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Promotores' perspectives on a male-to-male peer network

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Abstract

Little documentation exists about male community health workers (*promotores*) networks. The experiences of *promotores* can provide input on how to attract, train, supervise and maintain male *promotores* in CHW programs. We present the experience and perspectives of *promotores* who participated in a male *promotores* network assisting Latino immigrant men in an emerging Latino community. All *promotores* in this community-based participatory study received payment for work 10 hours a week. We conducted qualitative interviews with all *promotores* starting the program, after 5 and 13 months. Three main themes emerged: 1) Men decided to become *promotores* to help others, yet appreciated being paid. 2) *Promotores'* learning experience was ongoing and was facilitated by a cooperative dynamic among them. Learning how to listen was crucial for *promotores*. 3) Promotores experienced difficulty separating their personal lives form their role as a *promotor*. We conclude that paying *promotores* facilitates the fulfillment of their drive to serve the community. Enhancing listening abilities needs to be part of *promotores'* training curricula. Finally, it is advisable to build a project with many opportunities for *promotores* and project staff to share professional and non-professional time and discuss their challenges.

Introduction

Community health workers (CHW) (also called lay health advisors and, in Spanish speaking contexts, *promotores*) have worked extensively in health promotion [1–3]. CHW are trusted community individuals who are trained to build interpersonal rapport to provide health information and support to community members [2]. It is uncommon to find reports on CHW's perspectives about their role, especially men. This article presents a qualitative examination of the views of *promotores* in 'Lend a Hand to Health', an exclusively Latino male CHW intervention that helped Latino immigrants adjust to their new environment by offering social support and linkage to resources. The article focuses on why they became CHW, their thoughts on training and what helped them to be successful.

CHW have been especially successful in contexts of health inequality [4]. Their work in Latin America and among Latinos and other minorities in the United States is particularly well-documented [2, 5]. According to the World Health Organization, in order to be effective and have a chance for success CHW should be members of, selected by, and answerable to the community they serve; should be recognized by the health system, although not necessarily a part of it; and should have a shorter training compared to clinical workers [6]. In the United States, the Affordable Care Act calls for a larger role of CHW in health care complementing, not substituting, health care providers [7]. However,

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implementation is challenging despite their effectiveness. Providing inconsistent or unequal remuneration, giving inadequate training and supervision, or selecting CHW who are not appropriate (such as individuals not from the community) can lead to unsuccessful CHW programs. In some cases, concerns about CHW overstepping their training and engaging in clinician roles have been reported [8]. Programs that have underestimated these challenges and the costs and difficulties tied to them have undermined the credibility of CHW in general [6]. Successful CHW programs also need to have realistic expectations, with focus remaining mostly on disease management, improving access and continuity of care, and prevention in general, rather than curative care [6, 9]. Additionally, CHW turnover is high and there is a concern in the literature about decay of acquired skills [10].

While there have been many successful interventions with Latino female CHW, few publications report on male CHW working with Latino male participants [1, 2, 11]. Furthermore, qualitative research suggests that Latino men are not inclined to serve as CHW because they find this volunteer or low-paid activity more appropriate for women due to its pay, but also its role of health promotion, accompaniment and guidance [1, 12]. There are a few exceptions worth noting. In Connecticut, CHW organized groups of men who had sex with men and offered support on sexual identity, AIDS prevention and referrals [13]. In North Carolina, CHW from the HoMBRes intervention conducted volunteer outreach through soccer teams providing condoms and HIV prevention education [14]. Another intervention trained men to facilitate participatory, non-directive groups with farmworkers around intimate partner violence in four states [15]. Finally, in Florida CHW encouraged eyewear protection use among citrus migrant workers [16].

There are multiple possible employment modes for CHW, ranging from volunteers to paid full-time staff [17, 18]. Great variation exists in terms of selection processes as well as training materials, order [19], duration and topics covered [20]. The literature supports ongoing, supervised and goal driven training once the intervention starts [11, 19]. In terms of roles, CHW can provide mediation, education, outreach, support, bridging to resources and community building [1, 4, 21]. Sometimes CHW also perform research activities [22, 23]. Different patterns of Latino settlement foster different CHW roles. In particular, CHW in emergent or incipient communities are most useful as intermediaries between service providers and clients, serving as bridges in addition to more traditional health education roles [10, 24]. In all cases, clinical care is not one of CHW's main roles.

There are few studies reporting CHW's perspectives about their roles. Quantitative studies with CHW found consistent interest in and history of community involvement among CHW [5, 25]; CHW also expressed high reliance on neighbors to solve their problems [5]. Even fewer studies have reported on qualitative data on male CHW's views of their role. CHW in HoMBRes appreciated community recognition and the knowledge and skills gained through their work [26]. They reported their role included clarifying cultural misconceptions with the aid of appropriate materials, and also shared their perceptions on the challenges Latino men face, which include loneliness and changes in social norms.

Other studies reporting on CHW views include a majority of female CHW, with only a few men. In North Carolina, the program Protecting Our Community worked with Mexican immigrants on sexual health. Most CHW were women; three were men [27]. CHW identified the potential value of male CHW, recognizing their social skills and knowledge development [28]. In Detroit, MI, mostly female African-American CHW reported pride on their role and the program, described time and financial challenges, and explained the personal rewards of this role, such as learning and satisfaction [29]. CHW from the project Power for Health in Oregon (three Latino, one of them male, and three black, one male) valued having multiple roles, and having the opportunity to learn from other team members who had different experiences and knowledge from their own [30].

Finally, some exclusively female CHW initiatives have also described CHW perspectives. An

academic-*promotora* collaboration including multiple projects in South Texas reported on CHW empowerment, driven by engagement in research, as well as in training. *Promotoras* expressed satisfaction in learning, developing strong partnerships with researchers and helping others [23]. Focus groups with CHW recruiters in Arizona identified elements that supported success: talking about personal experiences, showing empathy toward potential participants and reaching as many women as possible [31].

In summary, the literature commonly mentions that CHWs report personal satisfaction derived from their role, and learning that goes beyond specific health topics. It is necessary to explore CHW's perspectives, especially male CHW as their potential engagement in this type of interventions has been called into question due to perceptions of it being a female activity, as explained above. However, little published information exists on male CHW views. The objective of this article is to report how Latino CHW in a male-to-male intervention build their role as CHW and what their perceptions on the project are.

Methods

Setting and intervention

The 19 070 Latinos in Allegheny County represented <2% of the total population in 2010, yet Latinos increased 71% from 2000 to 2010 [32] and lived mostly scattered throughout the county. The rapid population increase had not been matched with language and culturally appropriate services for Latinos, creating an acute need to respond to the situation. In 2010, slightly over half of Latinos in Allegheny County were male, and Mexicans represented the largest group (36%) [32].

De la Mano con la Salud was a community-based participatory research project designed by the Latino Engagement Group for *Salud* (LEGS), a coalition of community members, researchers and health and social service providers. The LEGS was formed in 2008 at the initiative of a researcher (leadership switched to non-research members on 2010) with the initial purpose of improving the health of Latino immigrant men in the region, focusing on the urban Pittsburgh metropolitan area but including the surrounding suburban and rural areas. Since its inception, LEGS has met every 2 months to discuss ongoing projects and the status of the community. As an area with a small but rapidly growing Latino population, many new immigrants are men. At the LEGS, members recognized the importance of identifying the challenges faced by these new immigrants to adjust to this new environment. In 2010, the group conducted a participatory health assessment of blue-collar Latino men that was subsequently published [33]. Data were collected through four focus groups with 25 total participants and 66 structured surveys with Latino immigrant men, as well as 10 key informant interviews with service providers that work with this population. In this assessment participants expressed suffering of social isolation and engaging in extra work and heavy alcohol consumption as common coping mechanisms. In addition, the assessment found limited access to health and social services, often due to misinformation and mistrust. These findings aligned well with literature that indicates that Latino immigrant men, particularly those who are poorer and less educated, have significant needs and vulnerabilities: the immigration experience exposes them to negative public opinion [34], loneliness and anxiety [35, 36], and they are at heightened risk of injury, alcohol abuse, depression and sexually transmitted infections [35, 37, 38]. Social support has been known to positively impact depressive symptoms [39], stress [40] and binge drinking [41], and can preferentially help those with lower incomes [42]. Based on the assessment and the known benefits of social support, we developed a model in which strengthening social support for Latino immigrant men in the region would be at the center of addressing their isolation and loneliness, the related depression and drinking, as well as limited access to care (Fig. 1). Based on this model the LEGS coalition designed *De la Mano con la Salud*, a pilot project using Latino male CHW to address men's isolation and limited access to services by: (i) providing social support and (ii) bridging to resources. CHW

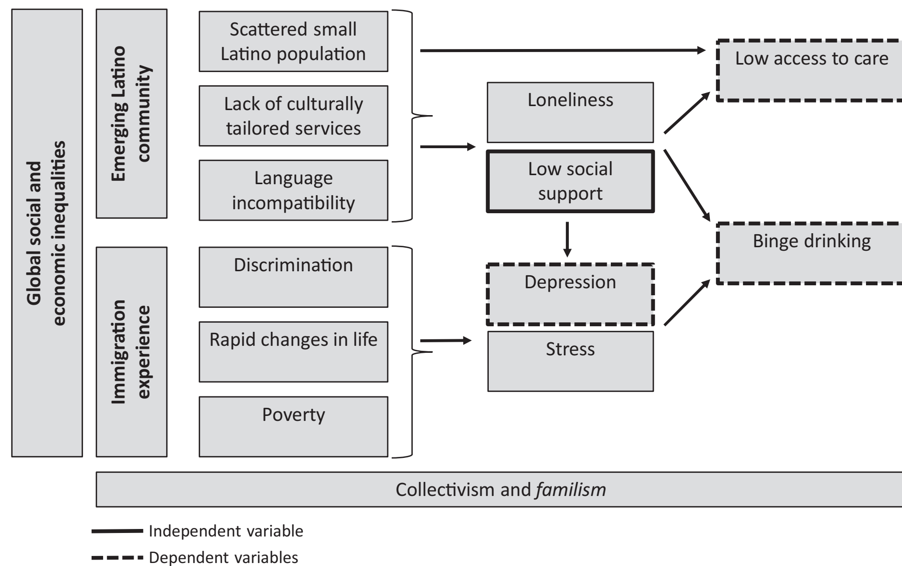

Fig. 1. *De la Mano con la Salud* theoretical model.

interventions are based on the ability of peers to build rapport, and consequently successfully deliver social support, in a culturally appropriate manner [3]. Because the target population was Latino immigrant men, all *promotores* were also Latino immigrant men, thus keeping with cultural appropriateness. The LEGS coalition specifically designed the intervention to be broad in its scope: although common health issues affecting Latinos were discussed, the coalition decided that no specific condition was to be targeted in the study. The main outcomes defined in the study were social support, access to care, depression prevention and alcohol consumption, addressing the main concerns identified in the assessment. *Promotores* worked closely with a clinical partner in LEGS, a Federally Qualified Health Center, which offers a range of services in Spanish and English. The University of Pittsburgh IRB approved the study.

CHW were recruited through community venues, word of mouth, email distribution lists, social media and the university employment website. LEGS members, Latino project investigators and staff suggested potential CHW and approached their contacts in the community asking for adult Latino men who could read and write, and who were trusted by, had knowledge of, and were committed to the local Latino community. We selected eleven Latino immigrant men to be trained as CHW. These men, in agreement with the LEGS coalition, chose *promotores*, a commonly used Spanish term, as the appropriate label for their role. All selected men were trainees first. Two trainers with experience in life coaching developed the curriculum and met weekly with the management team to refine the materials and schedule. The resulting 20-h training in Spanish included the topics chosen by the LEGS coalition, divided in five sessions: (i) workplace safety; (ii) US health system; (iii) case management; (iv) emotional health and recreation; and (v) values, nutrition and diabetes. Cross-cutting topics included ethics, available resources and communication. The communication component, which permeated all the training activities, was strongly inspired by Motivational Interviewing techniques. The focus was to develop trainees' skills on listening and responding with non-directive questions. These skills were meant to facilitate *promotores'* interactions with the project participants, including helping them identify, without influencing, the men's

needs, values and goals. At the request of *promotores* and trainers, an extra session was organized to role-play the first contact with a participant. At the end of the training, LEGS coalition representatives observed a role-play exercise and rated trainees on their performance on the intake, consent process, communication skills and referrals. Most of the trainees, with the exception of one, assumed the role of *promotor;* seven worked for over a year. All but one of the seven long-term *promotores* held full-time jobs that were not related with their *promotor* role: one worked in construction, two in restaurants, one in retail, one in security, one as a lecturer and the other was retired. *Promotores* were paid for up to 10 work hours per week. The initial training was supplemented during the project with eleven 1-h training sessions on topics *promotores* selected: immigration, housing, sexually transmitted infections, US health system, stress management when working with participants, dental health and relationships with the police.

Over 1 year *promotores* recruited participants from their own social networks and at places where Latinos congregated using flyers and word of mouth, reaching men with limited connection and access to health and social services. *Promotores* used an elicitation tool, the Wheel of Life ('Wheel of Life' is a trademark of Meyer Resource Group, Inc. We have no association or connection with this organization. Used with permission of Mind Tools, http://www.mindtools.com/pages/article/newHTE_93.htm), to help participants define goals for their life and develop a plan of action to achieve those goals. The Wheel of Life had eight domains defined by the LEGS coalition: nutrition, physical activity and recreation, health, emotional and spiritual life, use of alcohol and drugs, social life, family situation and work situation. Depending on the plan, *promotores* referred participants to health and social services, connected them to community venues and listened to them. In case of any health concern, *promotores* referred participants to health care providers, providing no direct health care service. Even if there were no immediate health concerns, *promotores* explained to the participants the importance of preventive health care, and informed them of health providers that were available locally. *Promotores* followed participants' well-being in person and by phone at least monthly, or more often as the plan of action required. Follow-up entailed inquiring about the goals identified in the plan of action. A total of 182 participants were consented, with each *promotor* maintaining 26 participants on average (range 19–40). The original goal was to have *promotores* work with each men for 6 months. In practice, some participants remained active only until their initial needs were resolved, whereas others remained in contact until after the end of the intervention. The immediate supervisor of the *promotores* was a lead *promotor*, called *super-promotor*, who was chosen from the original group of trained men based on his leadership and skills performing the job. His main role consisted of following-up with *promotores* on

Table I. *Questions for pre-interviews and debriefings*

Question	D1	D2	D3
How did you learn about this project?	X		
What does the experience of becoming a *promotor* mean to you?	X		
Why did you decide to become a *promotor*?	X	X	
Tell me about your experience as a *promotor*		X	X
How do you gain participants' trust?			X
Tell me about a case in which you feel you were successful		X	X
Tell me about a case in which you felt you couldn't solve the situation		X	X
Tell me about the *promotores* meetings [utility, problems, changes]		X	X
What project support was most useful for you?		X	X
What other support would you need?		X	X
What do you think about the *promotores* training, now that you have seen in practice what you need to do? [missing, unnecessary]		X	X
What do you think about the monthly refreshers?		X	X
Did being a *promotor* impact you as a person?		X	X

Notes: D1: Debriefing before fieldwork; D2: Debriefing at 5 months; D3: Final debriefing.

their successes and challenges, sharing suggestions about possible community connections and resources to share with participants, and advise on best ways to approach sensitive issues in a culturally appropriate way. The *super-promotor* also prepared the agenda for meetings held by all *promotores* every 2 weeks to discuss their work and emerging difficulties. During these meetings *promotores* filed project paperwork with the project coordinator, who was in charge of supervising time sheets and data collection. *Promotores* were active in the community in settings not directly related with the project; for example, they helped organize a soccer tournament and were involved in community events.

Data and analysis

This article is based on qualitative data from field-notes of all LEGS and *promotores* meetings, and debriefings collected in three occasions. The first time before the start of the project, where we asked trainees how they heard about the project, why they joined and what they thought being a *promotor* meant. This debriefing took ~15 min and the interviewer took notes, writing verbatim quotes when possible. The second debriefing occurred 5 months into the project and the last at 12–13 months, both inquiring about *promotores'* experiences in the project, techniques used by them to get rapport with the participants, successful and not successful attempts to give support, their perceptions on project meetings, training, project tools and the team as whole, and finally on the impact of the project on their lives (scripts are presented in Table I). These lasted 30–90 min (average 50 min), and were audio recorded and transcribed.

We analysed the Spanish transcripts using NVivo 10. Predefined codes based on the topics explicitly addressed in the debriefing questions were: training, *promotores'* role, project management, impact of work on personal life, team work, available resources, and challenges. These were complemented with open coding by three authors (L.M., H.C.R. and P.I.D.). We followed an iterative process of defining codes, coding, assessing reliability and refining the codebook. We measured intercoder reliability using Kappa, and defined 0.61 as acceptable to represent substantial agreement [43] and thus stop this iterative process. All disagreements were still discussed and solved by all authors to define the final codebook. Subsequently, one author coded all transcripts again (H.C.R.).

During analysis we strived to represent the experiences of *promotores* as authentically as possible. For this, we used the framework method [44, 45] to reduce the data. Two authors (L.M. and H.C.R.) developed tables with summaries by *promotor* and codes (i.e. training, outreach, follow-up, meetings,

Table II. *Basic characteristics of men interviewed or debriefed*

Affiliation	Country of origin	Highest education	Spanish/English proficiency	Sources
Promotor 1	Guatemala	Less than high school	Yes/Yes	D1, D2, D3
Promotor 2	Mexico	Associate's degree	Yes/Yes	D1, D2, D3
Promotor 3	Colombia	Graduate degree	Yes/Yes	D1, D2, D3
Promotor 4	Mexico	Less than high school	Yes/No	D1, D2, D3
Promotor 5	Guatemala	Bachelor's degree	Yes/Yes	D1, D2, D3
Promotor 6	Puerto Rico	Graduate degree	Yes/Yes	D1, D2, D3
Promotor 7	Venezuela	Bachelor's degree	Yes/Yes	D1, D2, D3
Trainee 8	Mexico	High School	Yes/Yes	D1
Trainee 9	Panama	Graduate degree	Yes/Yes	D1
Trainee 10	Ecuador	Bachelor's degree	Yes/Yes	D1
Trainee 11	Venezuela	Bachelor's degree	Yes/Yes	D1, D2
Community 12	Mexico	High School	Yes/Yes	D3

Notes: D1: Debriefing before fieldwork; D2: Debriefing at 5 months; D3: Final debriefing.

Table III. *Overarching themes and key-related codes*

Becoming a *promotor* to help the community
Why becoming a *promotor*[a]
Recognition (being recognized for work, personally or within the community)
Satisfaction (self-fulfillment, happiness derived from project)
Social status
Work (wanting a job, or being able to work)
Learning as an ongoing process
Training[a]
Initial[a]
Monthly[a]
Project management[a]
Attendance
Biweekly meetings[a]
Planning (regarding the project, recruitment and the future)
Resources[a] (individuals and materials available to perform their duties)
Confidence (feeling confident, feeling like an expert, knowing more than before)
Learning
Communication (with participants or other *promotores*, including miscommunication)
Recruiting skills
Conflicting expectations of the *promotor* role
Role[a]
Express emotions (participants opened up, wanted to share emotions or thoughts)
Help and support (helping others, guiding, giving back to the community or team)
Outreach[a]
Word of mouth
Confianza
Project management[a]
Follow-up[a]
Biweekly meetings[a]
Paperwork[a]
Planning (regarding the project, recruitment, and the future)
Resources[a] (individuals and materials available to perform their duties)
Challenges providing services to participants
Challenges originating in *promotores*
Abandonment (being unable to follow up a participant as often as desired)
Desire to do more (being unable to solve more, or all, problems)
Not knowing what participants are really thinking (questioning participants' honesty)
Setting limits (determining extent of personal involvement as *promotor*)
Challenges originating in participants
Participants' independence (ability, or lack of, taking charge of themselves)
Participants' excuses (provided to explain failure to meet expectations)
Loss of participants (losing track due to any reason, including unknown)
Participants' mobility (participants move frequently, change contact)
No shows to appointments
Time (lack of time, excessive time required for certain activities, difficulty scheduling)
Working with other *promotor*es and project members
Shared participants (sharing responsibilities over same participant with other *promotor*)
Team spirit (harmonic coordination beyond that needed for mere functioning)
Communication (with participants or other *promotores*, including miscommunication)

Notes: A. The same code may be present under more than one theme. B. Not reported in this table are: codes of specific issues *promotores* dealt with (29), very specific service characteristics (10), research-related codes (3), actors involved in the project (39) and valuation codes (positive/negative) (2).
[a]These codes were defined a priori. All other codes were developed in open coding.

team work, communication, confidence), and linked them to specific quotes. This structure enabled us to discriminate between overarching issues and those that arose only from few *promotores*. Three authors (L.M., H.C.R. and P.I.D.) then individually developed analytic memos for each theme in the table, which they discussed to identify the core themes that are the focus of this article. The results of this process were discussed with the fourth author (R.B.), who is a community member; the final manuscript was revised with his comments.

Results

We collected eleven pre-fieldwork [with all trainees (Debriefing 1 or D1)], eight 5-month [with seven *promotores* and one trainee that never assumed the role of *promotor* Debriefing 2 or D2)], and eight 12–13 month (with seven *promotores* and a co-chair of LEGS [Debriefing 3 or D3]) debriefings. In the last round of debriefings, we included one of the co-chairs of LEGS due to his role as a community member that had participated in the all stages of this project. His

participation began before the original needs assessment, included the planning and design stages, and continued throughout the implementation as co-chair of LEGS. Select characteristics of these individuals are shown in Table II. The final codebook included 52 codes. We identified three overarching themes that encompassed most codes (Table III): (i) becoming a *promotor* to help the community, (ii) learning as an ongoing process and (iii) conflicting expectations of the *promotor* role. We present the results organized by these core themes.

Becoming a *promotor* to help the community

'Mainly, to help the community' (Promotor 2, D3)

Without exception, all *promotores* indicated their desire to help other Latino men as the primary reason to become *promotores*. Often, they further explained how the plight of Latino men was personal to them. For instance, in their pre-fieldwork debriefings two of them manifested having experienced difficulties settling in the United States. *Promotor* 5 said: 'When I arrived in Pennsylvania I was isolated and nobody helped me. I know how it feels to be isolated'. Six *promotores* said they learned about the struggles of Latino immigrant men through their experiences helping other men, or having volunteered in other projects.

> Two years as a volunteer almost full time, I helped many clients, many Latinos in many circumstances. And it made me aware of people's needs of services and knowing where things are. (*Promotor* 3, D2)

For a community member deeply involved with the project, participation was a political decision:

> I got involved with LEGS because, honestly, I consider myself a problematic person in the sense that if I see injustice, I get involved. [. . .] I like to participate because one is also part of this. I feel that in here one is being political. (Community 12, D3)

Coming from a different context, one *promotor* appreciated what he perceived to be the reality imbued nature of the job as appealing. In his case, it provided him with a refreshing alternative to his regular job, which was removed from the community.

In the pre-fieldwork debriefing three *promotores* said they joined the project as they were seeking jobs; two of them learned about the project through the University's online job posting. All other *promotores* learned about the project through community connections (i.e. mailing lists, church, word of mouth). Two *promotores* explicitly mentioned the position being a paid job as a reason to approach the project. Both, however, also clearly couched this within a broader purpose to help other men. 'Well, first of all I was looking for a job and saw this opening in the Internet. Besides that I was interested also because it was a project to help Latino men'. (Trainee 11, D2)

Once they joined the project and worked as *promotores* for some time, they again identified the project's importance and its impact on the community as reasons to stay involved and engaged. *Promotor* 7, who had approached the project because he was looking for a job, shared about his work:

> It has helped me to feel more as part of a group. It makes me feel good to help other people. In addition to this job, I'm working in a restaurant and I didn't feel. . . challenged. This makes me feel that I am part of something bigger, something important. Something that helps people. (D3)

All *promotores* identified several benefits that they gained by working in the project: satisfaction of being helpful, receiving social recognition, developing a broader social network and gaining confidence and skills.

Recognition from the participants and the satisfaction of being helpful were the most prominent benefits identified by *promotores*. When remembering a conversation he had with one man he helped go to the dentist, *Promotor* 5 shared in his second debriefing what the man said to him: '"This is the first time I will go to a dentist since I'm in Pennsylvania," and he had a smile in his face. To me, that was the program's success'. In that same

debriefing *Promotor* 7 expressed a similarly emotional response to the men's show of gratitude: 'It has happened to me that they call only to say thank you and it is. . . excellent. [pause, and softer] Yes, it is beautiful'.

Learning as an ongoing process

'This hasn't stopped, the training continues' (Promotor 5, D2)

When asked about the training, all *promotores* expressed that it was valuable: it gave them information and skills to do a better job. *Promotores* identified activities that developed specific skills to work with participants as the most useful. *Promotor* 7 explained: 'more hands-on, more practical so one can feel more comfortable when one goes out to help the first [Latino immigrant man] about what needs to be done'. He then proceeded to suggest specific skills and know-how that should be transmitted to future generations of *promotores* in case the program extended.

> The steps of how to fill-in the medical assistance, how to fill-in the applications for the [health center]. For example, during the first month [. . .] *promotores* didn't know that they had to fill in an application to go to the dentist. That is something that needs to be done during training. (D3)

Promotores identified specific skills that they gained through the project's training and that they deemed particularly valuable to do their job: becoming better listeners and communicators, applying confidentiality practices, and creating atmospheres of trust and respect with participants. *Promotor* 1 explained what he learned in the initial training.

> Before, one interrupted a conversation or gave answers to the person before he finished saying what he had to say. Then one was brusque. Then one did not know how to listen, how to help the other person. And of course, confidentiality, learning to keep the secret of the private life of another person. In truth, I had not thought about it, that it could be harmful to someone. But it's true. That I have learned. (D3)

According to *promotores'* accounts, they learned best through avenues other than formal training, such as experience in the field, and team work.

> I was somewhat nervous, afraid of not doing this job well. [. . .] So along the way, in the process of working with the [Latino immigrant men] everything kind of came together, and along the way I gained my experience. And it felt good to be able to help the people, know how to help them in what they needed. (*Promotor* 4, D3)

All *promotores* also identified that a cooperative dynamic emerged between them after joining the project; *promotores* and other project members (the principal investigator and the project coordinator) became a team, and the project itself acquired almost a persona in *promotores'* eyes. *Promotor* 3, for example, expressed: 'I find it very interesting that the project has been learning and has been adjusting'. (D2)

Biweekly meetings facilitated the building of trust and closeness among team members and provided a space to share experiences and learn from each other. *Promotor* 5 explained in his second debriefing the benefits of this structure, as it provides 'a bigger help and one knows one is not alone; there is a group of people helping you'. *Promotor* 6 developed this thought as he considered how he found the regular meetings valuable:

> We exchange documents. . . Also *promotores'* input; their experience helps us all learn. As does [the project coordinator], who offers all the experience he has gained with the project; and [the principal investigator] as well. I mean, we share perspectives and experiences, and we all learn something. (*Promotor* 6, D2)

Conflicting expectations of the *promotor* role

'What [the participant] expects from you, and what you expect from him'. (Promotor 6, D3)

Promotores conceived their role as one that included a very broad range of activities that included outreach, support, help and *acompañamiento* (accompaniment). Main duties included finding people to join the program, gaining their trust, and being available and reachable. Due to the program's design, where each participant devised with the *promotor* his own plan of action based on the Wheel of Life exercise, the range of issues on which *promotores* provided help was also very broad. In addition to providing community connections and information on health care, communicating the importance of prevention and bridging health resources, all *promotores* also provided assistance on non-health topics such as the job market, housing or immigration. An important identified component of the role of *promotor* was to maintain frequent communication with participants through text messages or phone calls to ask them how they were doing, follow-up on the plan of action and its goals, keep participants posted with information, and invite them to activities. In *Promotor* 5's words, 'during the day I'd call them, leave a message, "how are you, just called to see how you are doing." I also did group messages'. (D2)

For all *promotores* but one (a retiree), being a *promotor* was a second job, and thus demanded to be available extra hours and sacrifice free time in order to accomplish the duties. The participants' schedules and needs were not standard, and some of their problems required high levels of commitment in time and energy. This in addition to time required for management activities such as training, biweekly regular meetings and participation in community events.

Promotores' support activities included interpretation, transportation, setting appointments for services and help understanding (and sometimes reducing the fees of) medical bills. *Promotores* mentioned instances in which little or nothing could be done to help participants as frustrating.

> I felt a brutal impotence not being able to get him out of jail, when the entire family had already fixed dinner for him thinking that he would be out that day. [. . .] Things such as this make me feel impotent, like I cannot do anything else. (*Promotor* 7, D3)

Occasionally *promotores* went well beyond their role when helping Latino men. For instance, *Promotor* 1 lent money to a participant who required it in order to receive immediate attention at the urgent care facility where he was accompanying him to.

> He needed $115 to receive the service there. So I lent them to him at that moment. So perhaps I got more involved than what I would've thought. . . but I'm a person. I wasn't doing it for the job, I was doing it for the person. (*Promotor* 1, D3)

This situation illustrates an issue that in one way or another all *promotores* dealt, and sometimes struggled, with: setting limits. Learning how to set limits became a very important skill that all *promotores* tried (not always successfully) to develop, particularly as participants sometimes requested things that challenged the frontiers of what were the original project objectives.

> Some [Latino immigrant men] are looking for friendship. [. . .] They are alone, they don't have many friends. [. . .] They call you for things that are not what one is supposed to be doing, [. . .] to talk, or for one to go there and spend time with them. And that role, I share it to some extent, but try to limit it. I try to limit it because I don't think that is good. In other words, I have not defined that *promotor* role, I don't have it clear. (*Promotor* 6, D2)

How these boundaries were defined changed from one *promotor* to the other, with each one of them finding a different comfort space. *Promotor* 2, for instance, had a different take on the relationships he forged with participants.

> With some of them we are [. . .] I'd say more acquaintances. [. . .] And there are some like two or three that are my friends. They became my friends, I spend time in their houses. One of them even made me his *compadre*,

[godfather] of his daughter. There is a closer friendship with some of them (D3).

Discussion

Three overarching themes emerged from debriefings: *promotores* joined the program to help the community, understood learning to be a *promotor* as an ongoing process and faced conflicting expectations regarding the *promotor* role. These three themes were tightly interrelated. For instance, a shared interest in helping, coupled with the collaborative structure of the project, fostered an environment in which *promotores* were interested and invested in learning from each other. In the same way, defining role boundaries was challenging, in part, due to *promotores'* interest in providing a service. As each *promotor* worked with participants they defined their own boundaries as *promotores*. They then shared their own struggles and decisions in the biweekly meetings, helping each other in this process.

As supported in the literature, recruiting men to be *promotores* is the first challenge in any male CHW network [10]. In our study, all but one of the *promotores* already worked full time jobs when training started; this illustrates one reason why Latino men can be a difficult group to attract. With the broad range of employment modes that have been used in CHW networks, from purely volunteer to full-time staff [17, 18], creating a part-time paid position helped us to successfully fill in the positions with Latino men: a paid, official position was attractive to the *promotores*. Literature supports funding CHW initiatives [7], although specific mechanisms for doing so have not been agreed upon [3]. The Affordable Care Act includes a provision to fund CHW as a way for improving health in underserved areas, but ways to reimburse for this work are still unclear in Pennsylvania. In our study, payment was enhanced by the non-monetary incentive of community recognition of the role. The satisfaction that came with the role of *promotor* has already been reported in the literature as an important aspect for CHW being engaged in their role [23, 31, 26].

All the men who initiated training as *promotores* shared an interest in helping their community. This view was supported by their actions, as all the men who became *promotores* opted to work more than the 10 h for which they were paid during weeks in which participants' needs required it. Within the framework of a paid, recognized and highly satisfying job, these Latino men were willing to also do unpaid work. This strong show of empathy reflects what has already been reported in the literature on CHW [3, 26, 31]. However, not all the long-standing *promotores* in our study had prior experience working with the community; two reported interest, but no previous involvement. This suggests that tapping men who are already engaged in the communities, as suggested by the literature [11, 27], is a sound idea when forming a male CHW network. At the same time, in situations when this is not achievable such as in the small Allegheny County Latino community, men who do not have this experience should not be disregarded. In our study, the two long-term *promotores* who had no prior entry in or experience with the community also provided the team with other valuable skills and resources: one had ample time and extensive experience as a caregiver for a family member, the other was the youngest *promotor*, which helped him build rapport with the younger participants. All of the men, including these two, were able to become successful *promotores*, work well within the team, and gain the trust of the other *promotores* and the participants, regardless of their previous community involvement.

Learning how to become a *promotor* was an important aspect of the *promotores'* experience. This process started with the initial training, which *promotores* found useful particularly on the modules of communication, listening and role playing. However, this was only a small part of *promotores'* learning process. According to *promotores*, it was during their actual work and in their interactions with other *promotores*, either working together in the field or in biweekly meetings, that they learned the most. In addition to acquiring new skills, these real-world spaces helped *promotores* foster a strong sense of team. *Promotores* in our study developed a highly cooperative dynamic that enabled them to

engage in a constant and challenging learning process with each other. This aligns with literature indicating that training needs to be ongoing [19, 23]. In our study this was partially achieved in informal contexts as well as in the more formal training sessions and refreshers, suggesting that it is important to incorporate in the design of CHW initiatives spaces in which CHW can collaborate and exchange ideas and experiences.

Team work was an important resource for *promotores* in fulfilling their role. Being a *promotor* was a challenging experience that required extensive time and effort. Knowing that they had the backing of a broader group made the role less daunting, and helped them manage the feelings of impotence that sometimes came from being unable to help some of the participants. This aligns with Fisher *et al.* [3], who call for backup and ongoing supervision for *promotores* to help them address challenges. Working closely with other *promotores* and with the management team was also beneficial; *promotores* thrived working with team members who had diverse experiences and knowledge, a finding similar to reports from the Power for Health study in Oregon [30]. During team meetings each *promotor* provided his unique perspectives, skills and resources, which enriched discussions and learning. It is unlikely this richness would have been achieved with only two *promotores* working full time. As such, when budgeting a CHW initiative, it might be advisable to consider structuring a network with multiple *promotores*, even if they are involved only part-time.

The intensity of *promotores'* work prompted them to question and redefine what their role entailed. For *promotores*, this definition went beyond the traditional roles of service, outreach, education or bridging to resources found in the CHW literature [1, 4, 21]. More pressing to them were the relationships that they forged with participants, and the level of support that they were willing to provide. In thinking about these questions *promotores* arrived at different answers. Some befriended their participants, whereas others preferred supportive but less personal relationships. In terms of level of support, one *promotor* even decided to lend money to participants (even while acknowledging that this went beyond 'the job'), whereas others set stricter limits to the times and activities that they agreed to engage in with participants. It is important to recognize this challenge, and provide CHW with resources to help them address these issues. While it might have been entirely possible that *promotores* overstepped their role to assume clinical duties, we did not find this problem in this study. Two design aspects may explain this. First, the focus of this project was broad. The training emphasized enabling the *promotores* to engage the participants and provide social support by using motivational interviewing techniques, as well as act as bridges by knowing and disseminating local available resources. With the exception of training on identifying mental health emergencies so they could put in place a protocol of reaching out to a professional, no in-depth health training was provided. This lack of any focused training on health issues may have prevented *promotores* from feeling capable of addressing health questions or concerns directly. Second, it is possible that the strong and close partnership with a Federally Qualified Health Center and a social service organization prevented this problem, as *promotores* always had clinicians and other health professionals available to them and the participants.

This small qualitative study has multiple limitations. This study adds a novel point of view to the literature on male CHW and their perceptions. However, the experience of the men that worked as *promotores* cannot be transferred either to projects with only female *promotoras* or to projects with male *promotores* and female participants. Another limitation is that we restricted our analysis to the perspective of the *promotores*, without addressing that of the participants. Including that data, from this and other CHW programs, would also give a broader and more accurate picture of these programs. Further research is needed that expands the scope of research by gathering data from multiple CHW programs, as well as by incorporating data from both participants and CHW.

This study enabled us to arrive at several conclusions and recommendations. Being a CHW is a demanding job, which is often performed by

individuals with little time and who themselves may have many needs. For these reasons, it is necessary to pay CHW for their work. As suggested by existing literature, it is advisable to recruit CHW from already active community members. However, when this is not achievable, it is possible to reach out to those who do not have that role but express an interest in helping the community. Listening and communication skills have to be part of initial trainings. The skills thus developed are important to achieve a participant centered approach, and were consistently recognized as useful, and novel. It is also important to stress in training the challenge of role boundaries, and appropriate ways of addressing it. The potential blurring of boundaries between participants and friends, which occurred often in our project, should be discussed during training so CHW have the opportunity to consider the risks and benefits of developing friendships with participants before work actually begins. The overstepping into clinical roles for which CHW are not properly trained is another role boundary challenge that, although it was not an issue in this project, can be addressed during training by laying out a clear protocol on how to address health questions and emergencies in case they arise. Another beneficial design consideration is to include multiple spaces for interaction among CHW such as regular meetings, workshops and gatherings. These spaces were crucial for developing collaboration, exchanging support for addressing the most challenging aspects of the work, and maintaining the CHW engaged and energized. Finally, providing CHW with organized and constant support and supervision helps them with the challenges of their role.

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