a prominent women's NGO in the study area.

Results

Concept of IPV

Participants' definitions of IPV and abuse were broad and included much more than physical violence alone. Health care providers stated IPV includes causing bodily harm, beating and scolding, and one participant included extramarital affairs. Health care providers said that in addition to physical hitting, the term *abuse* includes mental harm, such as not talking to one's partner; curtailed freedom; or a situation in which a husband does not pay attention to his wife, leaves her at home, and spends a lot of time outside. NGO staff members listed similar acts and added other behaviors, such as insulting; not allowing one's partner to attend events outside the home; withholding needed money from one's partner; disrespecting one's partner by being unfaithful; and a situation in which a woman is treated like a servant, has few rights in the family, or is viewed as the source of bad luck. The inclusion of extramarital affairs, not talking to one's partner, and spending a lot of time outdoors while leaving one's wife at home in respondents' definitions indicates a broad conceptualization of IPV and abuse.

When responding to questions regarding the definition of abuse, many providers focused more on the causes of marital conflict than on describing the parameters of abuse as such. This likely indicates a lack of a strong conceptual separation between abusive and nonabusive intimate partner conflict. For example, one provider stated,

> Q: *What is the meaning to you of the term "domestic violence"?*
>
> A: I think domestic violence primarily includes husbands and wives not getting along. Also like when the husband says he needs something, but the wife doesn't go [to get it], and then the husband says, "you didn't go" and then hits her. Also, sometimes when the husband and wife generally get along, but they have a disagreement about some work that is to be done or relationship—this happens a lot.

Similarly, an exchange with another provider was as follows:

> Q: *What is the meaning of the term "domestic violence"?*
>
> A: I don't know.
>
> Q: *What is included in domestic violence? Does it include a husband hitting his wife?*
>
> A: Yes.
>
> Q: *And besides hitting, anything else?*
>
> A: When a man sleeps with another woman. Many people have disagreements because of this.

These responses appear to indicate that physical violence was considered to be part and parcel of marital disagreement more generally. Violence and abuse were not distinguished as qualitatively different from nonabusive marital disagreement. This likely underpins respondents' broad definitions of abuse.

Effect of IPV on Health

Respondents' broad definitions of IPV and abuse were replicated in assessments of the health effect of IPV, with providers focusing on the emotional damage of IPV. Some providers also spoke of bodily harm and danger to the fetus of a pregnant woman. One provider linked the emotional harm of IPV to bodily health: "One's emotional state is not good [when you suffer IPV], and then because of this you have a lot of illness, like not being able to sleep at night, you cry a lot, and your body really has illnesses."

Another provider stated,

> Patients [who have experienced IPV] . . . are feeling emotional pain. Other patients have pain and illness that's a bit more common, but

> [patients who have suffered IPV] have emotional wounds. Even if their body is healed, they will still be angry in their heart.

Acceptability of Abuse and Placement of Blame

NGO members' descriptions of prevalent norms and practices that aggravate or give rise to IPV were at times directly replicated in the health care workers' accounts. Thus, NGO staff described local gender roles and norms that contribute to IPV, such as women's heavy workload, men's powerful position within the family, conflicts between a wife and her husband's family, men's drinking of alcohol, and men's infidelity. Health care providers listed many of these factors as well. Several NGO respondents explained that gender socialization and norms are to blame for IPV. An important gender norm in this regard is men's position of authority within the family. NGO staff members explained that men tend to believe that they have a right to hit their wives and no one can interfere. A man's violence against his partner is considered to be "like [the perpetrator is] breaking [his] own property," explained an NGO member. Many NGO members described these norms, but they did not endorse these views.

Health care providers, on the other hand, replicated the NGO members' descriptions, but did so by endorsing such views. Thus, reflecting the norm that men's place is one of authority within the household, many health care providers implied a wife's rightful place is to defer to others' authority, by implying that a wife's rightful place is one of silence, understanding, little anger, and hard work. Providers expressed the notion that the victim should be more conciliatory or understanding toward the perpetrator to prevent abuse. In the event of IPV, therefore, providers would advise victims to avoid conflict and be understanding. Following a perpetrator's threat to kill his wife, for example, one provider urged the perpetrator to stop his violent behavior and then told the victim that a bit of hitting is "not a problem" and instructed the victim to refrain from talking back. One health care provider noted that men have the right to verbally discipline their wives, explaining the situation of her own parents:

> Sometimes [my father] would say really bad things [to my mother], like "You're stupid," "You don't know anything." . . . When he talked like this, my mother felt really bad. When she felt bad, . . . [I] would feel angry at my father . . . When I was young, I didn't know . . . whether it was my father or mother who was right, but my father was the harsh one . . . But now that I've grown up . . . I know how to think through things, and I think my father's behavior was understandable. When he scolded my mother, it was because she didn't understand something, and so he scolded her.

She assessed that if her mother had done something wrong or "didn't understand something," the husband had the right to put his wife in her place using a disproportionate severity of language.

Although most health care providers stated hitting one's wife is a crime or generally unacceptable, a number of providers also indicated that in some instances beating is acceptable. According to these participants, instances in which abuse might be acceptable include if the wife has done something wrong, if weapons are not used, if the hitting is not serious, or if the wife will engage in bad behavior unless she is beaten. Some providers suggested that if beating is not too serious, it can or should be endured. A number of providers and one NGO member indicated that the victim is sometimes the guilty party responsible for conflict. One provider stated,

> If the husband beat his wife, he should think, "I beat my wife today. That wasn't right" and regret it . . . Afterwards, the wife should also think, "This time he hit me. But even if he hit me, he regretted it and apologized. He's gotten better. In the future, I will not do these bad things and will change." This kind of thinking is needed. Both people should try hard regarding their respective problems. If they do this, then violence won't occur.

In this case, the speaker assumed the wife had done something wrong to cause the beating. This same provider said that sometimes wives "should stay quiet. If you'll just properly be, then violence won't occur . . . if the wife still tries to say the other person was wrong . . . even though the other person was not wrong . . . then [violence] will occur."

Reconciliation as Response

In the cases of real and hypothetical occurrences of IPV to friends, family, and patients of providers, advising divorce was generally not considered an option, unless cases were severe. According to one provider, if a wife is not treated "like a person," she does not have freedom, or her life may be in danger, she should divorce. Several NGO respondents would only interfere in a case of IPV or recommend that a victim leave her perpetrator in serious or repeated situations.

When asked what type of help victims need, the health workers focused on reconciliation or emotional support. For example, one health care provider spoke of telling a woman to be more open-minded and not rush to divorce in anger. One health worker would advise patients to endure the extramarital affairs of their husbands, telling them "if you're truly in his heart . . . then it's not such a big problem." One provider conveyed that informing victims they do not deserve their partners' violence is incorrect.

Health care providers stated that they cannot interfere in patients' personal lives or that IPV is not a part of doctors' responsibilities. One provider stated, "We as doctors don't have the option of interfering in these matters. Patients never tell doctors directly about domestic violence." That victims will not speak honestly to health workers was also listed as a barrier providers would face if they attempted to help a victim. Several respondents believe providers' professional role in treating IPV survivors is only to treat survivors' physical injuries and illnesses.

Many health care providers have never come across patients they knew to be suffering IPV, and no provider has ever directly asked patients about IPV. Most health care providers said their workplace has no rules around IPV or none that they know of. No provider has ever received IPV-related training. Only one provider has come into contact with many known victims of IPV in her work. She explained her response to patients suffering IPV:

> With patients [who have suffered IPV], for example I would say, "You're in pain. All animals and people have pain. We also have pain. It's not a problem. It'll get better if you take medicine. It'll get better if you get an IV. It's not a problem. This is nothing . . . Is it only you? Go and watch TV." I talk to them like this, and like, "Oh! He hit you. This is not right"—you can't talk like this. If you say this, then they cry and feel bad, and you feel bad for them.

This provider gives similar advice to patients and friends, believing that by minimizing victims' experiences she is helping them focus less on their suffering, so as not to aggravate their pain. In the event that she came across a patient suffering IPV, one provider, likewise, said she would "teach [patients] that they can't be [sad/angry] like this; if you keep feeling like this, it will only get worse." Like the provider who prefers to minimize patients' abuse, this provider believes helping victims to focus less on their suffering is a positive response to IPV.

That providers focused on encouraging victims to manage better within abusive situations implies divorce is often considered an unacceptable option. This view may be driven by beliefs that divorce often places women in especially constrained and trying circumstances. Respondents mentioned a number of barriers preventing many women from divorce, such as concerns for the postdivorce welfare of children, the stigma to one's reputation that results from divorce, worries that remarriage after divorce would be difficult or impossible, and, perhaps most important, concerns around women's lack of independent material or economic assets.

In line with some respondents' predominant motive of reconciliation, advising the perpetrator to stop his violent behavior was a commonly mentioned response to IPV. One provider stated, "Somebody should talk to the husband nicely" so the couple can get along once again, and she also spoke negatively of those who encourage divorce. Several NGO members said they would respond to IPV by talking to the perpetrator, threatening the perpetrator with legal consequences, or convincing the couple to get along. Among health care providers, the notion that the perpetrator should be punished for his behavior beyond mere scolding or exhortations to change his behavior was largely absent.

When asked whether IPV would prompt health care providers to call the police, providers' answers were negative. Providers indicated that they would not call the police at all or would only call in the case of a threat to life or serious bodily harm. One provider stated that it is wrong to call the police as "the two of them can decide their own things themselves," and another voiced a fear that calling the police would aggravate the situation for the victim at home. All NGO staff members were likewise generally unwilling to call the police. NGO members stated that the police would not come quickly, would only come if the situation is serious, or would only come if given a bribe, and some feared calling the police would incite greater anger in the perpetrator. One NGO respondent spoke disparagingly of the police, stating the police would do nothing if called. Some NGO respondents implied IPV is usually not severe enough to warrant calling the police or to warrant either the perpetrator's arrest or a response by the authorities.

Discussion

Our findings provide exploratory insight into health care providers' attitudes and behaviors toward IPV in a region of Western China located on the Tibetan plateau, with background information on IPV and gender dynamics in this region provided through interviews with NGO staff. When asked about the causes of IPV, NGO staff members, most of whom have received gender awareness training, focused more on gender inequality and the prevalent societal view that IPV is often acceptable. They were also more likely to blame conflict and IPV on gender inequality than on individual personality conflicts. Health care providers, on the other hand, tended to imply that a husband and wife were equally to blame for male-perpetrated IPV.

Providers defined abuse in extremely broad terms. The broad definitions of IPV cited by health care providers and NGO staff members in this study included scolding, extramarital affairs, curtailed freedom, or abuse in addition to beating. The inclusion of extramarital affairs in the concept of abuse indicates a broad definition indeed. Moreover, when responding to the principal investigator's questions regarding the definition of abuse, some respondents focused more on the general causes of marital conflict than on describing the parameters of abuse. This appears to indicate a lack of strong conceptual separation between abusive and nonabusive intimate partner conflict. Feminist author Gloria Steinem, speaking of her upbringing and activism in 1950s, 1960s, and

1970s America, stated that in those decades, "we didn't even have a word for domestic violence. It was just called life . . . now we understand that it's not natural, it's not normal, it's not inevitable" (*Gloria Steinem,* 2013). Others have also written about processes by which feminist movements in a number of settings around the world have played a major role in adopting a public understanding of IPV as a social problem requiring active intervention and protection of victims' welfare and rights (Heo, 2010; Pleck, 1987; Walker, 1990; Yoshihama, 2002; Zhang, 2009). Thus, in settings in which such activism has not occurred or in which historical and social circumstance have not led to abuse or IPV to be viewed as something extraordinary or serious, something beyond "just life" and beyond the "normal and inevitable," as Steinem describes, a strong conceptual separation between abusive and nonabusive couple conflict may not be seen. This lack of a stark conceptual separation may be behind respondents' broad definitions of abuse, such that abuse is deemed to include behaviors such as extramarital affairs and husbands leaving home often.

Thus, in our study, broad definitions appear to be indicative of a lack of strong conceptual separation between abusive and nonabusive couple conflict, thereby giving rise to attitudes that do not consider IPV to be a serious problem. This is counterintuitive because narrow rather than broad definitions of abuse tend to be associated with victim-blaming or non-interventionist attitudes to IPV within the literature. In other words, as stated by Flood and Pease (2009), IPV studies usually reveal the following:

> The more that people maintain egalitarian gender attitudes, the better are their attitudes toward violence against women. They are more likely to see violence against women as unacceptable, *to define a wider variety of acts as violence or abuse* [emphasis added], to reject victim blaming, to support the victim, and to hold accountable the person using violence. (p. 128)

Those who define IPV as physical violence in addition to demeaning a victim through verbal insults, depriving a victim of money, or isolating the victim from family and friends are therefore more likely to display attitudes that are supportive to victims and favorable toward professional intervention in IPV. Those who define IPV as physical violence or severe physical violence alone, on the other hand, are less likely to hold to these supportive attitudes (Flood & Pease, 2009; Kim & Motsei, 2002). Unlike the literature, however, we found providers held to broad definitions of abuse, but this did not correlate in the study setting with interventionist or supportive attitudes that refrained from blaming victims.

When IPV is not viewed as a serious problem, it is likely to be understood as just another aspect of intimate partner conflict. In many settings around the world, then, it is likely that, in the absence of widespread feminist activism, prevalent notions by which a stark conceptual separation is made between abusive and nonabusive couple conflict do not exist. Instead, all conflict is likely to be understood as mundane and often as relatively trivial. This lack of a conceptual separation is likely to lead to attitudes toward IPV that are similar to attitudes toward nonabusive marital conflicts. The result, therefore, is perceptions of conflict as gender-symmetrical rather than a product of power imbalances between men and women, with blame equally apportioned to husbands and wives (Leung, 2011). This finding is likely to be relevant to other settings in which prominent and successful feminist movements specifically around the topic of violence against women have not occurred or to populations that have not been affected by feminist understandings of abuse as extraordinary and serious. Our findings are relevant to the study region as well as other settings in which abuse does not appear to encounter a strong conceptual divide differentiating abuse as significantly and qualitatively distinct from nonabusive intimate partner conflict. Our findings are relevant for IPV-related training programs provided to health workers and for other IPV interventions.

Our study is unique in that it includes interviews with NGO staff members, most of whom have received gender awareness training, unlike the health care providers. NGO staff descriptions of the broader social and cultural context within which IPV occurs, combined with providers' accounts, reveal that perceptions of women's difficult circumstances following divorce are an important factor reinforcing providers' responses to victims because they revolve around the notion that, in many cases, advising divorce is not an option. Some participants implied that the first order of response to IPV is always to attempt to reconcile the couple, with divorce being advised only if reconciliation proves impossible. Descriptions of women's or families' difficult circumstances following divorce reveal that preserving family unity is promoted not only for its own sake, because this is considered of greater import than women's rights or welfare, but also at times *for* women's welfare. That is, we reveal that providers do engage in victim-blaming, but respondents also commonly implied that divorce can be worse for women and families than remaining in abusive situations. This finding may be relevant to other parts of the world where significant barriers prevent women from divorcing their partners because of, for example, the prospect of poverty or social stigma. Such perceptions are therefore a point that may need to be addressed in training provided to health care workers or in IPV-related community interventions, in the study site and in other settings where similar perceptions are found.

NGO staff and health care providers appeared to believe that divorce or intervention by authorities is only warranted in serious situations. Providers' responses included minimization of abuse, and abuse was often seen as an inevitable or trivial fact of everyday marital life. Reconciliation, emotional support, and advice, often to change one's behavior so conflict does not arise, were the favored responses to IPV victims. Thus, acceptance of IPV, minimizing victims' suffering, and focusing on reconciliation without strong prior focus on victims' own desires were common interventions in IPV cases, although some have advocated divorce in some instances with friends or relatives. Scolding the perpetrator or exhorting him to stop his abuse were also mentioned as responses.

Most health care providers believed that dealing with IPV was not part of their professional responsibilities or that it was not their place to intervene in patients' private matters. Some providers felt providing medical treatment was their only responsibility in the case of IPV. In addition, most providers were unwilling to call the police or would only call in serious or life-threatening situations.

Studies from Western countries indicate the types of provider responses found in the study region do not meet the wishes of survivors. For example, IPV survivors in several North American studies stressed the importance of direct and provider-initiated questioning about IPV (Hathaway et al., 2002; Rodriguez et al., 1998; Rodriguez et al., 1996; Kelly, 2006). A minority of survivors in one study also voiced a preference for indirect questioning (Hathaway et al., 2002). Minimizing abuse, ignoring abuse to provide only medical treatment, and blaming the victim as responsible for the perpetrator's actions have been found to affect survivors negatively (Campbell, Pliska, Taylor, & Sheridan, 1994; Corbally, 2001; Hathaway et al., 2002; Hattendorf & Tollerud, 1997; Rodriguez et al., 1998; Rodriguez et al., 1996). Additionally, studies conducted in the United States, Australia, and the United Kingdom have found survivors want health professionals to respect their wishes and engage in joint decision making with them. Survivors were dissatisfied when their autonomy was not respected in this way (Feder, Hutson, & Taket, 2006). Survivor wishes in the current study area are unavailable, but if these wishes are similar to those in other settings, providers' responses are inadequate. When telling victims to keep quiet or change their behavior, providers in the current study have in effect blamed victims for the abuse they suffered. Moreover, when providers do not address the underlying causes of women's health complaints, women may continually return to health facilities with a similar set of unresolved health issues. In addition, our findings indicate a lack of clear workplace protocols or professional guidelines on assisting IPV victims. Instead of informing women of available options and supporting them in the decision-making process, therefore, professionals may further isolate victims and contribute to the perpetuation of violence.

The broader social and institutional context of the region significantly informed respondents' views and responses to IPV victims. Thus, for NGO respondents, a barrier to approaching the police was the belief that police responses would be inadequate. In addition, health care workers and NGO members spoke of difficulties that often result in divorce becoming a nonoption for women. These barriers included women's lack of independent material or economic assets, concerns around stigma and poor reputation that follow divorce, the inability of some women to remarry following a divorce, and concerns for children's welfare in postdivorce situations. These barriers may not be insurmountable in every case, but respondents appeared to feel they were insurmountable in many cases. This reveals that providers' focus on mediation of the marital relationship and the advice they provided to victims to find ways to prevent or minimize abuse while remaining within their marriages were informed not only by victim-blaming attitudes and by a view that IPV is not always a serious problem, but also by concerns for women's welfare.

In the study setting and in other settings where similar perceptions are found, training programs should address that providers perceive divorce as causing women and families to be worse off than remaining within abuse. Trainers should also emphasize conceptually separating abusive from nonabusive conflict and should build upon this conceptual separation to emphasize victims' welfare and refraining from victim-blaming rather than mediation alone as a response to IPV. Without a prior understanding of providers' broad definitions of abuse, training programs are likely to be ineffective. Our findings are therefore relevant to other settings where feminist movements have not engendered a notion of IPV as a serious social problem requiring external intervention.

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Appendix

Abbreviated Sample of Interview Questions for Health Workers

What is domestic violence? Please explain what you understand by this term.

Have you ever suspected patients of experiencing domestic violence?

> How did you come to suspect her/him of experiencing domestic violence? How did you react/respond? Can you describe the situation and your response?
>
> What kind of injuries or illnesses did they have? What are the most severe injuries that you have seen?
>
> Was the manner in which you spoke with, diagnosed, or provided treatment to suspected domestic violence victims different than that given to other patients? If so, how?
>
> Is there any special advice or suggestions you give to suspected victims of domestic violence? Do you ever advise them not to return to their husbands?

Has a patient ever told you about or have you ever suspected a patient of being raped by a husband or boyfriend?

Have you ever suspected that a patient's husband or boyfriend has used a weapon against her?

Among those patients you suspected or confirmed were experiencing domestic violence, why do you think the violence was occurring?

Would you ever or have you ever called the police on behalf of a patient? Why or why not?

In attempting to help a victim of domestic violence, what barriers do you think you might face (or have you faced)?

If you wanted to report an incident or situation of domestic violence, whom would you report to? What would likely happen?

Are there any hospital rules or policies regarding domestic violence?

What are your views on domestic violence? Why does it happen?

In general, who or what do you think is to blame for domestic violence?

In your opinion, when can a woman be called "abused"?

Are there other types of abuse besides hitting? If so, what type of abuse is okay and what is serious?

Have you ever had a family member or friend who was experiencing domestic violence? If so, how did you respond? How did this experience impact you?

Abbreviated Sample of Interview Questions for NGO Staff Members

Tell me a bit about the kind of work that you do and your work-related responsibilities. What kinds of projects or activities have you been involved in?

What benefits do you think women have gained from your work?

What is domestic violence? Please explain what you understand by this term.

Are there other types of abuse besides hitting?

> Do these other types of abuse fall within the realm of "domestic violence"?

Have you ever known anyone who was or is experiencing domestic violence? Can you describe any of these situations?

> How did you respond to this situation? How did this experience impact you?

What are your views regarding domestic violence? Why does it happen?

In your opinion, what are some common causes of conflict between husbands and wives?

In your opinion, when can a woman be called "abused"?

Who do women experiencing domestic violence tell about their problem?

Do women themselves go to the police for help with domestic violence? How do the police usually respond?

In your opinion, what type of help do women experiencing domestic violence want? Is there any help available to them?

What barriers might a woman face when trying to escape from a violent partner? Are these barriers the same for women escaping a single episode of violence and those wishing to leave a partner for good?

What or who might offer help and support to a woman trying to escape from domestic violence?

What more can/should the government do to deal with the problem of domestic violence?

Do you believe the police should ever be called regarding abuse within the family? In what types of situations should they be called?

Do you believe that any aspect of domestic violence or how it is dealt with in society will change in the future?

What can local people/Tibetans do to stop the problem of domestic violence?

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Female Genital Mutilation: Current Practices and Perceptions in Somaliland

Trista Dawn Smith, *Wright State University Boonshoft School of Medicine*
Cristina Redko, *Wright State University Boonshoft School of Medicine*
Nikki Rogers, *Wright State University Boonshoft School of Medicine*
Edna Adan Ismail, *Edna Adan University Hospital*

Abstract

Background: Somaliland, Africa, has the highest prevalence of female genital mutilation (FGM) in the world despite its recognition as a human rights violation and decades of campaigns to eliminate it. This study establishes baseline data for FGM prevalence in Somaliland and explores changing perceptions of FGM among Somalis. **Method:** A descriptive study was conducted among 6,108 women at the Edna Adan University Hospital (EAUH) from 2006–2013. Data were obtained regarding FGM status and knowledge and perception toward the practice. Chi-square analysis was conducted to compare current and previous studies conducted at EAUH. **Results:** The prevalence rate of FGM among respondents was 98.4% and procedures occurred at an average age of 8.47 years. Most participants (82.20%) underwent the most severe Type III or Pharaonic FGM. The most commonly cited reason for practicing FGM was to maintain cultural and traditional values (82.9%). Continuation of the practice was supported among 83.17% of respondents, the majority of whom reported a preference for the milder Type I or II Sunna FGM (95.15%). Women who attended university were subjected to FGM less than were their uneducated counterparts. Younger women reported a higher prevalence of the milder Sunna FGM. Comparison of the current and previous studies reveals a shift toward the less invasive Sunna FGM ($\chi^2 = 16.81$, $p = 0.0$). **Conclusions:** Prevalence of

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Trista Dawn Smith is adjunct faculty of Community Health for the Department of Community Health at Wright State University Boonshoft School of Medicine. **Cristina Redko** is an associate professor and Global Health Concentration director of the Master of Public Health Program at Wright State University Boonshoft School of Medicine. **Nikki Rogers** is an assistant professor of Community Health at Wright State University Boonshoft School of Medicine. **Edna Adan Ismail** is the director and founder of the Edna Adan University Hospital in Hargesia, Somaliland, and an activist and pioneer in the struggle for the abolition of female genital mutilation. Please send author correspondence to trista.smith@wright.edu.

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FGM remains high in Somaliland, suggesting that advocacy to abandon the act has been unsuccessful. Pharaonic FGM currently predominates; however, comparison with previous baseline data indicates a trend toward the milder Sunna FGM.

Keywords

Somaliland; Africa; female genital mutilation; Sunna FGM; Pharaonic FGM; trends; prevalence

Female genital mutilation (FGM), also referred to as female genital cutting (FGC) and female circumcision (FC), includes all procedures involving partial or total removal of the external female genitalia for nontherapeutic reasons (World Health Organization [WHO], 1997). Despite its recognition as an international human rights violation of girls and women, FGM continues unabated. Estimates from the United Nations Children's Fund (UNICEF, 2013) suggest that FGM has been performed on over 125 million girls and women throughout Africa and the Middle East where the practice is most prevalent. The practice is common in the majority of African countries and is concentrated in a belt of countries in northern Africa extending from Gambia to Somalia (UNICEF, 2013).

The WHO (1995) classifies FGM into four categories based on the invasiveness of the operation. Procedures that involve partial or complete removal of the clitoris are classified as Type I procedures. Operations classified as Type II involve partial or total removal of the clitoris and labia minora. Type III procedures are often referred to as infibulation and involve partial or complete removal of the external genitalia and suturing or narrowing of the vaginal opening. The last type, Type IV, is much less common and includes all other harmful procedures to female genitalia and may include pricking, piercing, stretching, incising, or scraping of the clitoris. In addition to this formal classification, FGM procedures are commonly described as Sunna or Pharaonic FGM in many Middle Eastern and African countries. Sunna FGM refers the less invasive Type I and Type II FGM procedures as denoted by the WHO and the more invasive Type III procedures are referred to as Pharaonic FGM.

Statement of Purpose

This study seeks to examine the prevalence of FGM among women in Somaliland, Africa, from 2006–2013 and to outline the details surrounding the FGM procedures performed. Additional investigation to explore the attitudes and perceptions among Somali women toward the continuation of FGM is also an objective. This study further seeks to compare the results of this study with that of a previous study that was conducted at Edna Adan University Hospital (EAUH) from 2002 to 2006. This analysis would also assist in identifying long-term trends regarding FGM in Somaliland and help to assess whether the strategies that have been implemented to eradicate the practice have affected the occurrence of the practice.

Literature Review

The Republic of Somaliland, situated in the Horn of Africa, is a small democracy bordering Djibouti, Ethiopia, and Somalia. Formerly known as the Somaliland Protectorate under British rule, it unilaterally declared its independence in 1991 after years of civil war (Walls, 2009). Prior to the collapse of the Somali government in 1991, efforts to eliminate FGM were underway; however, decades of civil war ended the academic research being conducted on FGM and the campaigns geared toward eradicating the practice. The practice continues in epidemic proportions, and although data reporting the prevalence of FGM in Somaliland are scarce, a recent cross-sectional study reported an FGM prevalence rate of 97% among the subjects (Gele, Bø, & Sundby, 2013b). Similar findings were previously reported in neighboring Somalia, with 98% of women aged 15–49 years having been subjected to the act (UNICEF, 2013). These findings mirror prevalence rates from studies conducted decades ago, with 98% of Somalis having reportedly undergone FGM in 1993 (World Bank & United Nations Population Fund [UNFPA], 2004). As such, efforts to eradicate FGM have had little to no progress in over 20 years.

Traditionally, girls in Somalia were subjected to the procedure as a rite of passage as they transitioned from adolescence to adulthood (World Bank & UNFPA, 2004). Although FGM is no longer considered a rite of passage, the custom continues to be passed down from generation to generation and is still widely practiced. There is some variation in the age at which the procedure is performed, but it is typically performed between the ages of 4 and 8 years in Somalia (Al-Dhayi, 2013). In the only study of its kind to date in Somaliland, a survey of women attending the Prenatal Clinic at EAUH revealed similar findings, with the average age at which the subjects underwent FGM being 8 years, with 7 years of age being the most commonly reported (Ismail, 2009).

Practitioners performing this tradition are typically, but not always, traditional circumcisers or traditional birth attendants (Ford, 2001; World Bank & UNFPA, 2004). The results of a survey conducted in Somaliland reported that 84% of the FGM procedures were performed by elderly women and traditional birth attendants (Ismail, 2009). These untrained medical personnel perform the procedures with no anesthesia in unsterile conditions (Nour, 2008). Moreover, the ability of traditional circumcisers to “circumcise” girls is considered a skill and is their employment. Mitike and Deressa (2009) found that the majority (77%) of traditional circumcisers who have no formal training perform FGM primarily to generate an income. Those performing FGM procedures are not limited to untrained medical personnel; however, the number of trained medical personnel performing the procedure is increasing (World Bank & UNFPA, 2004).

Because clitoral tissue is rich in vascular and nervous tissue, removal of the tissue is dangerous and can lead to complications (Toubia, 1994). Removal of clitoral tissue for Sunna procedures and additional genital tissue for Pharaonic procedures causes excruciating pain, resulting in complications such as hemorrhage, trauma to nearby structures, and failure to heal (Shell-Duncan, 2001; Toubia, 1994). Unsterile knives and razors that have been used on multiple females are often the instrument of choice for practitioners (Kun, 1997). The situation is further complicated when local mixtures including oil, honey, dough, and tree sap are subsequently used to suppress the bleeding (Nour, 2008). One complication resulting from such a lack of sterile conditions is infection, the likelihood of which is directly correlated with the degree to which unsanitary tools and techniques are used in the procedure. Research conducted in Gambia also indicates that women subjected to FGM are at greater risk for acquiring sexually transmitted diseases, including herpes, simplex virus 2, and HIV (Morison et al., 2001; Utz-Billing & Kentenich, 2008).

Additional long-term complications are likely with the more invasive infibulation or Pharaonic FGM procedures. Because the Pharaonic procedure entails cutting away a substantial amount of genital tissue and allowing only a small hole for urine and menstrual blood to flow through, it is recommended that women undergo deinfibulation to open the scar (Toubia, 1994). This release of the anterior vulvar tissue allows urine and menstrual blood to flow freely, makes intercourse less painful, and eliminates the threat of obstructed labor. Failure to do so can result in complications, including dysmenorrhea, infertility, abscess formation, and chronic pelvic infections (American Academy of Pediatrics, Committee on Bioethics, 2010; Royal College of Obstetricians and Gynaecologists, 2009; Toubia, 1994). Women are also at additional risk for obstetric complications, including prolonged delivery, postpartum blood loss, and perineal tears (Larsen & Okonofua, 2002; Utz-Billing & Kentenich, 2008). In addition, infants born to circumcised women have a greater chance of requiring resuscitation or experiencing perinatal death or stillbirth (Larsen & Okonofua, 2002; Utz-Billing & Kentenich, 2008). Some women may suffer mental health consequences that are often overlooked. The practice may lead to a variety of psychological symptoms, including inferiority, depression, psychosis, and neurosis (Utz-Billing & Kentenich, 2008).

Investigation into why this antiquated act persists indicates that motives for its continuation include tradition and religion (Almroth et al., 2001; Gele, Bø, & Sundby, 2013a). Qualitative in-depth interviews of Somalis regarding their understanding of the act revealed that a primary reason for mutilation was simply to "make the girl like her mother and grandmother" and further indicated that ritual was done "out of love" and was a practice passed from generation to generation that was never questioned (Schultz & Lien, 2013). Religious requirements have also been cited in support of continuing the act. A descriptive study conducted at a maternity clinic in Hargeisa, Somaliland, revealed that continuation of the practice was necessary, citing that FGM is required according to religious law (Fried, Warsame, Berggren, Isman, & Johansson, 2013). Similarly, a cross-sectional study of Somali men and women conducted by Gele et al. (2013b) revealed that 96% of the participants supported continuation of FGM based on the notion that it is a religious requirement. The men and women contended that Sunna FGM is not harmful and is a religious obligation (Gele et al., 2013b). However, there is no scriptural basis that suggests FGM is an Islamic requirement (Jones, Ehiri, & Anyawu, 2004).

Families are further compelled to mutilate their girls because failure to comply with the ritual can result in social sanctions and pressures because young girls who do not undergo FGM are perceived to be "unclean" (Fried et al., 2013; Schultz & Lien, 2013). The unmutilated female genitals are considered "dirty," and Somali girls who have not undergone FGM are prohibited from handling food in the kitchen or serving tea because the food is considered tainted (Schultz & Lien, 2013). Recent studies of Somali women also found that uncircumcised girls are bullied and called names, which implies that uncut girls are not virgins (Fried et al., 2013). Uncut Somali girls are also taught that remaining uncut will cause them to engage in abnormal social conduct through sexual activity (Schultz & Lien, 2013). In the long term, lack of circumcision can result in reduced marriageability and bring dishonor to a family (Fried et al., 2013; Schultz & Lien, 2013). Along these lines, the ideals held by Somali men also encourage continuation of the practice because circumcision is often a prerequisite for marriage. In fact, a cross-sectional analysis conducted in Hargeisa, Somaliland, of 215 randomly selected people found that 96% of men (n = 108) preferred to marry circumcised women as opposed to uncircumcised women (Gele et al., 2013b).

Despite that FGM is a flagrant form of violence toward women and has numerous ill health effects, there is staunch opposition toward total abandonment of the practice. After nearly 40 years of advocacy, there has been no decline in the prevalence of FGM and "zero-tolerance policies" have closed the door to discussion on abandonment of FGM and are more likely to cause dissension between the public and government than they are to establish order (The Public Policy Advisory Network on Female Genital Surgeries in Africa, 2012). Progress toward total abandonment has been further impeded because some advocacy has discouraged Pharaonic FGM but encouraged Sunna FGM (Gele et al., 2013a). One of the most compelling factors for continuation of the practice is the belief that it is required by the Koran (Gele et al., 2013b).

Furthermore, uncooperative religious leaders pose another obstacle because they are sympathetic to Sunna FGM and will not openly denounce the act and resolve confusion surrounding whether FGM is an Islamic requirement (Gele et al., 2013a). This has resulted in a trend toward increased prevalence of Sunna FGM, which has been reported in several studies (Mitike & Deressa, 2009). In a cross-sectional study, Mitike and Deressa (2009) found the less severe Sunna FGM to be nearly twice as prevalent as the more severe Pharaonic FGM among Somali refugees in eastern Ethiopia. Qualitative studies including in-depth interviews with Somali men and women in Hargeisa, Somaliland, revealed a similar trend of increased support of Sunna FGM (Gele et al., 2013a).

Method

Data Source

The study was designed to be a descriptive study of FGM among pregnant women who were seeking care at the EAUH from August 2006 to July 2013. The mutilation status of women presenting to EAUH was determined, and the mutilated women were asked to complete an oral survey that included limited demographic information; details concerning the nature of their FGM procedure; and information regarding their knowledge, opinions, and attitudes toward FGM. In addition to investigating current prevalence and perceptions of FGM in Somaliland, this study was intended as a follow-up to a similar study conducted at EAUH from prior to 2006. The same protocol was followed in both studies. The results were compared to determine whether the prevalence and perceptions of FGM in Somaliland were affected by awareness campaigns about the health risks associated with FGM procedures.

Data Analysis

The obtained data were manually collated and entered into Microsoft Excel, and all statistical analyses were performed using IBM SPSS for Windows (Version 21). Frequencies were generated for the subject's age, level of education, and various factors associated with the subject's FGM procedure including the age at which it took place, the type of mutilation performed, the location at which it took place, the people performing the procedure, and the reason for conducting the FGM procedure. Additional frequencies were also calculated regarding whether the subjects would elect to have FGM performed on their daughters and, if so, the type of FGM the mother would have performed on her daughter. A comparison to observe trends among several of the variables was conducted in Microsoft Excel using graphs.

Because this was a follow-up study to a previous study conducted at EAUH in 2009 in which the same protocol was followed for data collection, chi-square analyses were used to compare the populations with regard to the type of FGM performed, the educational level of the subjects, and the attitudes and perceptions of the respondents toward continuation of FGM. For all statistical analyses, p values of < 0.5 were considered statistically significant.

Results

The data consisted of 6,174 women who visited the Prenatal Clinic at EAUH in Hargeisa, Somaliland, from August 2006 to July 2013. The data pertain to the practice of FC or FGM and include individual demographic information as well as information on whether the patient has undergone FGM herself and whether she intends to have FGM performed on her daughter.

Of the 6,174 women invited for study, 98.9% ($n = 6{,}108$) participated. The mean age of the participants was 26.37 ± 5.62 years with a range of 12–50 years. The majority of the participants ($n = 4{,}468$, 72.38%) were between the ages of 20 and 30 years. Additional demographic information revealed that approximately half of the participants (53.2%) had no education. Primary, intermediate, and secondary levels of education were reported by 19.1%, 4.7%, and 13.6% of the participants, respectively. A smaller number of respondents reported having an education in Islamic studies (2.0%) or a university education (7.4%).

Among the 6,108 participants, 98.4% ($n = 6011$) reported having undergone FGM. Over three quarters of the respondents (77.77%) underwent FGM between the ages of 7 and 10 years. The average age at which FGM was performed on the women was 8.47 ± 1.93 years, with 7 years being the most frequently reported. Among those who reported having undergone FGM, the majority (82.20%) underwent the most severe or Pharaonic FGM in which part or all of the external genitalia was removed and the vulva was reapproximated and stitched together. This meets the standard of Type III FGM as classified by the WHO (2008).

Factors associated with having undergone FGM and the type of FGM experienced included level of education and age. Bivariate analyses of the level of education and whether participants had been mutilated revealed a trend toward women having higher levels of education being less subjected to FGM. Women who attended university were subjected to FGM less than their uneducated counterparts. Additionally, the type of FGM performed appears to be associated with age, with bivariate analyses of the respondent's age and the type of FGM undergone revealing a trend for a higher prevalence of the less severe Sunna FGM among younger women (Figure 1). Sunna FGM meets the standard of Type II FGM as defined by the WHO (2008).

The majority of respondents ($n = 4{,}454$, 72.14%) reported having undergone FGM in Somaliland. Other highly represented countries included Ethiopia (10%) and Somalia (7%). No statistically significant differences were observed among the mean age at which FGM was performed across the reported countries. Within the reported countries, the majority of the participants indicated that the FGM took place in an urban area (80.49%), not in rural areas. Further analysis to determine the prevalence of Pharaonic and Sunna FGM within these countries revealed that Pharaonic FGM is the most prevalent in all three countries; however, more respondents from Somalia (30%) reported having the less severe Sunna FGM than did participants whose procedures took place in Somaliland (15%) or Ethiopia (16%).

The most cited reason for undergoing the FGM procedure was maintenance of traditional and cultural values (82.9%; Table 1). Another 14.9% were unable to answer why they underwent the FGM procedure or reported that they did not know why they were mutilated. The majority of mutilated participants revealed that the procedures were performed by traditional birth attendants (60.6%) and old women (31.5%; Table 1). An additional 3.8% (*n* = 219) of the procedures were performed by trained medical personnel including physicians, nurses, and other personnel or occurred in hospitals. Further analysis to identify countries in which a higher frequency of procedures was performed by trained medical personnel revealed that respondents from Kenya (*n* = 15), Saudi Arabia (*n* = 27), Somalia (*n* = 447), and the United Arab Emirates (*n* = 35) were more likely to have undergone FGM at the hands of trained personnel (Table 1). In contrast, respondents having undergone FGM in Somaliland (*n* = 4,454) were the least likely to have had the procedure performed by trained personnel.

Table 1
Details Surrounding FGM Procedures

a. Reason for FGM Procedure[a]

Reason	**Frequency**	**%**
Culture/Tradition	4790	82.9
Unknown/Don't Know	861	14.9
Religion	127	2.2
Total	**5778**	**100**

b. Persons Performing FGM Procedure[b]

Person performing	**Frequency**	**%**
Home/Mother	125	2.2
Man	10	0.2
Midwife	51	0.9
Old Women/Grandmother	1812	31.5
TBA	3486	60.6
Trained Medical Personnel (physician, nurse, hospital)	219	3.8
Woman	50	0.9
Total	**5753**	**100**

Table 1 (cont.)

c. Location and Frequency of Cases in Which Trained Medical Personnel Performed FGM Procedures[c]

Country	Number of cases performed by trained medical personnel	Number	%
Somaliland	74	4454	2
Ethiopia	23	589	4
Djibouti	5	95	5
Qatar	1	7	14
Somalia	75	447	17
Sudan	2	11	18
Saudi Arabia	9	27	33
United Arab Emirates	14	35	40
Syria	1	2	50
Kenya	8	15	53
Tanzania	1	1	100

[a]Totals do not reflect individuals with no response (n=396). [b]Totals do not reflect individuals with no response (n=420) or who responded “unknown” (n=1). [c]Totals do not reflect individuals who responded “unknown” (n=6).

The survey also assessed attitudes and perceptions toward the continuation of FGM when asked if they would have FGM performed on their daughter. The majority of women (83.17%) favored continuation of the practice, indicating that they would have FGM performed on their daughter. However, the majority of these respondents (95.15%) reported that they would prefer that the less severe Sunna procedure be performed on their daughter. The type of FGM the mother had undergone did not influence the proposed type for her daughter, with the majority of mothers having undergone Pharaonic (94.5%) and Sunna (98.20%) mutilation opting for the less severe Sunna mutilation for their daughters. Among respondents reporting that they would have FGM performed on their daughter (*n* = 4,588), the most commonly cited reasons for continuation of the practice pertained to maintaining cultural (40.0%), traditional (31.0%), and religious (26.5%) values. Those reporting that they would not have FGM done on their daughter also cited that they would avoid doing so for religious reasons (33.8%) or stated that the practice was "not good" for women (16.7%) or was "a big problem" (22.5%). Additional analysis revealed that mothers possessing greater levels of education were less likely to respond yes to continuation of the practice (Figure 2).

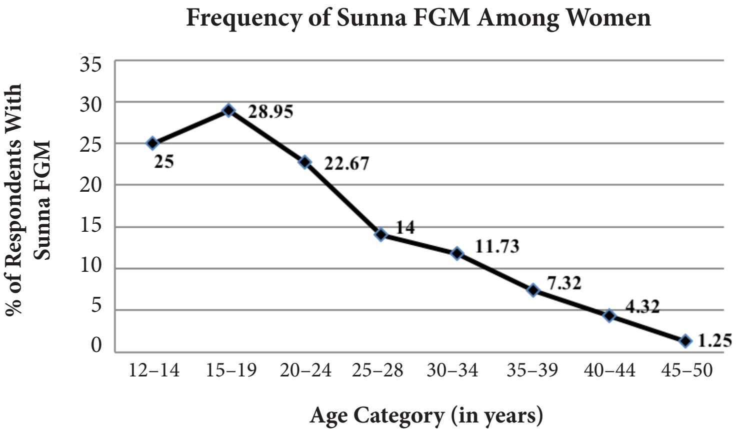

Figure 1. Frequency of Sunna FGM among women.

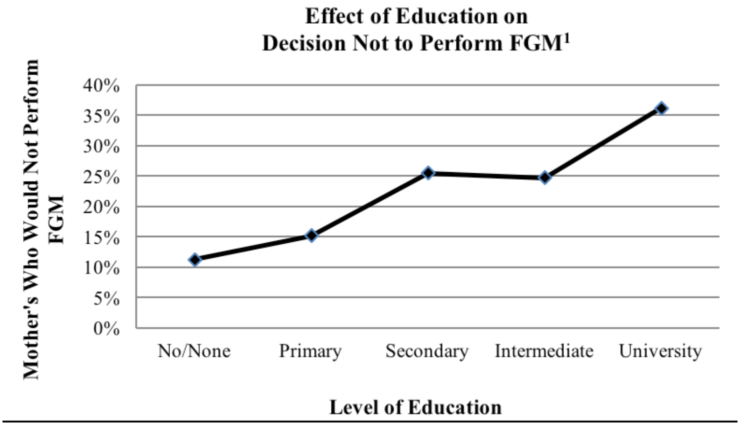

Figure 2. Relationship among education and attitude toward FGM continuation. [1]Results for primary education reflect responses from respondents reporting primary education (n = 166) and Islamic studies (n = 1), which is considered to be at the primary level of education in Somaliland.

Previous Study

The current study is a follow-up to a study previously published by the EAUH in 2009 in which 4,500 women from 2002 to 2006 were invited for study, and 88.18% (*n* = 3,968) participated. Comparison of the two populations indicates significant differences in education, with participants in the current study being more highly educated ($\chi^2 = 6.82, p = .009$). Additional comparison of the studies revealed a highly significant difference in the most commonly performed type of FGM, with a mere 1% of respondents in the previous study reporting having undergone the less severe Sunna FGM compared to the current study in which 18% of the respondents underwent Sunna FGM, thus indicating a shift toward Sunna FGM ($\chi^2 = 16.81, p = 0.0$). Further analysis of the mothers' attitudes and perceptions toward having FGM performed on their daughters was also highly significant. In the former study, 38% of the respondents indicated that they would not have their daughter mutilated compared to the current study in which only 17% indicated they would not have this done ($\chi^2 = 11.06, p = .001$). However, although the likelihood of mothers subjecting their daughters to mutilation has increased, the type of FGM preferred for daughters remains consistent. In both the previous (94%) and current (95%) studies, mothers indicated that they would subject their daughters to the less severe Sunna FGM ($\chi^2 = .096, p = .756$).

Discussion

The results of this study reveal that FGM is deeply entrenched in Somali culture and continues to be widely practiced in Somaliland. The average age at which the procedure occurred was 8.47 years of age and the majority of the subjects (77.8%) underwent FGM between 7 and 10 years of age. The prevalence of FGM in this study (98.4%) is consistent with that of two previous studies conducted in Somaliland, both of which reported the prevalence of FGM to be 97% among participants (Gele et al., 2013a; Ismail, 2009). Moreover, the present findings are consistent with studies conducted in the 1980s and 1990s, which reported the prevalence of FGM among Somalis to be 99% and 100% among the participants, respectively, thus indicating that efforts to curtail and eradicate the act have been largely unsuccessful (Ismail, 2009; World Bank & UNFPA, 2004).

Factors associated with having undergone FGM and the type of FGM experienced include level of education and age. Younger Somali girls who are more educated tend to object to the act more than their elders do (Gulaid, 2008). This study confirms this notion, with women who attended university being less likely to have been mutilated. Moreover, younger women were also more likely to undergo the less severe Sunna FGM compared to their older counterparts. Consistent with this study, a cross-sectional study of Somali refugees in eastern Ethiopia found that Sunna FGM was more likely to be performed on younger girls, with the rate of Sunna FGM performed on the younger and older girls being 80% and 59.8%, respectively (Mitike & Deressa, 2009).

Statistical analysis further indicates that the majority of the subjects underwent the most severe form of FGM, Pharaonic FGM (82.4%), which has been the most prevalent form of FGM in Somaliland for decades. Similar results were reported in a former study conducted at EAUH in which the majority of the participants (99%) reportedly underwent the more severe Pharaonic FGM (Ismail, 2009). Comparison of the former study with the results of this study thus reveals a shift away from the more invasive Pharaonic FGM—with this representing a 23% decrease in the performance of Pharaonic FGM and a concomitant 15% increase in the performance of Sunna FGM. This is consistent with the literature, with quantitative and qualitative studies recently conducted in Somaliland revealing a shift from Pharaonic FGM to Sunna FGM (Fried et al., 2013; Gele et al., 2013b). This trend is likely in part due to religious leaders and information provided through media (Fried et al., 2013). In a qualitative study, Fried et al. (2013) reported that the trend may in part be due to religious influence, with the study revealing that participants began to oppose Pharaonic FGM when they became aware that infibulation was prohibited by Islamic law, but that the milder Sunna FGM was required according to the Koran. Additionally, advocacy efforts initiated in Somaliland that encourage Sunna FGM were also cited as a reason for abandonment of the more invasive Pharaonic FGM.

Analysis of the data further revealed that cultural requirements (33.5%) and maintaining tradition (49.4%) were the most commonly cited reasons for FGM practice among the subjects. However, the degree to which culture and tradition overlap in Somali culture is unknown. Another contingent of the study population (14.9%) indicated having undergone the procedure for reasons unknown to them. Results of the former study conducted at EAUH indicated that the majority of participants (55%) did not know why they underwent the procedure (Ismail, 2009). This is likely due to FGM being so ingrained into Somali culture that girls undergo the procedure "to be like mom" and never question the act or are never educated on what is about to happen. Treating this act is a normalized part of upbringing for Somali girls and thus neglecting to inform and educate them on FGM results in a lack of knowledge of female anatomy and properly functioning female genital organs. Such lack of knowledge and ignorance leads to embarrassment and shame that inhibits girls from seeking appropriate medical attention in the future (Fried et al., 2013).

The majority of the procedures were conducted by old women (31.5%) and traditional birth attendants (60.6%), which is consistent with the previous EAUH study in which the majority of the procedures were performed by old women (84%; Ismail, 2009). Trained medical personnel were responsible for 3.8% and 4.3% of the procedures in the current and former study, respectively (Ismail, 2009). It may seem alarming that any trained medical personnel would be involved in a harmful act that has no therapeutic benefit, but the number of trained medical personnel mutilating women may actually rise in the future. This is due to Somalis beginning to abandon traditional circumcisers in favor of having trained medical personnel perform the procedure in private and public clinics because of growing concerns of HIV/AIDS transmission (Gulaid, 2008).

In this study, a large contingent of the women (83.17%) favored continuation of the practice, indicating that they would have the act performed on their daughter. The majority of those in favor of continuing the act indicated that they would prefer the less invasive Sunna FGM be performed on their daughter. Qualitative findings of a study conducted in Somaliland are consistent with those of the present study, with nearly all the participants supporting continuation of FGM, but opting for the milder Sunna form (Gele et al., 2013a). Another study conducted in Somaliland in the city of Burao found a high level of interest in abandoning Pharaonic FGM among interviewees who preferred Sunna FGM (Gulaid, 2008). Commonly cited reasons supporting continuation of the act included maintaining cultural, traditional, and religious values. Interesting enough, those opposing continuation of FGM most often cited religious reasons for not wanting to subject their daughters to the act. This underscores that there is some confusion concerning whether FGM is required according to Islamic law.

Limitations of the Study

Although the study provided useful baseline date, it has several limitations. Because the data were collected in a hospital, the results may not be representative of Somaliland as a whole because values and preferences differ among urban and rural dwellers in Somaliland. Therefore, because EAUH is in the urban town of Hargeisa, the results are skewed to suggest that FGM occurs in urban areas more than in rural areas. However, this merely reflects that the majority of the people surveyed were urban dwellers. Moreover, this also has the potential to skew the results of the preferred type of FGM (i.e., Pharaonic or Sunna) because people living in town often prefer the milder Sunna FGM (Gulaid, 2008). As such, the frequency of the preferred type of FGM may be skewed toward Sunna FGM.

Additionally, there was a coding error when the data were manually entered into Microsoft Excel. In the survey, women were asked whether they would have FGM performed on their daughters. A follow-up question then asked which type of FGM the individual would then have performed on their daughters. Some women responded that they would *not* have FGM performed on their daughters, but then indicated which type of FGM that they would have performed (i.e., Pharaonic or Sunna) on their daughters in the subsequent survey question, and this was coded as having indicated that they *would* have FGM performed on their daughters. This error slightly increased the frequency of women indicating that they would have FGM performed on their daughters. However, given the large size of the sample (n = 6,108) and the small number of miscoded responses, this coding error had a minor effect (less than 1%) on the frequency of mothers indicating that they would have their daughters circumcised.

Public Health Implications and Recommendations

FGM still continues in epidemic proportions in Somaliland despite decades of efforts to eradicate the act. The pervasive resistance toward eradicating FGM in Somaliland will likely require an approach that encourages harm reduction but does so in a way that systematically eliminates obstacles and resistance toward total abandonment, which has not been possible to date. Because public support for Pharaonic FGM is waning with Somalis vehemently supporting Sunna FGM, it is apparent that abandonment of the practice is not directly attainable. As such, harm reduction strategies may be a means of facilitating the health of Somali women in the interim until total abandonment is achievable. Education on the negative health consequences of Pharaonic FGM, in conjunction with clarification of Islamic law, which does not require FGM, may go a long way toward steering Somali women and children to improved health. Involvement of religious leaders is a necessity as well because much religious misperception and the notion that Sunna FGM is mandated by the Koran are major obstacles and are compelling many Somalis to continue the act. A joint effort advocating for women's and children's health from local leaders, religious leaders, and international platforms is the only means by which FGM will be eliminated. Rendering the act a crime has had no success and will only bolster support of this harmful act that is entrenched in this culture, just as it has done in neighboring Somalia.

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

Jody O. Early, *University of Washington Bothell*
Sloane Burke-Winkelmann, *California State University Northridge*
Aditi Joshi, *University of California Los Angeles*

Abstract

Thousands of studies 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 Latina/o CHWs (e.g., promotores) in developing countries and in underresourced communities within the United States. This article presents a review of the scholarly literature published in the last decade (2005–2015) and provides a snapshot of characteristics and factors that affect the important role of promotores as trusted liaisons and contributors to prevention and primary care. After filtering articles by inclusion criteria, we reviewed the final sample of 63 articles. Eight 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 effect of lay health work on self-efficacy, (6) the role of promotores in community health advocacy, (7) occupational challenges and potential barriers to practice, and (8) best practices for training and supporting promotores as contributors to community health and health care systems. This review presents evidence that promotores, in their varied responsibilities and settings, are essential partners to improving health outcomes for Latina women, their families, and communities.

Jody Early is an associate professor in the School of Nursing and Health Studies at the University of Washington Bothell. **Sloane Burke-Winkelmann** is a professor in the Department of Health Sciences at California State University Northridge. **Aditi Joshi** is a researcher in the School of Medicine at UCLA. Please send author correspondence to jearly3@uw.edu.

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Keywords

community health worker; promotores; Promotoras de Salud; lay health worker; primary care

Women around the globe, in 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 (2007) emphasized that the delivery of medical care was only a limited part of improving individual and population health. Vertical (e.g., top-down) ideologies soon gave way to a focus on primary prevention involving community and grassroots 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 *Promotores de Salud* in Latin America and Latino communities in other parts of the world.

Lay health workers are known by many names throughout the world, including (but not limited to) *community health worker* (CHW), *Promotores de Salud* (Spanish for promoters of health), *promotora* (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 and others are paid, some work in rural settings and others work in urban communities, and some are focused solely on navigating individuals to (and through) hospital systems and health care and others have a broader scope of practice, engaging in more community organization and advocacy work (WHO, 2007). One of the most common umbrella definitions for lay health workers, or CHWs, is defined by the WHO (2007) as someone who is "trained to carry out one or more functions to healthcare" (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 the 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 (2015) expands this definition by acknowledging the broad range of lay health worker responsibilities, outside of just health care, 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. (para. 2)

Promotores work primarily in Hispanic/Latino communities and are CHWs who are "respected and visible" and "share a common identity with the members of their community" (Hansen et al., 2005, p. 48). No matter the term used to describe them, lay health promoters play a role in primary care, community health, and advocacy that is similar from country to country. CHWs have proven to be vital contributors to global and population health and are important liaisons between health systems and communities (WHO, 2007). 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 underserved and/or marginalized groups.

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 3 decades (Figure 1). However, little is systematically documented in the literature about *promotores* specifically and their contributions to primary care for women and their families in Latin communities. Therefore, the purpose of the critical review of literature is to provide a descriptive snapshot of promotores, to examine factors that draw them to their role and affect their practice, and to explore the effect of promotora work not only on individuals and communities, but also on themselves.

Method

We used methods similar to those presented in the *Cochran Handbook for Systematic Reviews of Interventions* (Higgins & Green, 2011) to guide the literature search and to refine the selection of the sample. Although this article is *not* a systematic review, we include empirical and nonempirical articles. The *Cochran Handbook* provided helpful insight on determining search terms, choosing databases and eligibility criteria, and filtering the sample.

We examined literature relating to the work and role of promotores using four research databases: CINAHL, PubMed, Ovid, and Medline. The search terms used were *Promotoras de Salud, Promotores de Salud, promotoras, promotor, promotores,* and *Latina Community Health Worker (CHW)*. Articles in the sample were limited to peer-reviewed works available in full text within the databases searched online or retrieved through interlibrary loan. Most often,

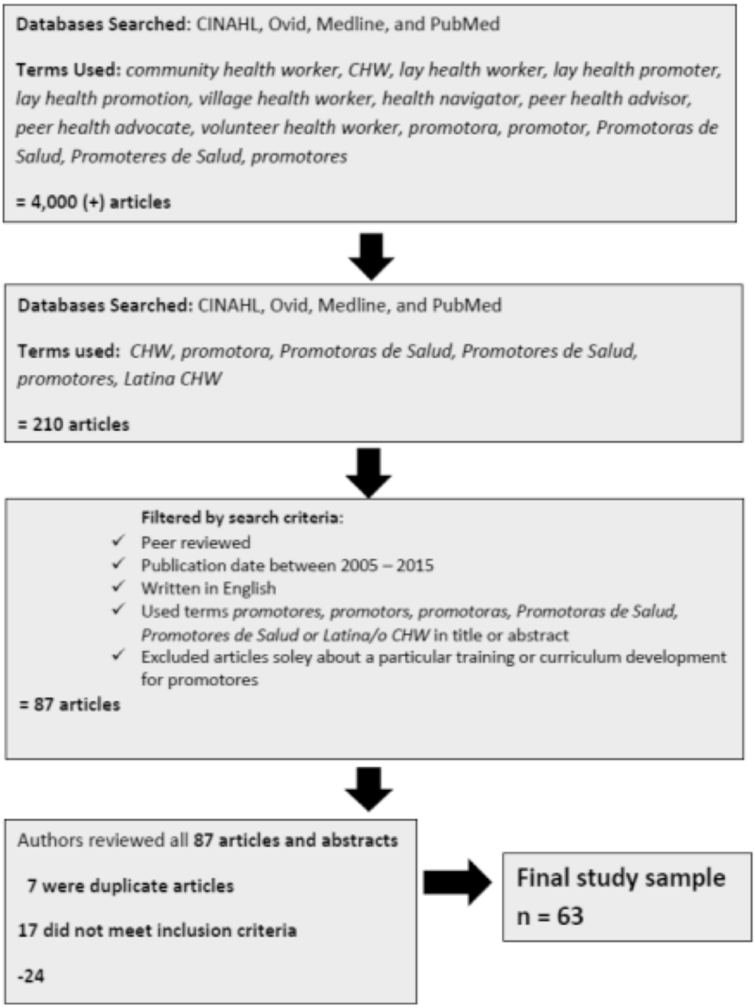

Figure 1. Flow diagram of review process for identifying articles that met inclusion criteria.

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. From this initial search, 210 articles were retrieved. The articles in this original sample were filtered further to include peer-reviewed articles that included empirical research and systematic reviews written in English and published within the last decade (2005–2015). We included studies in which promotores provided services to women and their families and promotores' involvement with cardiac disease prevention programs.

After articles were extracted outside of the search criteria (Figure 1), the sample was reduced to 87 articles. The sample was further distilled to exclude 24 articles that 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. This narrowed the final sample to 63 (see Figure 1).

Results

Through an examination of the literature in the study sample (*n* = 63), eight categories emerged relating to promotores and lay health promotion: (1) factors that motivate individuals to become promotores, (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 effect of lay health promotion on the self-efficacy of participants as well as promotores, (6) the role of promotores in community health advocacy, (7) occupational challenges and barriers to practice, and (8) best practices for training and supporting promotores as contributors to primary health care.

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; Hansen et al., 2005; Ruano, Hernandez, Dahlblom, Hurtig, & Sebastian, 2012; Sherrill et al., 2005; Squires & O'Brien, 2012). Ramirez-Valles (1999) first provided a compelling historical overview of the CHW's role and its place within various societies. Ramirez-Valles cautioned that the history of promotoras as community volunteers could influence the relationship between promotores/CHWs and their employers (or host organizations) and 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 nonexistent, or when proximity to a medical school posed a barrier, becoming a promotora was the next best option (Hansen et al., 2005). 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 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; Sherrill et al., 2005).

A number of studies indicated that promotores describe their work as a "service" to their community (Albarran, Heilemann, & Koniak-Griffin, 2014;

Alfaro-Trujillo et al., 2012; Ingram, Sabo, Rothers, Wennerstrom, & de Zapien, 2008; Keller et al., 2012; Reinschmidt et al., 2006; Sabo et al., 2013; Squires & O'Brien, 2012; St John, Johnson, Sharkey, Dean, & Arandia, 2013; Tran et al., 2014). The intrinsic reward that comes from serving in the role of a promotor/a and a deep desire to help others was a strong theme throughout the literature. Squires and O'Brien (2012) reported the initial reasons promotores gave for participating as a CHW: "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). Squires and O'Brien (2012) offered this perspective from a promotora in their study: "*I want more light in my life and to give this to others as well. To do something more*" (p. 463). Lucio et al. (2012) presented a case for including promotores as leaders in the research process. Promotores in the study were not merely a linguistic bridge and 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 approaches and ultimately improved research (Lucio et al., 2012).

Financial compensation *did not* emerge as a repeated theme in the literature as a reason for becoming a promotor/a (Alfaro-Trujillo et al., 2012; Glenton et al., 2013; Ingram et al., 2008; Stacciarini et al., 2012; Wasserman et al., 2006). Alfaro-Trujillo et al. (2012) reported that the pay for most promotores was often in the form of travel reimbursement, food, medication, or cash. As mentioned earlier in this article, service and "wanting to help" were driving forces for seeking the role. 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 U.S.–Mexico border, 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" (Alfaro-Trujillo et al., 2012, 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 operating with limited funding. Promotores may attrite or reduce their involvement in search of other sources of income (Alfaro-Trujillo et al., 2012). Furthermore, Ingram et al. (2008) found that promotores who were full-time employees outside of their promotor/a role and who received a stipend or who were paid hourly by an employer for nonrelated promotor/a work were more likely to express that their primary motivation for taking the role of the promotor/a was to give back to their communities (Ingram et al., 2008; Stacciarini et al., 2012; Wasserman et al., 2006). This finding was less likely among promotores who did not work full time or who served in economically marginalized communities where jobs were scarce.

Throughout the literature examined, there were opposing views on whether promotores should be viewed as "volunteers" or "health workers." Some promotoras view the emerging "profession" of a CHW as a new opportunity for employment and empowerment, and others view the institutionalization of the CHW role as "altering the core elements that could help them develop quality relationships with members" (Arvey & Fernandez, 2012, p. 1636). Witmer et al. (as cited in Arvey & Fernandez, 2012) 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 Swartz and Colvin (2015), CHWs in Khayelitsha (a township near Cape Town, South Africa) with high rates of poverty, unemployment, and ill health reported altruism as the primary factor driving their work. The intrinsic motivation to volunteer was often privileged within the community over the extrinsic (e.g., financial), which was seen by some in the community or other CHWs to be a "threat to moral principles" (Swartz & Colvin, 2015, 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 (Swartz & 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 (e.g., mother, grandmother, aunt, uncle, or brother) had served in this role (Ingram et al., 2012; Ruano et al., 2012; Squires & O'Brien, 2012).

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, Mangadu, Jacquez, & Corona, 2007; Glenton et al., 2013). They share language (Spanish primarily), ethnic and cultural backgrounds (e.g., Latino heritage), and sometimes occupational experiences (e.g., agricultural work). Many of the published studies relating to CHWs within Latino/Hispanic communities highlighted the work of *promotoras,* as the literature indicates that the majority of lay health workers in Latin and Spanish-speaking communities are females. However, studies related to male *promotors* are emerging (Arredondo et al., 2013; Brown, Malca, Zumaran, & Miranda, 2006; Moralez, Rao, Livaudais, & Thompson, 2012). Brown et al. (2006), for example, explored the role of the CHW in rural Peru and found that most of the 171 CHWs were male (76%) and participated voluntarily. 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 that held esteem in the community. This was an outlying case example; however, most of the promotores in the studies reviewed were women over 35 with significant life experience and were respected in the communities they served. Younger promotoras (18–34) were most commonly involved with postpartum or substance abuse programs (Ingram et al., 2008).

Demographic information specifically on promotores globally is scattered and incomplete, but Ingram et al. (2012) published one of the first "profiles" of CHWs in the United States. In this study, the National Community Health Worker Advocacy Survey (NCHWAS) was used to collect descriptive benchmark data that would provide a general profile of CHWs in the United States. In the 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%) that closely matched CHW workforce estimates from the Bureau of Health Professions at 77.9% (Ingram et al., 2012). In this same study, Ingram et al. (2012) also found that the majority of CHWs/promotores in their sample worked with nonprofits, 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 a variety of settings. Promotores may work with community health agencies and departments, hospitals and clinics, community health centers, government, schools, nonprofits, churches, factories, and corporations. They 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, and 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; Forster-Cox, Mangadu, Jacquez, & Fullerton, 2010; Ingram et al., 2007; Livaudais et al., 2010; Reinschmidt et al., 2006; Ruano et al., 2012; Sherrill et al., 2005; Wasserman et al., 2006).

Health Issues Most Commonly Addressed by Promotores

The range of health issues addressed by promotores can be classified into three broad categories: *chronic disease and injury prevention, disease management,* and *environmental health and occupational safety* (see Table 1).

Table 1
Health Issues Addressed by Promotores/CHWs by Category and Theme

Category	Themes and examples	Sources
Disease & Injury Prevention	Activities relating to prevention: creating awareness about a disease, providing education about prevention measures, encouraging screening, promoting healthy behaviors, providing referrals, and making home visits	Alfaro-Trujillo et al., 2012; Arredondo et al., 2013; Marsh et al., 2015
	Breast, cervical, and/or colorectal cancer prevention	Hansen et al., 2005; Larkey et al., 2006; Larkey et al., 2012; Livaudais et al., 2010; Marshall et al., 2014; Moralez et al., 2012; Smith et al., 2013; Wasserman et al., 2006
	Promoting cardiovascular health	Albarran et al., 2014; Alfaro-Trujillo et al., 2012; Ayon, 2014; Koniak-Griffin et al., 2015; Ingram et al., 2012; Lewin et al., 2006
	Diet, nutrition, and obesity prevention	Baquero et al., 2009; Bustillos et al., 2013; Faucher, 2008; St John et al., 2013; Stacciarini et al., 2012; Tran et al., 2014
	Diabetes prevention	Cherrington et al., 2008; Ingram et al., 2007; Lujan et al., 2007; McEwen et al., 2010; Rothschild et al., 2014; Salant et al., 2013; Spinner & Alvarado, 2012
	HIV/AIDS and HPV prevention	Fernandez et al., 2009; Ingram et al., 2012; Ramos et al., 2009
	Maternal, reproductive, and sexual health	Betancourt et al., 2013; Blanco, 2011; Bonilla et al., 2012; Glenton et al., 2013; Ingram et al., 2012; Lewin et al., 2010; Prue et al., 2010
	Domestic violence prevention	Alfaro-Trujillo et al., 2012; Ingram et al., 2012
	Health screenings	Fernandez et al., 2009; Hansen et al., 2005; Ingram et al., 2012; Reinschmidt et al., 2006

	Asthma prevention & air quality	Ingram et al., 2012; Lucio et al., 2012
	Alcohol & substance abuse	Ayon et al., 2006; Ingram et al., 2008
	Mental health & stress management	Lucio et al., 2012; Stacciarini et al., 2012; Tran et al., 2014; Waitzkin et al., 2011
	Dental health	Ingram et al., 2012
Disease Management	Diabetes management	Balcazar et al., 2006; Faucher, 2008; Ingram et al., 2012; St John et al., 2013
	Cancer, including survivorship & co-survivorship	Borges & Ostwald, 2008; Cherrington et al., 2008; Hansen et al., 2005; Ingram et al., 2012; Koniak-Griffin et al., 2015; Larkey, 2006; Lujan et al., 2007; Marshall et al., 2014
Environmental Health	Walking trails & parks	Albarran et al., 2014
	Pesticide exposure & pesticide safety	Betancourt et al., 2013; Forster-Cox et al., 2007
	Disaster planning & preparedness	Eisenman et al., 2009

Disease and injury prevention. Promotores conduct a 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, including access to health care, food, counseling, and job training.

As Table 1 also indicates, promotores promote health in a number of ways, but the most common activities pertaining to prevention were providing health education, distributing health information, organizing events, referring people to community resources, and making home visits (Alfaro-Trujillo et al., 2012; Arredondo et al., 2013; Marsh, Derose, Rios, & Cohen, 2015)

The health topics pertaining to chronic disease and injury prevention most frequently addressed by promotores in the literature included breast, cervical, and/or colorectal cancer; cardiovascular health; diet, nutrition, and obesity prevention; diabetes; HIV/AIDS and HPV; maternal, reproductive, and sexual health; domestic violence; and health screenings. Additionally, multiple studies in the sample of literature addressed that promotora led programs for asthma and air quality, alcohol and substance abuse, mental health and stress management, and dental health.

Disease management. Studies included in the sample also revealed that promotores were sometimes tasked to help individuals manage chronic illnesses, such as diabetes and cancer. In addition, they may provide health information and resources for survivors as well as co-survivors (Table 1).

Environmental health & occupational safety. Researchers have also participated 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), prevent pesticide exposure and teach pesticide safety (Betancourt, Colarossi, & Perez, 2013; Forster-Cox et al., 2007), and promote disaster planning and preparedness (Eisenman, Glik, Maranon, Gonzales, & Asch, 2009).

The Effectiveness of Programs Involving Promotores

A number of published studies report positive outcomes for prevention programs involving promotores compared to control groups (Table 2). Researchers have reported positive results for increased awareness about particular health issues, 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; 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 knowledge and behavior change pertaining to physical activity (Arcury et al., 2009; Forster-Cox et al., 2010), depression (Albarran et al., 2014), nutrition and diet (Baquero et al., 2009; Bustillos et al., 2013), and maternal and child health (Albarran et al., 2014; 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 effects on health outcomes when comparing lay health models to other interventions (Viswanathan et al., 2009). Many published studies reported low sample sizes, lacked control groups, used cross-sectional methods, and used volunteer or convenience samples. Rigorous research designs are lacking. Regardless, there is still strong evidence to underscore promotores' effect on social measures, such as social support, self-efficacy, social connectedness, and trust, which are valid theoretical constructs of behavior change (Table 2).

Table 2
Positive Outcomes Associated With Health Programs Involving Promotores

Health-related issue	Studies reporting positive outcomes
Disease Prevention	Arcury et al., 2009; Balcazar et al., 2006; Borges, 2008; Fernandez et al., 2009; Forster-Cox et al., 2007; Ingram et al., 2007; Larkey et al., 2006; Lewin et al., 2010; Lujan et al., (2007); Ramos et al., 2009; Reinschmidt et al., 2006
Disease Management & Rehabilitation	Albarran et al., 2014; Arcury et al., 2009; Baquero et al., 2009; Bustillos et al., 2013; Forster-Cox et al., 2010; Ramos et al., 2009
Physical Activity	Arcury et al., 2009; Forster-Cox et al., 2010
Mental Health	Albarran et al., 2014; Stacciarini et al., 2013; Tran et al., 2014
Nutrition & Diet	Baquero et al., 2009; Bustillos et al., 2013; Faucher, 2008
Diabetes	Borges & Ostwald, 2008; Cherrington et al., 2008; Ingram et al., 2007; Lujan et al., 2007; McEwen et al., 2010; Salant et al., 2013
Addiction (e.g., tobacco, alcohol)	Ayon et al., 2006
Environmental Health	Arcury et al., 2009; Arredondo et al., 2013; Forster-Cox et al., 2007; Forster-Cox et al., 2010
Maternal and Child Health	Albarran et al., 2014; Blanco, 2011; Glenton et al., 2013; Lewin et al., 2010; Prue et al., 2010
Cardiovascular Disease Risk	Balcazar et al., 2006; Koniak-Griffin et al., 2015; Spinner & Alvarado, 2012
Breast & Cervical Cancer	Albarran et al., 2014; Fernandez et al., 2009; Hansen et al., 2005; Larkey, 2006; Larkey et al., 2012; Livaudais et al., 2010; Smith et al., 2013
Colorectal Cancer	Moralez et al., 2012; Smith et al., 2013
HIV Prevention	Ramos et al., 2009
Sexual Health	Betancourt et al., 2013; Bonilla et al., 2012
Literature Reviews Indicating Positive Outcomes	Lewin et al., 2006; Viswanathan et al., 2009

One of the few randomized control trials published (Koniak-Griffin et al., 2015) 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 led by promotores are more effective than lifestyle programs without them. At the end of the 6-month intervention (that included eight classes followed 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 (see Table 2).

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 (*companerismo*), 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). Additionally, multiple examples from the literature illustrate the positive effect 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), colorectal cancer (Smith, Wilson, Orians, & Byrd, 2013), and HIV (Ramos et al., 2009). Although the focus of this particular review of literature is on the contributions of promotores to women's health, it is important to note that men, teens, seniors, and a variety of other populations have also benefited from programs involving promotores (Arvey, Fernandez, LaRue, & Bartholomew, 2012; Borges & Ostwald, 2008; Lewin et al., 2010). The evidence is clear that promotores and lay health promotion programs play an effective role in primary prevention for everyone.

The Effect of Promotor/a Work on Self-Efficacy

Self-efficacy, a person's personal belief that he or she has 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). Multiple studies included in this review indicated that serving as a lay health promoter increased individual 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, May, & Tai-Seale, 2007; Koniak-Griffien et al., 2015; Reinschmidt et al., 2006). Kash et al. (2007) also observed that promotores helped women in the study access 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 indicated in studies involving a variety of topics and audiences. In a study by Balcazar et al. (2006), 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 (i.e., Community Health Workers Against Hypertension) for 9 weeks achieved improved measures of sodium, fat, and cholesterol and higher self-efficacy scores on performing heart healthy behaviors. In another study, Ayon, Pena, and Naddy (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 et al. (2015) found that involvement of promotoras as health coaches in a lifestyle and behavior intervention for low income Latina women living in Los Angeles (i.e., Healthy Women Prepared for Life) led to more positive outcomes and increased self-confidence among program participants. Participants in the intervention group also achieved improved measures on risk factors such as body mass index, weight, blood pressure, and 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 (Hansen et al., 2005; Larkey, 2006; Reinschmidt et al., 2006; Wasserman et al., 2006).

The work of being a promotor/a is often characterized in the literature as being transformative not only for the communities each serves, but also for each promotor/a (Alfaro-Trujillo et al., 2012; Hansen et al., 2005; Sherrill et al., 2005; Squires & O'Brien, 2012; Wiggins et al., 2009). In the process of promoting health in their communities, and in inspiring others to take control of their health, promotoras' self-efficacy may also be reinforced as reflected in the words of this promotora:

> 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. (Squires & O'Brien, 2012, p. 464)

Otiniano, Carroll-Scott, Toy, and Wallace (2012) presented a case in which 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 (see Figure 2).

Figure 2. Championing health for women and communities: Promotores de Salud of Familias Unidas in Snohomish County, Washington, celebrating after a breast health event. Photo by Sandra Solano-Huber. Used with permission.

The Role of Promotores in Community Health Advocacy

A number of studies provide evidence that promotores can serve as powerful community health advocates and catalysts for individual and organizational change. For example, Sabo et al. (2013) surveyed a U.S. sample of 371 CHWs (53% Latina/o) and found that over 75% of them were participating in 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 an 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. e64)

Studies have also provided evidence that promotores can help build a community's capacity 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. Farquhar et al. (2008) conducted qualitative interviews with promotoras and reported that their work as CHWs helped to build their leadership skills and sense of efficacy to create change in their communities. 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 et al. (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 a study by Forster-Cox et al. (2007), promotoras provided education to Latino immigrant families on the Texas–Mexico border to reduce pesticide exposure.

As reflected in the literature, there is a gradual shift in focus over time among promotores from the individual to the family and then to the larger community. Alfaro-Trujillo et al. (2012) examined characteristics of promotores serving communities on the Texas–Mexico border and, through mixed methods, observed a "transformation" and shift away from their initial focus on individual and family health to concerns for the larger community. Strengthening promotores' collective efficacy (i.e., ability to achieve a task or goal as a group), in addition to self-efficacy, can improve lay health workers' ability to initiate change within their communities.

For example, Farquhar et al. (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, and 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 the value of their civic and community involvement. However, advocacy was also mentioned as an area in which more promotores felt they lacked sufficient training (Alvillar, Quinlan, Rush, & Dudley, 2011; Ingram et al., 2012; Ingram et al., 2008).

It is also important to recognize that because of the differing roles and settings for promotores, advocacy is not always a requirement 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).

Occupational Challenges and Potential Barriers to Practice

Occupational stressors, such as long hours, unmanageable workload, physical demands, and poor organizational communication, can also serve as barriers to practice and affect 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 reported by Latina/o CHWs as physical side effects to their work. Spinner and Alvarado (2012) suggested that organizations that work with promotores 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 improve teamwork and reduce turnover.

Poor communication within organizations can also lead to increased stress and frustration among promotoras (Alvillar et al., 2011). When the role of promotores is unclear to them or to other staff members on the team, this can spark conflict. Maintaining open communication about the assigned responsibilities of the promotores 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, such as social media (e.g. Facebook), e-mail lists, and/or text messaging, to keep communication flowing (Alvillar, et al., 2011).

Studies have increasingly advocated for financial and managerial support for lay promotor/a-led health promotion programs (Lewin et al., 2010; Otiniano et al., 2012). Promotores working in low resourced and vulnerable communities often come from those same communities, hence providing suitable means for 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) and that their work environment may be confined to areas such as garages and churches or they may have 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 turnover.

As mentioned earlier, lack of financial incentives may understandably lead to attrition and burnout. 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).

Bonilla et al. (2012) reported that providing 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 et al., 2012). In some training programs, promotores were paid through a third party, such as Medicaid (Albarran et al., 2014), and had opportunities for paid employment, which improved retention.

In addition to needing financial and logistical support, promotores may also lack 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 et al., 2007). In another study, promotores leading a physical activity program for postpartum women needed equipment, such as strollers, to increase participation (Albarran et al., 2014).

Despite the barriers mentioned in the literature, most promotor/a-led programs in the literature reported positive outcomes for the populations they served. It could be surmised that 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 burnout. When promotores are well cared for by organizations and systems, they can extend better care to individuals and to the communities they serve.

Training and Supporting Promotores as Contributors to Primary Health Care

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 also from province to province or state to state. For example, in the United States, training in California to become a CHW differs from state requirements in North Carolina; requirements for a lay health worker in Brazil differ from those in Cuba. One challenge in developing a standardized curriculum for CHWs is that each community's needs are different. Thus, trainings may differ from program to program and by region. Promotores who work in rural settings may receive more on-the-job training from an experienced promotora or by the program coordinator who mentors and supervises the promotores than by way of more formal educational pathways. The training curriculum may be created from existing resources or what is believed to be best practices (Rural Health Information Hub, 2011).

A person does not necessarily need to have professional certification to practice as a promotora or a promotor. However, a strong theme throughout much of the literature is that training, coaching, and ongoing mentoring from other health professionals and/or experienced promotores are key ingredients for program success and retention of promotores (Murray & Ziegler, 2015). Providing CHW certification opportunities for promotores was found to enhance their retention in lay health promotion programs (Arvey et al., 2012). Ingram et al. (2008) recommended that promotores be provided with basic outreach training as well as ongoing professional development, leadership training, and advocacy skill building.

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 effective alternatives (Wasserman et al., 2006). Ayon (2014) underscored the need for providing training materials in Spanish as well as in English, for including vibrant colors and culturally appropriate images in the design, and for materials to be written at a reading level of 10th grade or lower. The training material must be culturally sensitive to the community being served (Cherrington et al., 2008). Hi-tech training material (e.g., mobile apps) may be appropriate for some educational strategies and audiences, but Koskan, Friedman, Brandt, Walsemann, and Messias (2013) found that low-tech materials, such as flip charts, are still commonly used among promotoras so they can control the pace of training and work in most rural and low income communities.

Furthermore, there is evidence in the literature that promotores are also seeking professional development opportunities beyond CHW certification. Health-related and culturally tailored trainings were identified to be of the highest need (Alfaro-Trujillo et al., 2012; Alvillar et al., 2011; Ingram et al., 2008). In addition, promotores may require training about confidentiality because their clients may be sharing sensitive and personal information (Reinschmidt et al., 2006).

Additionally, creating opportunities for interprofessional 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 team-based primary care models in areas of the world where this is emerging. This approach will also enable other health professionals to gain more understanding about the importance that CHWs/promotores play in primary care. A study was conducted in Brazil of people served by a promotora program for which the promotora provided primary health care along with health awareness. A baseline survey was conducted in the study, followed by a follow-up survey after 2 years of promotora services. The results indicated that the rating for the survey item "overall performance of the CHW was satisfactory to maintain your health and your family's health" increased significantly (Kawasaki et al., 2015). This study underscores the promise of health care delivery models that include promotoras as contributors to primary care.

Limitations

This review of the literature was limited by multiple factors. A primary weakness is that only articles published in English were included. This likely accounts for why so many more U.S.-based studies were in the final sample. Future reviews should focus on the research published in Spanish and in 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 in the last decade (2005–2015). The findings of this review are further limited by the subjective search terms and databases used in the inclusion criteria (Figure 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 interlibrary loan. Thus, 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. A number of studies have documented the history of CHWs and their evolving role in population health. However, this article focused specifically on the contributions of promotores 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. Preventive 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 and Young (1992) 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 important factors when designing health programs and services, and promotores play a key role in addressing them.

Efforts to clarify the role of promotores and CHWs continue and issues, such as 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 these? And is a one-size-fits-all approach to training and certification appropriate? Future studies should explore the effect of "institutionalizing" the role of promotores and CHWs into formal health systems in places where this has already occurred (e.g., 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? Many questions still remain, but one thing is clear: improving the health of Latina women and their families and communities calls for an increased focus on preventive care, primary care, cultural humility, and an expanded team-based approach of which promotores are essential partners.

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Global Journal of Health Education and Promotion

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- All materials must be double-spaced on 8.5 × 11-in. (or 22 × 28 cm) pages.
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  - Times or Times New Roman, pt. size 12.
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  - Only the title should appear on the manuscript itself. The title should appear at the top of the first page, followed by the abstract, and then the body of the manuscript.

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Practice Perspectives Guidelines

The focus of the Practice Perspectives is to embrace ways of knowing about the field of health education and promotion experience and the facilitation of service delivery in both participant relationships and clinical, administrative, and interdisciplinary contexts. This section has been expanded to invite two distinct components:

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The manuscript should describe any of the following:

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