School of Rural Public Health – Texas A&M University System Health Science Center

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MUJER Y CORAZÓN: COMMUNITY HEALTH WORKERS AND THEIR ORGANIZATIONS IN COLONIAS ON THE U.S. - MEXICO BORDER AN EXPLORATORY STUDY

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A Comparative Study of Outreach Workers and Their Organizations in Health Promotion on the U.S.-Mexico Border

This document constitutes the final report of the research project *A Comparative Study of Outreach Workers and Their Organizations in Health Promotion in Colonias on the U.S.-Mexico Border*. The study is aimed at understanding the practice of community health worker programs on the U.S.-Mexico border, with the purpose of informing practitioners, policy-makers and researchers regarding the strengths of this model of community outreach, health promotion and education. The study was conducted in 2001 and 2002 in communities in Texas and New Mexico.

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FINAL REPORT

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MUJER Y CORAZÓN: COMMUNITY HEALTH WORKERS AND THEIR ORGANIZATIONS IN COLONIAS ON THE U.S. - MEXICO BORDER
EXECUTIVE SUMMARY

This report focuses on *colonias* along the border between the U.S. and Mexico and, more specifically, on unique organizations and people who help meet the basic health and infrastructure needs of residents of these colonias. Hundreds of thousands of people who live in proximity to this 2000 mile border that extends from the West Coast of California to the Gulf of Mexico in Texas reside in colonias. The colonias are poor and frequently lacking several elements of basic community infrastructure, such as water, sewer, gas, electricity, and paved roads. They are equally underserved with respect to access to education, employment, and health care. Many people in colonias, however, own the property on which their home is built and have a strong attachment to their home, their neighbors, and their community.

Health conditions among colonia residents reflect the consequences of poverty and poor living conditions. Hepatitis A and Tuberculosis are twice as prevalent in colonias as in the U.S. as a whole. Diabetes rates are also high, affecting an estimated 30 percent of the border population. Occupational risks, limited access to nutritious food, poor access to medical care, and cultural practices and beliefs about medicine further compromise the health of the population. Pesticides and hazardous fertilizers affect agricultural workers and their families, while exposure to dangerous chemicals and physical and ergonomic hazards threaten those employed in local industry. Finally, access to health care is severely limited by lack of health insurance and further compromised by undersupply of physicians, clinics, hospitals, as well as language and cultural barriers between many providers and colonias residents.

With the colonias as context, this report analyzes community-health worker (C-HW) *organizations* and community-health worker (C-HW) *practices*, with an eye to understanding how and why these organizations and workers do what they do and why they are key resources in colonias for improving the health of the communities and enabling the population to make the most of available resources. Moreover, it examines their relationships with and their impact on the communities they serve. Finally, the report discusses the implications of our findings and how these results can support and advance the crucial work of C-HWs and the organizations they represent.

Using qualitative and ethnographic methods, the research focused on addressing four specific objectives: (1) to describe variation in structures and processes among C-HW organizations; (2) to describe the work of C-HWs and explain why they do this work; (3) to identify factors that shape the work of C-HWs; and (4) to identify the policy implications of the study findings. To accomplish these goals, the study examined twelve C-HW organizations and their workers: six organizations in Texas and six in New Mexico. The research relied on

interviews with leaders of the organizations and their workers, observation of the C-HWs as they provided education and other services, and focus groups conducted with community residents. This Executive Summary provides an overview of the main study findings and the policy and research implications of those results.

COMMUNITY-HEALTH WORKER ORGANIZATIONS

The study found that the C-HW organizations varied programmatically in their focus, structurally in their relationships to the communities served, and geographically in terms of the areas they served.

Programmatic Variation. The C-HW organizations included in the study had a variety of programmatic foci. These included education and community building, early childhood development, comprehensive community development, health, economic capacity building, child and maternal health, and environmental health. Of the 12 C-HW organizations studied, seven had health as a major focus. The remaining five had a broader focus but included health among their goals in some form. However, even C-HWs working in health-focused C-HW organizations were not precluded from practicing in a manner that addressed client needs well beyond strictly health-related issues.

Structural Variation. C-HW organizations also differed in their relationship to the communities they served. Some were deeply embedded structurally in the community, focused on one or a few communities, and were served by C-HWs who were both residents of the community and administrators of the organization. Others had very different structural natures. For example, some C-HW organizations were much less embedded in local communities and more widely connected to regional, state, multi-state, or even national programs and resources. They had more complex administrative structures and served large geographic areas. Others fell between these two extremes.

Geographic Variation. C-HW organizations ranged from those that served one or a few colonias to those that served only one part of a county to those that served an area that encompassed two or more counties.

COMMUNITY-HEALTH WORKER PRACTICES

The study found that among the C-HW organizations operating in the 12 border-area colonias, the work of C-HWs was a complex whole, involving five basic *domains of practice*. This was largely true despite the particular programmatic focus of the C-HW organization and their formal assignment. Each domain incorporated specific *processes*, that is, the means by which the practice domain was achieved, and specific *community impacts*, that is, the outcomes that affected the residents and community as a whole.

The information and referral domain generally included disseminating information on health and human service providers, immigration issues, and other essential topics in the community setting, schools, churches, and homes. The process for achieving these activities

involved exchanging information, establishing relationships that bridged cultures, creating a shared understanding of issues, and overcoming barriers to accessing services.

The **education domain** included education about parenting, job-related concerns, health and well-being, and other topics. C-HWs themselves received ongoing formal training about how to effectively perform their educational functions.

The **community and capacity building domain** focused on creating social networks, the most important aspect of this domain, as well as identifying and nurturing leadership in the community, building economic capacity among residents, and recognizing, promoting, and preserving the Mexican culture.

The **emotional support domain** included nurturing relationships between residents and C-HWs, based on creating and sustaining trust, respect, and confidentiality. C-HWs provided emotional support around many personal and community areas of need, such as social isolation, domestic violence, and family celebrations. The study found that this aspect of C-HW practice was especially valued by the new immigrants, enabling them to function more effectively in a new country and culture.

For C-HWs, the **advocacy domain** included acting with and on behalf of the interests of the residents, such as advising service providers and other organizations about how to most effectively interact with residents. For example, the study found instances in which a C-HW would accompany a resident to a clinic appointment, observe how the resident was treated, and teach the resident how to deal with the situation, such as how to improve communication or deal with issues of cultural sensitivity. However, advocacy by C-HWs for residents and the community was observed in multiple contexts, involving issues related to education, human services, immigration, and others.

The essential message, however, was that from the perspective of how they viewed their role and how they operated, being a C-HW meant practicing in all of these domains.

COMMUNITY

The well-being of communities in which C-HWs lived and worked was a primary motivation in their daily work. Community represents the intertwining of Mexican and border culture with the larger U.S. culture, social networks, and the formal and informal partnerships that C-HWs established with residents. Community was a template that shaped C-HW practices. Indeed, understanding C-HW practices requires understanding that three elements formed the C-HW practices system: C-HW organizations, C-HWs themselves, and the community.

The study concludes that a major challenge to C-HW practices is creating and sustaining a correct balance in the relationships among these three elements, a challenge growing more difficult as the recognition and employment of C-HWs becomes more institutionalized and professionalized. Imbalance in the C-HW system poses a potential threat to the shape of C-HW practices.

PROGRAMMATIC AND POLICY IMPLICATIONS

The study findings, which are addressed in much greater detail in the full report, raise a number of programmatic and policy issues. Some are necessarily specific to the particular context in which the study was focused, namely colonias located in the U.S. – Mexico border region. Others, though emerging from this context, may well apply more broadly to other settings, C-HW organizations, and to the variety of C-HWs across the country. This is particularly critical, since this is a time in which there is increasing recognition of the critical role C-HWs can play, of expansion in the types of organizations using C-HWs, and of potential changes in their role as a result of calls for credentialing or certification and reimbursement. Further, these changes may lead ineluctably to changes in their relationship to the communities they serve.

Variation among C-HW Organizations: Policy Questions and Research Implications.

The study findings suggest that the "mix" of structural, programmatic and geographic features that C-HW organizations adopt significantly affects the shape of C-HW practices. Thus, these findings about the wide variation among C-HW organizations raise several research questions related to identifying the effect of this variation and how to achieve the most effective mix among structural, programmatic and geographic characteristics of the C-HW organization. Examples of such policy-relevant research questions include the following:

- What is the most effective structural relationship for C-HWs to have with the communities they serve? For example: how deeply can and should a C-HW organization be embedded in a particular community? What are the costs and benefits of the different arrangements? Does the nature of the programmatic focus of the C-HW organization imply that one model or another of structural relationship to the community is more or less effective? How does the structural relationship to the community affect recruitment and retention of C-HWs?

- Does the programmatic focus of C-HW organizations affect their ability to recruit, retain and sustain a C-HW workforce? For example, are narrowly focused C-HW organizations more or less able to attract and retain C-HWs?

- What are the effects of differing geographic service areas on C-HW organizations? For example, are some structures more effective for certain types of programmatic foci? Are there potential tradeoffs between the availability of resources (e.g., state-level resources might be available for multi-county programs) and the ability to link the C-HWs to their home communities or between sustainability of the C-HW organization and retention of C-HWs? Are their economies of scale associated with one model but more effective recruitment with another?

Policies Affecting C-HW Practices: Research Questions, Programmatic Implications, and Policy Issues.

Policies affecting C-HW practices should recognize and consider the dynamic nature of the C-HW system in which C-HWs operate. This system or context within which C-HWs practice has implications for policies related to (a) recruitment and training; (b) credentialing; and, (c) the use and effectiveness of C-HWs.

Recruitment. The study findings suggest that C-HW recruitment policies should emphasize selecting workers from the community(ies) in which they will work and seek individuals who demonstrate basic talents and a strong interest in the community and its people. C-HW organizations should also seek individuals who are committed to ongoing learning, able to model the behavior and activities that will support both individual development and community capacity-building, and possess communication and other interpersonal skills that can ensure an ability to work with local people as well as external organizations.

Training. The study findings indicate that policies and programs on training for C-HWs should recognize the importance of imparting information about the local community settings in which C-HWs will function. Although a statewide or regional program may be charged with developing and implementing a C-HW program, the training component should include input from local C-HW organizations and local experts from the communities in which C-HWs are expected to work.

Role Definition. The study findings on C-HWs' conceptions of their responsibilities and role in the community strongly imply that policies and programmatic decisions should encourage employment of C-HWs in roles that reflect all elements of C-HW practice. The tendency of some organizations and some policy-makers is to view the role of C-HWs more narrowly, as a vehicle to market or promote a particular organization or service. Such a limited view of their roles is likely to generate problems in recruitment and retention of C-HWs who have a natural inclination toward a more holistic approach to helping individuals and communities.

Further, policies and programmatic foci that are organized around particular service specialties or age groups should take into account the willingness and ability of C-HWs to attain additional education that will enable them to serve the complex needs of the residents more effectively.

Credentialing/Certification. Policy development and implementation for credentialing, certification, and other recognition for C-HWs by government agencies and funding organizations should ensure that full consideration is given to the range of work expected of C-HWs, as well as the variety of community settings in which such work is conducted. Such policies should seek to ensure quality and effectiveness among C-HWs without

creating unjustifiable hurdles that might exclude persons with significant abilities to meet local needs.

Recognizing the Role of C-HWs and Cultural Connectivity. Regulatory and professional organizations should give full consideration to the capabilities of C-HWs to work with and enhance the effectiveness of health professions, programs, and organizations in working with populations that require cultural "connectivity" and healthy community-building that go well beyond popular notions of cultural sensitivity.

Policies Related to C-HW Organizations.

Policies and programs should recognize the need for flexibility in contractual or programmatic relationships between funding organizations and C-HW organizations, enabling the latter to manage C-HW activities in a manner that balances community expectations with sponsors' expectations.

Local Control. Stakeholders interviewed in this study favored significant involvement of the local community. They argued that regardless of the degree of external administrative control or sponsorship that is formally required of a C-HW organization, a guiding principle should be assurance of a significant degree of local control and design in C-HW service programming and implementation.

Funding for Organizational Infrastructure. The study suggests that funding agencies should include a significant proportion of funding that can be allocated at the discretion of the local organization and C-HWs to support infrastructure development or other capabilities that can prepare a foundation for more effective implementation of the program being funded.

Flexible Forms of Funding for Community Development. To address gross disparities, some funding policies should be flexible, offering funding akin to community development block grants. These should be specifically targeted to C-HW organization in colonias to support the broad-based development of healthy communities, not merely health initiatives aimed at individual members of the community.

Need to Focus the Regulation of C-HW Organizations on Processes and Outcomes, Not Structural Features. The study findings on variation among C-HW organizations suggest that different arrangements facilitate different outcomes, in terms of services to individuals and communities and in terms of their effect on C-HWs. Thus, the findings point to the need for policies and programs governing the creation and diffusion of C-HW organizations and C-HW activities that emphasize conformance to principles, competencies, core processes, and outcomes rather than compliance with specific structures or models. This recommendation reflects the fact that the diversity of communities and the cultures in which C-HW organizations and C-HWs functioned were inconsistent with the notion of "one size fits all."

The Need for Additional Research.

We recommend the adoption of policies that support additional research. Some of these issues were discussed above; however, more research is also needed on the critical roles played by C-HW organizations and workers in order to guide policy development and programmatic improvement in order to facilitate full-use of the capabilities offered by C-HWs and their organizations. In particular, additional research should be directed at the following topics and issues:

- **The roles and activities of C-HWs that are deemed most important to various groups of residents of the colonias** and how those views may differ across the residents served, such as new immigrants, women, men, children, and the elderly.

- **The effects of C-HWs.** Research should address the working relationship between C-HWs and staff of health and human services organizations, immigration, local governments, and schools, that reflect the benefits C-HWs bring to the work of these other organizations and professionals for the colonias and their residents. In particular, research should seek to capture the multiple impacts that the work of C-HWs might have on the residents in terms of well-being and identity; the developmental capacity of the community; the various programs, services, and infrastructure elements of the community; and elements of the "C-HW experience" that can be usefully translated into the policies, programs, organizations, and professions that benefit the colonias and settings throughout the dominant culture.

MUJER Y CORAZÓN: COMMUNITY HEALTH WORKERS AND THEIR ORGANIZATIONS IN COLONIAS ON THE U.S.-MEXICO BORDER

Introduction

Several hundred thousand persons live in unincorporated areas known as *colonias* along the border between the U.S. and Mexico. Often these areas do not have adequate sanitation, including clean water supplies, and the people living there typically have inadequate insurance coverage (public or private) and poor access to a regular source of health care and essential preventive health services. The Comparative Community Health Workers Study is an exploratory, qualitative analysis of the practices of community health organizations and the community-health workers (C-HWs)[1] who work in them, in the colonias along the Texas and New Mexico border areas with Mexico. It also examines the strategies these C-HWs use for community health outreach and education, the effect of their work on the communities and on the service providers with whom they work, and their own experience, satisfaction with their roles, and the factors that affect these. Finally, it uses these findings to reflect on the implications for policies on the use of C-HWs and any new requirements for training and licensure or credentialing.

Organization of the Report.

- Chapter I provides an overview of the study's geographic, social, economic, and cultural base.

- Chapter II addresses Objective 1 of this study - to describe the varied organizational structures within which C-HWs practice. It discusses the organizations that employed C-HWs, examining their structures along three dimensions: their predominant mission foci, their relationship to the communities they serve, and their geographical scope of service. Although these three dimensions provide a rich picture of the diversity of C-HW organizations, the findings suggest that an additional factor – the fundamental commitment to make programming community-tied and community-tailored – makes it possible for the organizations, regardless of structural variation, to facilitate major impacts on the communities served.

[1] In this report we use the phrase "community health worker" and hyphenate the initials for the purpose of emphasizing the community dimension of their practice. Such workers are referred to by a variety of name, such as Animadoras, Promatoras, and Community Volunteers.

- Chapter III focuses on the structure and content of C-HW practice, describing five domains of the C-HW practice. This chapter responds to Objective 2 of the Study – to describe the work of C-HWs and how and why they do it.

- Chapter IV draws together the results of the analyses in Chapters II and III, summarizing the findings and interpreting those finding in the context of Objective 3 - to clarify the factors that shape C-HWs' practices.

- Chapter V responds to Objective 4 – to identify the policy implications of the findings.

- Appendix includes the study methodology.

- The report concludes with a list of references.

Chapter I
Community as Context: The Study's Geographic, Social, Economic, and Cultural Base

I. Background: The Community Context of the Border and Colonias

Community-Health Workers (C-HWs) and the organizations that implement community health outreach programs included in this study are located in small, rural settlements called colonias along the U.S.-Mexico border in Texas and New Mexico. The residents of colonias are predominantly Hispanic and live in communities with little infrastructure and limited access to health care. Understanding the realities of C-HWs and C-HW organizations requires knowledge of the social conditions that shape day-to-day life in the colonias and the region in which these are located. These conditions are related to the geography of the region, its relative rurality and poverty, and a population with significant health needs but few resources.

I.1. The Border

The U.S.-Mexico border region comprises an area that stretches 2,000 miles from San Ysidro, California, to Brownsville, Texas, extends some 60 miles on either side of the legal border, and includes 48 border counties in four U.S. states (Texas, New Mexico, Arizona, and California) (HRSA, 2000). While some regions are highly populated (California, Baja California, El Paso-Ciudad Juarez region, McAllen-Reynosa region and the Brownsville-Matamoros region), most other border areas in Texas and New Mexico are sparsely populated – several counties and municipalities have fewer than ten persons per square mile (EPA, 1997).

Exhibit 1. Percent of Families Living Below Poverty Level With Related Children By Location in Study Counties

Geographic Area	Families Below Poverty	Families with Children ≤ age 18	Families with Children ≤ age 5
Texas	12.0%	16.6%	20.7%
Cameron	28.2%	36.5%	42.5%
Hidalgo	31.3%	39.1%	43.8%
Starr	47.4%	53.8%	60.7%
Willacy	29.2%	36.2%	67.3%
New Mexico	14.5%	20.8%	26.4%
Dona Ana	20.2%	28.9%	35.6%
Hidalgo	23.9%	31.5%	35.1%
Luna	27.2%	39.9%	53.0%

Source: U.S. Census Bureau, Census 2000

In addition to rurality, the border is characterized by poverty. The Texas and New Mexico

border counties, on average, have a higher rate of poverty than the average poverty rate for their states as a whole and than the United States as a whole. Among the border population in the late 1990s, more than 20 percent had incomes below the federal poverty line compared to 12 percent in the country as a whole (EPA, 1997). Three of the poorest counties in the U.S. are located in the border area and 21 U.S. border communities have been designated as "economically distressed" (EPA, 1997). The counties included in our study in the Lower Rio Grand Valley of Texas and the border areas of New Mexico exemplify this high level of poverty along the border, as shown in Exhibit 1.

Approximately 80 percent of the border region population is of Mexican origin, and Spanish is the predominant language in a number of U.S. border communities (Anzaldua, 1987; EPA, 1997). However, the communities along the border are not homogeneous, as they contain cultural, class and race-based differences that are powerful signifiers within these communities. Recent immigrants from Mexico and second or third generation Mexican-American or Chicano families may have different social class positions, as well as different attitudes towards Mexican and U.S. culture (Richardson, 1999).

I.2 The Colonias

The population served by C-HWs and organizations that are the focus of this study live in colonias. The EPA defines colonias in the U.S. as rural settlements with substandard housing and poor living conditions along the U.S.-Mexico border. They lack some or all of the following aspects of community infrastructure: paved roads, sewer systems, electricity, gas, clean water and/or health care services (EPA, 2001). Colonias are frequently located in low population density areas, many existing in what is essentially an "administrative no-man's - land" (Ward, 1999).

Prior to 1950, much of the land now occupied by colonias was a vast acreage of ranches and farms. In the 1950s, however, landowners began to sell off poor quality tracts of land, especially those tracts prone to flooding or erosion, to their farm workers and to immigrants from Mexico (Vila, 2000; Richardson, 1999). In fact, one of the unusual characteristics of colonias is that a great majority of the residents own the land on which they live. However, the parcels of land were sold via a "Contract for Deed" at approximately fourteen percent interest (Richardson, 1999). The contracts were not officially registered with the counties. Further, the agreement stipulated that the buyer must pay off the entire amount agreed upon for purchase of the property before receiving the deed. If the buyer missed one payment, the land could be repossessed (Ward, 1999).

Despite the drawbacks of these types of contracts, there are benefits to buying one's own plot of land in a colonia. Most low-income border residents could not afford to buy land and a house in a suburban development, or even a rural development. Unlike most urban economically distressed areas, a vast majority of colonias residents own their homes, and many built them with their own hands. This in turn facilitated the development among homeowners of social bonds to their neighborhoods and an underlying community ethos

(Richardson, 1999). Thus, defining colonias solely by their dire conditions misrepresents them and the residents.

I.3 Health in the Border Region

The border population suffers from increased prevalence of certain diseases including Hepatitis A and tuberculosis which are twice as prevalent along the border compared to the country as a whole, and non-communicable diseases, such as diabetes, are also a problem in the area (HRSA, 2000). According to the Centers for Disease Control and Prevention (CDC), diabetes is the seventh leading cause of death on the U.S. side of the border, while on the Mexican side, it is the third leading cause. The CDC estimates that up to 30 percent of the total border population has diabetes, and up to one-third of these individuals don't know they have the disease (CDC, 2001).

The existence of health problems in the border region is complicated by social, economic, and cultural factors – occupational risks, limited ability to purchase nutritious food, barriers to affordable medical care, and, sometimes, cultural practices and beliefs about medical care (Texas-Mexico Border Health Coordination Office, 1998). Agricultural workers and their families continue to be subjected to pesticides and hazardous fertilizers. The current increase in industrial employment increases exposure to dangerous chemicals and to physical and ergonomic hazards (Texas-Mexico Border Health Coordination Office, 1998).

These health problems and risks are exacerbated by poor access to health insurance and health care providers by much of the border population living in colonias. The U.S. Mexico border states contain nearly three million people who have no form of health insurance (Department of Health and Human Services, 1997). The lack of health insurance and/or underinsurance has been associated with delayed health care, increased mortality, and adverse health consequences (Sanchez-Bane and Moya-Guzmán, 1999). This is further complicated in many of the most rural and lowest income border areas by the lack of reliable forms of health care, including primary care physicians, clinics and hospitals (Texas-Mexico Border Health Coordination Office, 1998). Moreover, language and other cultural barriers may increase the likelihood of service underutilization.

In such an environment C-HWs provide a means for addressing the multiple barriers to health care through their knowledge of the community, its residents, and their needs.
It is in this context that many organizations have used community health workers in a variety of ways intended to improve the health of rural colonia residents – to reach out to colonias' residents, to educate them about health issues, and in some cases, to enroll residents in health-related programs.

I.4. Research Goals, Objectives and Methods

The study had four goals:

- To describe variation in structures and processes among C-HW organizations;
- To describe the nature and scope of C-HWs' work;
- To identify factors that shape the work of C-HWs; and
- To determine whether and how the organizations and the C-HWs affect the communities served.

Conducted over an eighteen-month period, the study's setting was the colonias along the U.S.-Mexico border in two states – Texas and New Mexico. A total of twelve C-HW organizations – six in the Lower Rio Grande Valley of Texas (i.e., the counties of Cameron, Hidalgo, Starr and Willacy) and six in the New Mexico counties of Doña Ana, Hidalgo, and Luna. [2,3]

[2] In Texas, the organizations were: ARISE, Inc., AVANCE, Texas A&M Colonias Program, Migrant Health Promotion, Nuestra Clinica del Valle, and Texas Agriculture Extension. The organizations in New Mexico were: La Clinica de la Familia, Ben Archer Clinic, Luna County Healthy Start, Southern Area Health Education Center (AHEC), Hidalgo Medical Services, and Success by Six.
[3] Discussion of the study methodology is located in the Appendix.

CHAPTER II
Organizations as Context: The Study's Organizational Base

Table II.1 provides descriptive information about the twelve organizations included in the study. The organizations are labeled "A" through "L" to protect their confidentiality. Each column of the table is discussed below.

Table II.1. Four Factors of Organizational Variation

State	Organizations	Label Given to CHWs	Geographic Scope	Embeddedness	Predominant Focus
TEXAS	*A*	Animadoras	One section of one county	Local	Education Community-Building
	B	Promotoras Home visitors	More than two counties	Supra-Local	Early childhood development
	C	Promotoras	More than two counties	Supra-local	Comprehensive outreach
	D	Promotoras	More than two counties	Supra-local	Health
	E	Promotoras	One county	Local	Health
	F	Volunteers	More than two counties	Supra-local	Economic capacity building
NEW MEXICO	*G*	Promotoras	One section of one county	Local	Health
	H	Community Advisors/ Promotoras	Two counties	Local	Health
	I	Promotoras	One county	Local	Child and maternal health
	J	Promotoras	One county	Local	Environmental health education
	K	Promotoras	One county	Local	Health
	L	Promotoras	One county	Local	Early childhood development

II.1. Label Given to Community Health Workers

The data show that in the U.S.-Mexico border, community health workers are most often referred to as 'Promotoras', with some exceptions. One of the participating organizations calls its workers *animadoras*, another uses a combination of *home visitors* and *promotoras*, another identifies them as *community advisors*, and finally, one refers to them as *master volunteers*. A national study conducted by the University of Arizona (Rosenthal, 1998:pp.1-2) states:

> *'Community Health Advisor' (CHA) is used in the Study to encompass an array of health practitioners known nationally and internationally by many different titles. Some other names for these practitioners are: Lay Health Advocate, Promotora, Outreach Educator, Community Health Representative, Peer Health Promoter, and Community Health Worker....In the Study's national survey...66 distinct (although often similar) titles for CHA were identified. These varied titles reflect the diversity of the field, diversity that contributes to CHA programs' success in meeting the needs of culturally distinct communities.*

The data also suggest that the term CHA (or 'community health advisor') is not comprehensive enough, for they are much more than 'health advisors.' The data are clear in that lay outreach workers are always members of a community they serve. Even when lay outreach workers are not working in their own community all of the time, in all cases workers are members of a common border with many cultural commonalities in similar communities (in the case of this study, colonias). As a consequence, the lay outreach workers share with the residents of the communities in which they work a common set of life experiences as border residents. Secondly, lay outreach workers are commonly engaged in helping develop healthy communities, which may include a wide range of activities to improve their communities, from housing, to recreation, to education, to finding resources making access to sewer and water possible, to access to health care.

Therefore, we propose to make a change of emphasis by using the phrase 'community-health worker'. Hyphenating 'community' and 'health', i.e., Community-Health Worker (C-HW) reflects the study's finding that the practice of C-HWs is focused on the health and well-being of the community. Even in the cases when the mission of the C-HW organization and/or the C-HWs is to improve individual health and access to health care, workers cross those boundaries and focus on a larger scope of community needs. Thus, C-HW is used throughout this report.

II.2. Geographic Scope of Each C-HW Organization

Organizations varied in the range of their targeted service areas. The data show three types of geographical scopes of service:

- Organizations A and G serve one section of one county, meaning that the organizations work only in one colonia, or a small cluster of colonias, but not an entire county;
- Organizations E, I, J, K, and L serve one county; and
- Organizations B, C, D, F, and H serve two or more counties.

Four out of seven C-HW organizations in Texas claim multiple counties as their service area, while in New Mexico, the same number of C-HW organizations serve one county.

II.3. Embeddedness

The term "embeddedness" refers to:

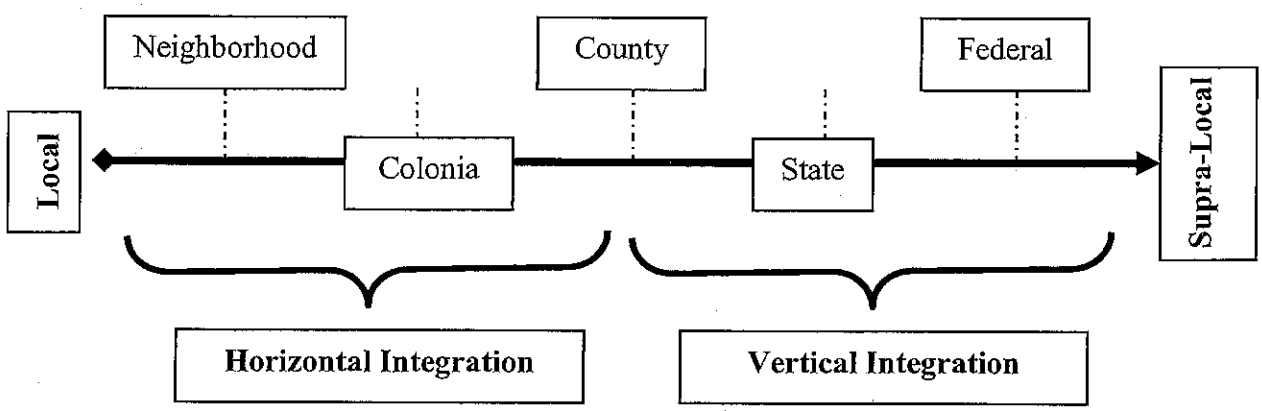
(a) The extent and nature of an organization's administrative, financial and programmatic integration with outside, larger organizational networks beyond the local community (i.e., vertical social integration); and

(b) The nature of an organization's integration within the community/communities in which it works (i.e., horizontal social integration).

Peter Ward (1999) distinguishes between "horizontal social integration" and "vertical social integration." Horizontal social integration, he asserts, refers to those social interactions that connect across persons and groups within a social grouping, within communities. Vertical social integration consists of the interactions that tie a social group, its institutions and actors, to a world outside the social group, connections so important to accessing resources that augment those existing within the social group.

Data from this study suggest that C-HW organizations fall along a continuum of horizontal and vertical social integration, with two types of organizations forming the two ends of the continuum, as shown in Figure II.1.

Figure II.1. Embeddedness Continuum.



Examples from the study's participating C-HW organizations illustrate the continuum.

(1) At one end of the continuum are Organizations A and G that have their administrative control embedded locally, within the organization itself, and are not densely connected vertically. These organizations are almost exclusively focused on one community, or on a very small number of communities, out of which they were created and in which they serve. Their administration is local, the C-HWs almost always reside in the exact same communities in which they work, and their social and practice orientation is inside a community. Their funding comes from local and regional sources primarily, and their programming is largely created by and for the local communities. These organizations do not have much vertical connectedness with state and/or national programmatic organizations, e.g. Workforce, Gear Up, etc. They are more likely to be connected horizontally to local/regional organizations. For example, in Organization A the total administrative apparatus is located in the same building out of which the C-HWs work; moreover, the organization is administered by the C-HWs, the same ones that carry out the education and outreach program of the organization.

(2) At the other end of the organizational continuum are Organizations B, C, and D in which administrative connections are local, state, regional, and in some cases, national in scope. These organizations have broader service areas in multiple counties and/or states; they have a complex administrative structure, with multiple layers of administrative decision-making, some of which may reach to a multi-state administrative level. Likewise, their funding sources reach broadly to the state and, often, federal levels, in support of a wide variety of programs. It follows, therefore, that this type of organization does not have the unique connections to community as described in (1).

This fact notwithstanding, it is essential to note that C-HW organizations that are more integrated vertically also are concerned with maintaining horizontal integration with the local and regional communities they serve. These are the communities in which they had their beginnings and they take care to avoid becoming horizontally disconnected from the communities in which they work. They explicitly make it a point to have staff indigenous to the specific communities and regions they serve and the indigenous staff hold primary administrative and decision-making responsibilities.

(3) All other organizations lie somewhere between these two types. Organization E, for example, in the middle of the continuum, has funding sources that are state, and to some extent nationally, based; it serves clients primarily in one county that has nearly one half million residents and many small rural communities. Organization H has similar conditions.

Embeddedness in this study also refers to how C-HW organizations vary in the ways they are horizontally connected to (i.e. 'sit' in) the communities they serve, the extent to which they are uniquely and exclusively part of a community.

(1) For example, Organizations A and G 'sit' deeply in their communities. These organizations are in and of the community – they were born there, they have matured there, their whole organizational existence is there, and they have as their primary focus serving their specific communities. It is as if the community 'owns' the C-HW organization. They think of themselves as 'locals.' Gouldner (1958) describes the dedicated 'locals' as:

> *the true believers who are identified with and affirm the distinctive ideology of their organization....They are deeply committed to their organization – and to it as a whole – on the grounds that it embodies unique values which they regard as important....They are also more likely to insist that their colleagues possess certain local value orientations rather than technical competence* (p. 446).

In a similar manner, these organizations are grounded in a network of 'strong ties.' Mark Granovetter (1973), defines 'strong' ties (local, horizontal integration) as "a collection of close friends, most of whom are in touch with one another – a densely knit clump of social structure." These are persons and organizations who know each very well and whose interactions are rich and substantive. "Weak ties" (supra-local or external, vertical integration), on the other hand, are "a collection of acquaintances, few of whom know one another" (p.106). Weak ties are those with persons and organizations outside the community, whom are not known well, and have little substantive connection to the community ('cosmopolitans').

(2) Significantly different in orientation is another set of organizations that are more cosmopolitan in their outlook. The key to understanding this set of organizations is that they sit in and serve multiple communities. Therefore, the ways in which they sit in a community become different because the C-HW organization can no longer be 'owned' by just one community, or a few communities. These organizations have multiple bases, none of which uniquely defines the organization. They expand their horizons beyond the local, and while attempting to maintain strong ties in the communities they serve, they intentionally establish weak ties as the organization expands in order to sustain its mission, goals and objectives. They seek to maintain a balance of both kinds of ties.

Organization C illustrates this set of C-HW organizations. Organization C is widely extended administratively, financially, and programmatically. It serves multiple regions along the Texas-Mexico border and has multiple centers in and out of which C-HWs work. Thus it cannot think of itself as serving any one community, as being uniquely tied to one, over another, community.

At the same time, Organization C strongly believes in the importance of its work being community-tailored. Consequently, to make this possible, it has created community resource centers in specific locations along the Texas-Mexico border from El Paso to Brownsville, and through these centers the organization serves residents within a local cluster of communities surrounding each center. To localize its mission, Organization C makes sure that each center is owned and operated by a local/regional organization

(usually a school district or county government). In this way, it could be said that each center sits locally in its cluster of communities, is connected to them, and in some sense maintains some strong ties to that community/those communities. Furthermore, in most cases, the C-HWs who work out of each center are from a local community and have strong loyalties to it, enriching a sense of local attachment. Organization C's presence and belonging to community is not completely lost. It sees itself as being in and serving communities, keeping community at the center of its programming, and maintaining a significant network of 'strong' ties in each center location.

Nevertheless, organizations like Organization C do not relate to their communities in the same ways as Organizations A and G do. They are extensive in nature, related to larger organizational structures and a widening network of 'weak ties' on which they depend for their continued existence. Decisions concerning community needs and programming come to include outside organizations and organizational staff who do not have strong ties locally. As the organization grows and the program diversifies, it may be that C-HWs from one community, or one organization, on occasion, are directed to work with C-HWs in another community when the program (or other demands) calls for it, affecting how C-HW organizations relate to the communities they serve and how the communities they serve will perceive the organization and the C-HWs.

We can now be more precise about the similarities and differences in roles that C-HWs hold in different types of C-HW organizations with different types of embeddedness. Organizations like A and G strikingly illustrate the community-tied nature of C-HWs and C-HW organizations. In this type of C-HW organization, C-HWs are the organization – directing it, setting policy and designing program, implementing program and policy – and the organization is the community. They are tied to the organization and the community holistically and any changes that interrupt that connection diminish a sense of meaning and accomplishment for the C-HWs. In C-HW organizations represented by Organization C, the embeddednesses is different. C-HWs not only continue to be essential to maintaining 'strong' ties between the organization and the community(ies) it serves, they take on the added responsibility of bridging the 'strong' ties to the 'weak' tie functions of the organization. C-HWs are *the bridge* that translates 'weak' tie organizational behavior (e.g. in decision-making, funding, staffing, etc.) into 'strong' tie relationships at the local level. Performing these bridging responsibilities calls for an added set of skills among C-HWs, as well as a different perception of what it means to be a C-HW.

II.4. Predominant Focus

In this study, organizations varied widely in their predominant programmatic focus. As shown in Table II.1, the following are the prevailing foci among the organizations:

- Education and community building
- Early childhood development
- Comprehensive community development
- Health

- Economic capacity building
- Child and maternal health
- Environmental health

Within this variety, however, C-HW organizations embody two characteristics:

(A) They vary regarding the predominant focus of their mission, ranging from an exclusive single mission approach to a comprehensive, multifaceted mission approach. Some have health as the predominant focus, and others do not.
(B) Among those organizations that do not have a mission focus on health, their programmatic goals and objectives usually include health-related activities.

Seven organizations explicitly identified health as the primary mission (D, E, G, H, I, J, K) while the five others did not (A,B,C,F, and L). These latter organizations focused on such issues as "connecting isolated communities to programs and services" or education. This variety in mission suggests different understandings of what the definitions and roles of C-HWs are. Yet, even with narrowly defined missions, most organizations recognize broader needs in the communities they serve and support the idea that their C-HWs will do more than just serve the predominant mission of the organization. Although the C-HW organization may not train the C-HWs specifically for broad-based outreach and education, it may not restrict its C-HWs from finding out information for community residents who have needs other than health. Some organizations 'give permission' to their C-HWs to hold a broader perception of their work than prescribed by the organization's mission. Other organizations go further and even provide more broad-based training for their C-HWs.

Communities – their needs and their assets – define what C-HW organizations and C-HWs do and how they perceive their work. This becomes apparent in the discussion of C-HWs' practices in Chapter III.

CHAPTER III
Community-Health Workers: The Shape of Practices

The practice of the C-HWs is multi-dimensional, including a diversity of roles and strategies for implementation that derive from community needs and assets and that impact in the community. Table III.1 summarizes the study's findings in a framework called "Dimensions of C-HW Practice." Within the 'dimensions' there are five domains of practice, i.e., areas of the community well-being that are affected by the C-HWs. These are:

- Information and referral
- Education
- Community capacity building
- Emotional support
- Advocacy

Each domain is associated with implementation processes and impacts. Implementation *processes* refer to the means by which C-HWs connect with communities, the organizations with which they work, and service providers in general. *Impacts* refer to the ways in which the communities are affected through C-HWs' work. Impacts may occur at the level of individuals, families, communities, and system. Note that in reality the five domains of practice cannot be easily distinguished one from the other; much overlapping and intertwining occur among the domains in the course of practice. Table III.1 shows the framework "Dimensions of C-HW Practice."

TABLE III.1 – Dimensions of C-HW Practice

Domains	Process	Impact
What do C-HWs do?	**How do C-HWs do their work?**	**How do C-HWs impact the community?**
Information and referral	• Home visits to identify needs, inform and refer to services • Organize health fairs and presentations at colonia homes • Organize health fairs at schools and other places • Inform community residents at community center/office • Distribute information in public places	• Link residents with service providers • Contribute to diminish isolation of colonia residents • Contribute to change providers' attitudes towards working in colonias • Build individual capacity in community residents
Education	• Teach parenting • Teach early childhood care • Teach disease prevention strategies • Teach healthy life styles • Teach environmental health • Teach arts and crafts	• Educate community residents, particularly children and women • Empower community residents, particularly children and women • Build healthy communities
Community and Capacity Building	• Organize the community • Recruit volunteers • Organize health fairs at people's homes • Value people's strengths • Teaching money earning activities • Organize (and outreach for) folklore activities	• Connect residents • Build leadership • Empower community residents • Build economic capacity • Recover and empower local and Mexican culture
Emotional Support	• Counsel and advise women of community • Give advice to children and youth	• Increase self-esteem of women, children, and youth • Comfort and orient residents with emotional needs
Advocacy	• Advise community residents on issues related to discrimination and access to services • Talk with service providers about cultural competence and discrimination concerns	• Empower community residents • Build self-reliance in communities • Indirectly educate service providers on cultural competency

The domains of practice described in Table III.1 vary in time and context during C-HWs' practices. The emphasis placed on one domain over the other by a C-HW, or a group of C-HWs, is in part a function of the organization's goals and objectives, and in part, the personal interests and commitments established between the C-HW(s) and a community. For instance, information and referral, education, and community capacity building are commonly emphasized by C-HW organizations as explicit domains of practice. However, emotional support and advocacy are domains of practice that C-HWs often find essential in accomplishing their work, although not explicitly instructed to do so by the organizations. Emotional support and advocacy activities occur, not surprisingly, as a result of the C-HWs' being a part of the community and feeling a strong commitment to its well-being.

III.1. Information and Referral

All C-HW programs provide information and referral services. C-HWs are a bridge that connects residents to providers, and opens up understanding between two different cultures. In this sense, C-HWs are cultural brokers.

III.1.1 Processes

All of the organizations that participated in the study have information and referral as a priority domain of practice. Information is provided on diverse topics, including health services, environmental dangers, education, child care, immigration, and housing. C-HWs receive training on these and other topics from the employing organization as well as from health agencies, service providers, and non-governmental organizations. C-HWs are provided with fliers, booklets, and other forms of written information to disseminate in the community. During home visits, C-HWs regularly ask residents about needs and, based on the responses, they provide them with relevant information. This information could be about specific services, or general guidance about how to navigate the system. On some occasions, particularly if the person does not speak English, the C-HW calls the service provider, asks pertinent questions, or makes an appointment. Regularly, C-HWs follow-up through phone calls or home visits to make sure that the referral was followed through.

Home visits are central to the C-HW experience.[4] In home visits, C-HWs' skills and comparative advantage as insiders are made evident, as they demonstrate a high sense of cultural sensibility and respect for the people. They also demonstrate skills and knowledge acquired through training, about how to engage families. A C-HW describes a home visit in the following terms:

> *The first thing we find when we visit homes is that sometimes people don't want to talk with us because they think we represent a Church. They have said that to us on some occasions. We dress in a certain way so that we can be identified as promotoras. We first tell them that we are promotoras and that we work with the*

[4] A few C-HWs do not do home visits since some of them are trained to only teach, or to help people complete a diversity of applications for assistance programs at the office, among other things.

[community project]. Then, we tell them about what we do as promotoras and as a result they start trusting us. Trust, however, is developed slowly, visit after visit. We go back to a home as many times as it is necessary in order to develop trust. We tell people about services available to them. [...] Simultaneously, we complete a needs assessment questionnaire; we always show them the questionnaire. They always ask us why we need to ask those questions. We tell them that it is for the well-being of the community, so that services are made available...then we give them the information they need...

C-HWs provide both a general and detailed orientation about a diversity of issues or services through several strategies: health fairs at colonia homes, schools, or churches; distribution of materials or oral presentations at the waiting rooms of health clinics, community centers, and even in public spaces such as malls and supermarkets.

III.1.2. Impact

The information and referral practices during home visits are highly regarded by community residents. C-HWs connect community residents to a variety of external provider systems, e.g. health, mental health, education, employment, training, housing, and immigration. In doing so, they fill an outreach gap. Several coordinators and directors who participated in this study stated that before having the C-HWs component in their agencies, they and service providers in general did not go into colonias to inform residents about available services because they did not have an infrastructure by which to do so. Another Director of an organization commented: "We discovered that it was not only colonias residents who were isolated. Service providers were just as isolated." With the inclusion of the C-HW component, organizations were able to bring providers to the community, adapting to the existing colonia conditions. C-HWs' ability to hold community meetings in multiple settings – under the shadow of a tree or in a small living room with no air conditioning - proved to providers that they did not require a complex infrastructure before they could reach out to colonia residents. Accordingly, C-HWs' impacts not only bridge the divide between colonias and the system of providers, but contribute to changing attitudes of service providers and the paradigms through which they operate.

The concept of "bridging the divide" has a particular significance from the point of view of colonia residents, especially for residents who are new to the colonia and the United States. To recent immigrants who know few people except the C-HW who knocks on their door, providing information acquires significance beyond the act of making knowledge available. C-HWs become a friend and a resource throughout the complex process of adapting to the new life in the colonia and the country.

As C-HWs connect residents with the service systems, they facilitate communication and understanding and conduct a cultural translation. C-HWs make understandable to community residents the messages that service providers want to convey, while simultaneously, the C-HWs carry and interpret information about the residents for the service providers.

As one Director noted regarding the role of C-HWs: "*They can open doors that we cannot. Because they know the people, they know what their needs are. They ...tell me what I need to do.*"

III.2. Education

C-HWs contribute to the general education of the community through outreach that informs people about multiple issues, and activities that train and educate people on specific topics. Furthermore, C-HWs educate by virtue of the synergy produced between themselves and residents, from which comes the respect that residents feel for them.

III.2.1 Processes

Education is one of the common areas of intervention for C-HWs. Although not all of the organizations have education as a predominant mission focus, all of them involve their C-HWs in educational activities of some sort. In fact, every informational activity carried out by a C-HW has an educational dimension. Through information delivery, C-HWs are building a knowledge and awareness base in the community.

Some organizations have C-HWs teach following structured curricula. For instance in Organization C, C-HWs teach a parenting curriculum that is part of a nine-month intensive parent-child education program serving low-income families with children under 2 ½ years of age. In this same program, C-HWs are trained to visit homes on a monthly basis to observe parent-child interactions.

As preparation to conduct educational activities, C-HWs receive training from specialized agencies. In the organization specializing in early childhood development and child and maternal health, some C-HWs registered in a community college in order to obtain a Child Development Certificate. Another C-HW organization hired C-HWs who were already certified in an allied health specialization. C-HW trainings are educational opportunities and become part of their integral education.

III.2.2. Impact

C-HWs who participated in the study provide education in a diversity of areas, including parenting, infant and child care, sewing, opportunities for building economic capacity in the community, nutrition and healthy cooking techniques, environmental health, and miscellaneous topics such as driving lessons.

C-HWs' educational impact in communities is a function of the value that they assign to it. Although roughly 85% of the C-HWs who participated in the study did not have high school diplomas, they value education for themselves, their family, and their communities. A common incentive is their aspiration to educate themselves in order to be able to educate the community. C-HWs reflect daily their enthusiasm for learning and excelling in their practice. Their deep commitment to education embodies a model to those in the community

with whom they work, creating a symbiotic relationship between the C-HW, the C-HW's work, and community residents.

III.3. Community and Capacity Building

C-HWs build community as they connect residents to residents and residents to resources. They create and strengthen social networks as they build leadership and economic capacity among residents, promote local and Mexican culture, and mobilize the community around issues of community improvement. Community capacity building promotes and builds mechanisms for community sustainability.

III.3.1. Processes

Although only two of the C-HW organizations in the study have community capacity building as an explicit mission (Organizations A and C), it is clear that this domain of practice exists in the daily work of every C-HW interviewed, and is also reflected in the views provided by residents in the focus groups. This is a significant finding because it goes well beyond the specific missions of most organizations. It seems to us that this practice can be explained partially by the integral connectedness C-HWs have to the communities where they work and the residents they serve. Out of their strong ties to the communities arises a 'natural' interest in strengthening those communities. The data indicate that C-HWs emphasized these activities:

- Connecting community residents
- Building leadership
- Recognizing and developing strengths
- Building economic capacity
- Promoting local and Mexican culture

III.3.2. Impact

Connecting residents is a supreme expression of community capacity building. C-HWs help to connect people who may live in small colonias but do not know each other, or do not know each other well enough to constitute a social network of support. Connecting residents has implications for breaking through isolation and building horizontal integration and social support networks within individual colonias, and even between colonias. C-HWs connect residents through the group activities they organize at community centers, schools, churches, and the homes of community residents. These activities provide people opportunities to meet and establish relationships and overcome the isolation felt by some colonias residents.

Many times isolation results from fear of the environment (social, economic, political), particularly when the resident is a newly-arrived immigrant. In this context, the C-HW's role as bridge between residents and builder of social networks acquires a critical significance for

community building. Community celebrations, parties, and *tardiadas*[5] are vehicles used by C-HWs and their organizations to help build and strengthen relationships among neighbors who sometimes live disconnected from each other.

Building leadership in the community is another expression of community building. The study found that one key way of building leadership is through recruitment of volunteers to assist C-HWs in several capacities, e.g. helping C-HWs organize and carry out health fairs at residents' homes. Volunteerism is an important component of the C-HW organization that contributes to the sustainability of programs. Volunteers are recruited by C-HWs to help in general activities at the office or community center where they are based, including teaching residents on a variety of topics. For example, a C-HW from a program that focuses on education said that youth are recruited as volunteers to help in a summer program in which children from the community are involved in educational and recreational activities. These volunteers are given a small donation at the end of their participation in the program. Another example is a walking group which is maintained through the continuing effort of community volunteers to recruit additional members.

In nine of the twelve participating organizations, women volunteer for several months before they are hired as C-HWs. While volunteering, others in the community and the C-HW organization recognize them as resourceful and potential leaders, and facilitate their transition to a formal leadership role. Also, programming held at residents' homes constitutes an opportunity for the identification of people (usually women) who become known as people who have access to resources and are themselves resourceful.

Recognizing strengths of residents by C-HWs contributes to building community and capacity. In one of the organizations, C-HWs incorporate mothers from the colonia in an arts and crafts participatory learning process. Women are invited to the community center and asked to teach other women the skills they have and the crafts they know. In that way, C-HWs are helping women value themselves and their capacities. A C-HW made the point:

> *Look, many people have a lot of skills to do arts and crafts from recyclable material, such as using the newspaper to make fans and other things. Something that is very inexpensive and that makes their homes look nice. Women do things like that in their homes. We motivate them to come to the Center so that they can learn more and they can teach other people. It is like learning from another person and at the same time that person is going to learn from you. It involves giving and receiving...Every week they bring with themselves an idea that they teach to the other people. That is how they express their skills.*

Building economic capacity is another important dimension of community capacity building. C-HWs have an impact by serving as resources to residents who are seeking job opportunities. As depositories of information on diverse topics and community needs, C-HWs know of people or businesses that offer jobs, as well as about people who seek jobs.

[5] *Tardiadas* are community gatherings around food and music.

In other situations, the C-HWs provide training to community residents, women in particular, in money earning activities. A clear example comes from a C-HW program whose main purpose is to create economic capacity by training women in sewing. Women are trained by other women from the colonia who themselves are certified by the program as 'Master Volunteers.' Once the trainers are certified, they are required to train a number of others on a volunteer basis. Moreover, since Master Volunteers receive a certificate, they can also sell the product of their work at home or be employed by a company while they do their volunteer work.

Finally, *recognizing and promoting Mexican culture* by C-HWs , on several levels of explicitness, empowers both individuals and the community. This empowerment is embodied in a number of programs that help preserve and promote the Mexican cultural heritage, traditions, and customs through education of the C-HWs and the communities they serve.

III.4. Emotional Support

C-HWs, through their presence and work, exert an impact on the mental and emotional well-being of the community. Emotional support results from the interplay of a culturally-based practice called *confianza* (trust), something residents come to feel toward C-HWs, and of the C-HWs' deep identification with residents rooted in their common history and culture. Many times C-HWs are the only people residents know and trust, and as a result they become confidants- providers of comfort and advice. This is particularly the case around personal issues such as marriage crises and the process of adaptation to life in the colonia in the case of recent immigrants.

III.4.1. Processes

Although emotional support is not an explicit mission, goal, or objective of any of the participating C-HW organizations, the majority of C-HWs that were interviewed noted that they provide some form of emotional support to the people of the community they serve. Community residents, likewise, consistently mentioned emotional support as a main area of impact of the C-HW.

C-HWs as providers of emotional support to community residents, in particular women, are a reflection of three related elements: *confianza* (trust), *respeto* (respect), and confidentiality. *Confianza* and *respeto* are central values in which the practice of C-HWs is rooted. People open themselves to C-HWs because of the *confianza* that C-HWs instill in them, and because residents see them as part of the community.

Generating *confianza* is a priority for C-HWs. They know that *confianza* is essential in order to be effective in the help they have to offer. A C-HW, living in the same colonia where she works, comments on the significance of *confianza* for her work, which in part consists of asking people information about their families and their needs:

> *I knock on the door and step back a few feet, because you never know who you are going to find. Since a requirement of the program is that the promotora should live in the colonia, we know a lot of the people, and if we don't know them personally, at least we know who lives where; we know that lady from the Church, or that other lady from the school and we know that she is got a bad temper, but anyhow we knock at the door. Then we introduce ourselves and try to be gentle even if they are not. Even if the sun is burning hot and the dogs have us frightened, or whatever, we try to be gentle and to instill 'confianza' so that they can feel 'confianza' towards us. We try to understand that we are strangers, that they don't know us, and that we are asking for personal information. We try to inspire 'confianza' so that they accept to answer our questions.*[6]

Secondly, *respeto* (respect) motivates people to share personal issues and problems with C-HWs. Finally, confidentiality, something that all C-HWs offer and keep, is the third element motivating women to share their issues and problems and accept emotional support. Confidentiality as a value generates *confianza* and invites *respeto*. In other words, *confianza* exists in part because C-HWs keep private conversations confidential. At the same time, safeguarding confidentiality is a sign of *respeto*. This commitment to confidentiality speaks to the professional quality of C-HWs. In part, this is a reflection of the training C-HWs have received from their organizations and seriousness with which C-HWs take their work.

III.4.2. Impact

Generally, C-HWs provide emotional support on issues related to personal crises and to cultural shock related to acculturation among recently arrived immigrants. Emotional support may be provided in the form of advice about how to deal with discrimination at health services, school, or other settings. Many times people are alone in colonias, disconnected from neighbors and institutions. In these cases, the C-HW who visits them may be their only contact with the outside world and the only person who can help them navigate the new environment. C-HWs provide emotional support in delicate cases ranging from low self-esteem to domestic violence. Often, the capacity of C-HWs to successfully intervene in these situations is a reflection of their own experience dealing with similar situations and overcoming them. This capacity is beautifully summed up by a New Mexico C-HW, who said that "...being a promotora means being a *mujer* (woman) and having a *corazón* (heart). *Corazón* because you have to feel and deeply understand what the women from the community go through, and *mujer*, because only women have the sensibility to do that."

III.5. Advocacy

Advocating for the rights of colonia residents is a common impact that C-HWs have on communities. Just like the impact resulting from emotional support, advocacy is an underlying dimension of C-HWs' practice. That is, it is present even though organizations may not have it as an explicit goal or objective.

[6] Author's translation of the original Spanish.

III.5.1. Processes

Among other means, C-HWs facilitate communication between the culture of the provider and that of the colonia resident by educating residents about how to best protect and defend their rights as clients. As a result, C-HWs empower individual residents, contribute to building a self-reliant community, and educate service providers about serving residents in culturally sensitive and respectful ways.

Interviewees commonly expressed the conviction that their work was motivated, in part, by the need to educate community residents in order to prevent them from experiencing some of the negative situations experienced by CH-Ws by teaching them self-advocacy. This motivation is evidenced by one C-HW's reflection: "Many people have not had to go through the same experiences I went through because of the knowledge I now have. To many people going through the system has been easier given my help."

III.5.2. Impact

Advocacy is represented in the following examples:

- C-HWs express concern for the way her client-residents are treated at clinics.
- C-HWs accompany undocumented client-resident to clinic.
- C-HWs explain to community residents how systems work, e.g. Medicare and school systems.

Advocacy is commonly practiced in health clinics,where C-HWs ensure that patients are treated respectfully. This is a form of direct intervention legitimated by C-HWs' recognition and status in clinics (i.e., they are insiders and know the system well). As mentioned earlier, the C-HW has a dual competency, as an insider of the community and the system. Another important component of the advocacy intervention of C-HWs is the role they can play in facilitating services to undocumented residents.

Finally, advocating for residents' rights seems to be at the center of C-HWs' sense of responsibility and care for the community. Several of them described how they did not want their fellow colonia residents to go through the same experiences of discrimination and abuse they went through as recent immigrants. Thus, they educate residents on how to function in the system, on what their rights are, and on how to defend those rights. Very importantly, they also educate the service providers on how they should treat colonia residents. As such, C-HWs add another dimension to their role as cultural brokers, a dimension that clearly reflects their deep identification with and commitment to the well-being of the community.

CHAPTER IV
C-HWs: The Shaping of Practices – Conclusions and Interpretations

The study includes three major variables: communities (in which C-HWs work and live), organizations (in and through which C-HWs work), and C-HWs themselves. Figure IV.1 presents these variables as a dynamic model explaining how the practice of C-HWs is shaped and its translation into impacts in the community.

Figure IV.1. The Shaping of C-HWs' Practices

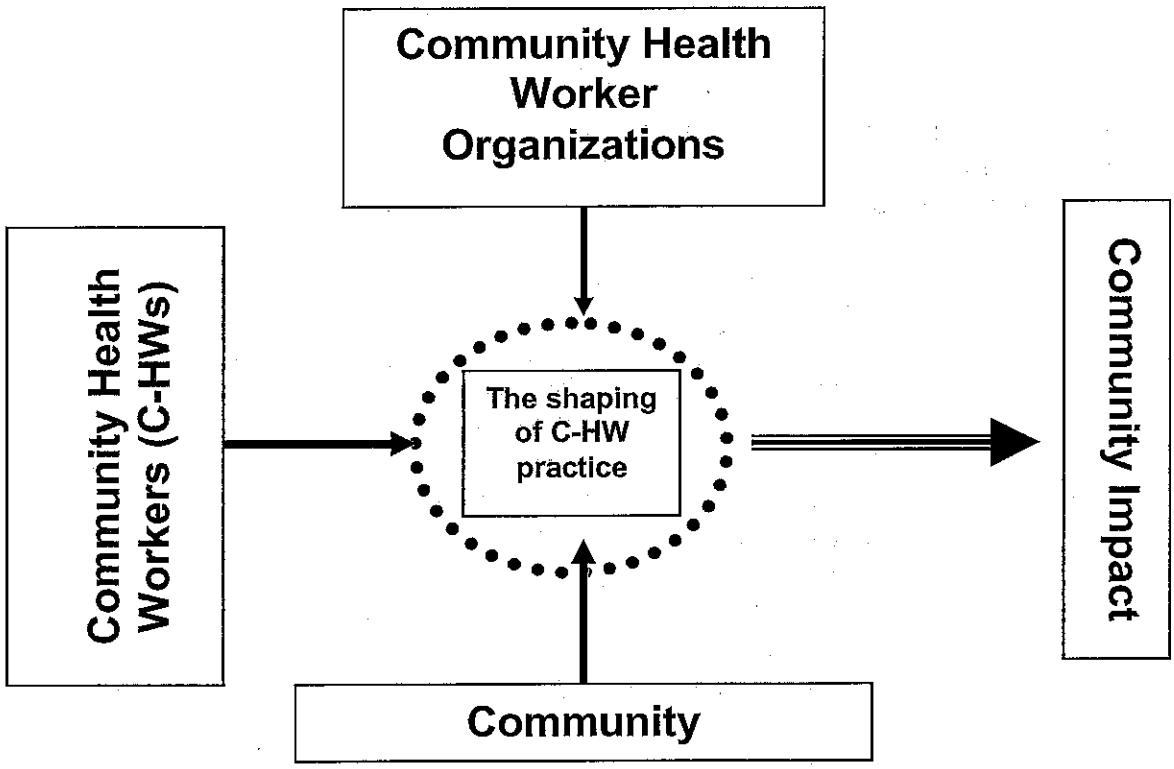


Figure IV.1 represents the process undergone by C-HWs as they do their work. The central thesis represented in this figure is that C-HWs' practice or work (dotted circle) results from the synthesis of three main factors:

a) The organizations where they work, which provide C-HWs with an organizational context including a mission, a structure and strategy for conducting their work, and knowledge and skills provided through trainings;

b) The C-HWs themselves, with their individual characteristics, their own local knowledge, their experience as border residents (usually women), and their high level of identification with the people from colonias; and

c) The communities where C-HWs live and work, whose well-being is what motivates them in daily work. In this model, communities represent an intertwining of Mexican and border culture, social networks, and the formal and informal partnerships that C-HWs establish with residents as they do their work.

The relative weight of each factor is not always the same. The data show that there are those organizations that rely more on local culture and on workers' individual characteristics, while there are others that provide a strong organizational framework that may exert a more directive influence in shaping C-HWs' practice.

IV.1. Conclusions

Study conclusions are organized around three main concepts, i.e., community-health workers' organizations, community-health workers, and the community served by the workers and their organizations.

A. Organizations in which C-HWs work

1. Variation around three dimensions. C-HW organizations vary significantly in nature around three structural dimensions:
   a. The degree of overlap of the organization with the community/ies it serves (embeddedness), encompassing those in which the organizational structure and programming is deeply based in community(ies) served to organizations whose structures are extended across counties, even states.
   b. The range of geographical service area, from C-HW organizations serving multiple counties (sometimes states) to those serving only one, or a few clustered, communities.
   c. The predominant mission focus, from a narrow specific mission to a comprehensive general community development mission.

2. Programming must be community-tied or community-tailored. Organizations consistently believe and practice the following principle: programming must be community-tied, or at least community-tailored, emphasizing what we identified in the report narrative as a 'strong tie' principle, even when 'weak tie' relationships are many. This commitment to being embedded in the community(ies) served is a crucial shaping factor in the existence and work of the C-HWs, more than any particular type of organizational structure.

3. Commitment to community helps shape C-HWs' work. Organizational commitment to this principle helps shape and encourage the holistic work of the C-HWs by:

   a. Providing a positive environment encouraging the C-HW holistic practice,

even to some extent in organizations with specific missions;
b. Providing resources that enable the practice; and,
c. Staying 'out of the way' by recognizing that the C-HWs know better than the organization leaders what is needed and what can be done.

B. Community-Health Workers

1. Appreciation and respect for organization. C-HWs consistently express enthusiastic appreciation and support for the organizations in which they work. Additionally, they recognize that the organization provides them with more than a job, pay, and tasks to do. They consistently credit the organization for helping them grow into a person different than they would have been had they not come to work for the C-HW organization.

2. Comprehensiveness of practice and impact. C-HWs work diligently to carry out the tasks required by the organization in which they work. However, regardless of the type of organization for which they work, they consistently perceive their work as including all five of the following elements – information and referral, education, community capacity building, emotional support, and advocacy.

3. Mirror principle: "I am the community." Although it is normal in any situation that translation of organizational plans into action involves some degree of creativity, C-HWs have and practice autonomy and agency as they translate organizational plans into action. This autonomy and agency is a direct reflection of what one C-HW referred to as the mirror principle. Intrinsically part of the community, C-HWs tend to see themselves as a mirror of community. Said one C-HW: "I am the community." Being a 'mirror' motivates them in varying degrees and ways to transcend the boundaries of practice as defined by the organization.

4. Bridges for horizontal and vertical integration. C-HWs are bridges between community residents, and residents and the system of service providers. Thus, they contribute to horizontal development of social networks that support colonias and help build vertical networks between the community/ies and service providers. A C-HW represented this well: "Promotora connects agencies with the community, with residents. The promotora is like a bridge, like a link between agencies and the community."

5. Community-health workers are cultural brokers. As they build vertical bridges, C-HWs facilitate communication and understanding between residents and service providers. It is a two-way process. They not only take knowledge of the community and translate it to service providers; they take knowledge of the service providers and translate it to community residents. 'Translating' between two often widely different worlds requires that C-HWs have dual competency, the

capacity for understanding and communicating in ways few others have. This lends added meaning to their role as cultural brokers.

C. Communities Served by C-HW Organizations and C-HWs

1. Communities are the focal point. Communities and their improvements are the focal point for C-HW organizations and C-HWs' practice, although organizational missions might have specific stated objectives and daily practices are often with individuals.

2. C-HW organizations and C-HWs regularly serve communities in which they reside. C-HWs regularly work and serve the community in which they live, and many serve additional communities.

3. Dynamic interaction. A dynamic interaction between the C-HW organizations, the C-HWs, and community is central in the shaping of their work.

4. Community residents perceive C-HWs positively. Residents of the communities consistently perceive C-HWs as essential and valuable to them and their community's well-being, regardless of the nature of the C-HW organization serving that community. This is reflected in the expression of respect for and trust of C-HWs by residents.

Interpretations

1. A first significant finding is that C-HWs, individually and as a group, perceive who they are and what they do as a 'whole cloth.' That is, no matter what specific task they may be undertaking at a given moment, they see that task as a part of a holistic understanding that includes informing and referring, educating, building community capacity, providing emotional support and advocating for members of their communities and the communities themselves.

2. A second essential finding is that the shape and shaping of C-HW practices lies in the dynamic interface of organization, community/ies, and C-HWs. Each needs and builds on the other. It is apparent that the organizations rely fundamentally on the knowledge of C-HWs, their rootedness in community, and their strong commitment to serving those communities and making them better. The C-HWs are the organizations' primary, direct means of knowing what to do, what assets exist in the communities, and how best to accomplish what needs to be done. C-HWs simultaneously depend on the organization to help them do what they, as natural helpers, know and want to do in their communities.

It works the other way, too. C-HWs appreciate having an organizational tie, not only or primarily because it provides them income (not all do), but because it provides them the opportunity to take their natural helper abilities deeper and wider. The organization is a platform on which and through which C-HWs extend their reach, a platform that brings to

the C-HWs a mission with goals and objectives, a structure with direction and opportunities, and resources to do more for more people and communities. In addition, C-HWs have the opportunity within the organization to gain through training greater amounts of valuable knowledge.

From another point of view, however, the C-HW has the benefit of serving her/his community/ies by making the residents' interests, assets, and needs known to agencies outside the community. The community, therefore, shapes the work of the C-HW in two ways. It forms the unique knowledge base of the C-HW, and it encourages and enables the C-HW to reach out beyond the community and connect vertically. Again, the organization comes into play because it is through the organization that the C-HW has the support and resources to connect vertically.

In still another way, community shapes the work of C-HWs by being the 'template' that forms the C-HWs' holistic understanding of their work. Living in and being part of the community, C-HWs perceive first-hand and understand communities as having a fabric of needs and assets, likes and dislikes, beliefs and distrusts, hopes and despairs. Because the organizations operate on the principle that programming is to be community-tied or community-tailored, they encourage the C-HWs to accept the whole fabric, even though organizations cannot always make available the time and resources necessary to address each element of the community fabric.

3. A third finding is that C-HW organizations, while varying a great deal in their mission focus, geographical service area, and in the degree they are embedded in the communities they serve, all operate on the principle that programming must be community-tied, or at least community-tailored. This principle, when it functions well, keeps the organization tied to the communities it serves, enabling it to tailor its programming to those communities.

4. A fourth finding follows directly from the first three, namely that the challenge is in the balancing of the relationship between organizational structures, communities served and the C-HWs' understanding of who they are and what they do. The discussion thus far clearly asserts that the mix of community, organization, and C-HWs is crucial in understanding the shape and shaping of C-HWs work. But what mix and who determines it? Each organization has to answer that for itself, in part based on its mission, goals and objectives, and in part in the context of what it wants its geographical service reach to be, and what kind of relationship to the community it wants and can create. Although the study's purpose was not to describe every conceivable type of organization, the data do provide some indication of when the mix may become problematic. A Coordinator for Organization G notes the following regarding programming and decision making in the organization:

> *I think it's different in the different communities that we serve because again they're all different....I know the supervisor works very closely with the promotoras and promotoras are active and very independent. They know what needs to be done....[But] a lot of it is driven by funding. Obviously in order to have those positions, we have to meet certain requirements, numbers, numbers of outreach to*

this population through this funder. And so we make sure that we get that done and that we are able to get the other things done, because we see the value of promotoras in our clinic; they do outreach, education and follow-up when needed. But again, decision making has to be based on the funding source, what our requirements and our contracts are in order for them to be on board as a promotora.

The value of C-HWs is that they work from the inside out, bringing local culture and local knowledge into the organizations and helping to define what is essential for the community and therefore the organization. This is the 'strong tie' relationship between the organization and the community. If that local knowledge and culture is restricted, or the organization cannot act upon it, because it has other 'weak tie,' connections to fulfill, the organization's community embeddedness is changed, as is the relationship to the C-HWs. Few, if any, would deny the necessity of 'weak tie' connections for support of the organization. In fact, larger and more vertically connected organizations are able to hire, train and sustain more C-HWs and therefore provide more services to more people. They have more resources to bring more needed programs to the communities they serve. They have the advantage of a denser network of 'weak ties' and therefore more likelihood of securing more resources. However, as greater reliance upon 'weak tie' funding sources changes the organizational balance of programming, decision-making and potentially of C-HWs' work, the problem lies in their encroachment upon the 'strong tie' programming needs.

Imbalance, then, poses a potential threat to the shaping of the C-HWs' work. Too many 'weak tie' contracts in which 'strong tie' relationships are not central or apparent, or in which the C-HWs are taking on increased amounts of piece-work that do not clearly fit into the fabric of their work as they see it in their communities, means a couple of things for the C-HWs. One, they find themselves with less time to devote to identifying and working with issues that arise out of the communities in which they work. Two, C-HWs find that they are focusing mostly on two or three elements of their work – for example "information and referral," and/or "education" – having to ignore the other elements. One serious result is a truncated functioning for the C-HWs, even while the organization is managing to sustain its program financially.

CHAPTER V
The Practices of C-HWs: Programmatic and Policy Implications

The study findings addressed in this report raise a number of programmatic and policy issues. Some are necessarily specific to the particular context in which the study was focused, namely colonias located in the U.S. – Mexico border region. Others, though emerging from this context, may well apply more broadly to other settings, C-HW organizations, and to the variety of C-HWs across the country. This is particularly critical, since this is a time in which there is increasing recognition of the critical role C-HWs can play, of expansion in the types of organizations using C-HWs, and of potential changes in their role as a result of calls for credentialing or certification and reimbursement. Further, these changes may lead ineluctably to changes in their relationship to the communities they serve.

Variation among C-HW Organizations: Policy Questions and Research Implications.

The study findings suggest that the "mix" of structural, programmatic and geographic features that C-HW organizations adopt significantly affects the shape of C-HW practices. Thus, these findings about the wide variation among C-HW organizations raise several research questions related to identifying the effect of this variation and how to achieve the most effective mix among structural, programmatic and geographic characteristics of the C-HW organization. Examples of such policy-relevant research questions include the following:

- What is the most effective structural relationship for C-HWs to have with the communities they serve? For example: how deeply can and should a C-HW organization be embedded in a particular community? What are the costs and benefits of the different arrangements? Does the nature of the programmatic focus of the C-HW organization imply that one model or another of structural relationship to the community is more or less effective? How does the structural relationship to the community affect recruitment and retention of C-HWs?

- Does the programmatic focus of C-HW organizations affect their ability to recruit, retain and sustain a C-HW workforce? For example, are narrowly focused C-HW organizations more or less able to attract and retain C-HWs?

- What are the effects of differing geographic service areas on C-HW organizations? For example, are some structures more effective for certain types of programmatic foci? Are there potential tradeoffs between the availability of resources (e.g., state-level resources might be available for multi-county programs) and the ability to link the C-HWs to their home communities or between sustainability of the C-HW organization and retention of C-HWs? Are their economies of scale associated with one model but more effective recruitment with another?

Policies Affecting C-HW Practices: Research Questions, Programmatic Implications, and Policy Issues.

Policies affecting C-HW practices should recognize and consider the dynamic nature of the C-HW system in which C-HWs operate. This system or context within which C-HWs practice has implications for policies related to (a) recruitment and training; (b) credentialing; and, (c) the use and effectiveness of C-HWs.

Recruitment. The study findings suggest that C-HW recruitment policies should emphasize selecting workers from the community(ies) in which they will work and seek individuals who demonstrate basic talents and a strong interest in the community and its people. C-HW organizations should also seek individuals who are committed to ongoing learning, able to model the behavior and activities that will support both individual development and community capacity-building, and possess communication and other interpersonal skills that can ensure an ability to work with local people as well as external organizations.

Training. The study findings indicate that policies and programs on training for C-HWs should recognize the importance of imparting information about the local community settings in which C-HWs will function. Although a statewide or regional program may be charged with developing and implementing a C-HW program, the training component should include input from local C-HW organizations and local experts from the communities in which C-HWs are expected to work.

Role Definition. The study findings on C-HWs' conceptions of their responsibilities and role in the community strongly imply that policies and programmatic decisions should encourage employment of C-HWs in roles that reflect all elements of C-HW practice. The tendency of some organizations and some policy-makers is to view the role of C-HWs more narrowly, as a vehicle to market or promote a particular organization or service. Such a limited view of their roles is likely to generate problems in recruitment and retention of C-HWs who have a natural inclination toward a more holistic approach to helping individuals and communities.

Further, policies and programmatic foci that are organized around particular service specialties or age groups should take into account the willingness and ability of C-HWs to attain additional education that will enable them to serve the complex needs of the residents more effectively.

Credentialing/Certification. Policy development and implementation for credentialing, certification, and other recognition for C-HWs by government agencies and funding organizations should ensure that full consideration is given to the range of work expected of C-HWs, as well as the variety of community settings in which such work is conducted. Such policies should seek to ensure quality and effectiveness among C-HWs without creating unjustifiable hurdles that might exclude persons with significant abilities to meet local needs.

Recognizing the Role of C-HWs and Cultural Connectivity. Regulatory and professional organizations should give full consideration to the capabilities of C-HWs to work with and enhance the effectiveness of health professions, programs, and organizations in working with populations that require cultural "connectivity" and healthy community-building that go well beyond popular notions of cultural sensitivity.

Policies Related to C-HW Organizations.

Policies and programs should recognize the need for flexibility in contractual or programmatic relationships between funding organizations and C-HW organizations, enabling the latter to manage C-HW activities in a manner that balances community expectations with sponsors' expectations.

Local Control. Stakeholders interviewed in this study favored significant involvement of the local community. They argued that regardless of the degree of external administrative control or sponsorship that is formally required of a C-HW organization, a guiding principle should be assurance of a significant degree of local control and design in C-HW service programming and implementation.

Funding for Organizational Infrastructure. The study suggests that funding agencies should include a significant proportion of funding that can be allocated at the discretion of the local organization and C-HWs to support infrastructure development or other capabilities that can prepare a foundation for more effective implementation of the program being funded.

Flexible Forms of Funding for Community Development. To address gross disparities, some funding policies should be flexible, offering funding akin to community development block grants. These should be specifically targeted to C-HW organization in colonias to support the broad-based development of healthy communities, not merely health initiatives aimed at individual members of the community.

Need to Focus the Regulation of C-HW Organizations on Processes and Outcomes, Not Structural Features. The study findings on variation among C-HW organizations suggest that different arrangements facilitate different outcomes, in terms of services to individuals and communities and in terms of their effect on C-HWs. Thus, the findings point to the need for policies and programs governing the creation and diffusion of C-HW organizations and C-HW activities that emphasize conformance to principles, competencies, core processes, and outcomes rather than compliance with specific structures or models. This recommendation reflects the fact that the diversity of communities and the cultures in which C-HW organizations and C-HWs functioned were inconsistent with notion of "one size fits all."

The Need for Additional Research.

We recommend the adoption of policies that support additional research. Some of these issues were discussed above; however, more research is also needed on the critical roles played by C-HW organizations and workers in order to guide policy development and programmatic improvement in order to facilitate full-use of the capabilities offered by C-HWs and their organizations. In particular, additional research should be directed at the following topics and issues:

- **The roles and activities of C-HWs that are deemed most important to various groups of residents of the colonias** and how those views may differ across the residents served, such as new immigrants, women, men, children, and the elderly.

- **The effects of C-HWs.** Research should address the working relationship between C-HWs and staff of health and human services organizations, immigration, local governments, and schools, that reflect the benefits C-HWs bring to the work of these other organizations and professionals for the colonias and their residents. In particular, research should seek to capture the multiple impacts that the work of C-HWs might have on the residents in terms of well-being and identity; the developmental capacity of the community; the various programs, services, and infrastructure elements of the community; and elements of the "C-HW experience" that can be usefully translated into the policies, programs, organizations, and professions that benefit the colonias and settings throughout the dominant culture.

Appendix

Methodology

In order to accomplish the study's research objectives, twelve case studies were conducted, six in the Lower Rio Grande Valley, Texas, and six in Southern New Mexico. The research methodology is qualitative and ethnographic and includes a triangulation approach to data collection, combining semi-structured interviews, observations, and focus-groups. Findings are based on a comparative analysis among cases.

Sampling.

Data were collected from participants of six C-HW organizations in the Texas Lower Rio Grande Valley, and six organizations in the New Mexico border counties of Dona Ana, Luna, and Hidalgo. Within each of the twelve organizations, interviews were conducted with program directors/coordinators, C-HWs, and service providers working with the program. in addition, focus groups were conducted with community residents served by the program. Finally, C-HWs' were observed in the course of their work.

The study followed a non-probability, snowball sampling procedure, both for identifying the programs to participate as case studies and for identifying the interviewees, both individual and in focus groups. Guiding sampling criteria were as follows:

C-HW organizations

i) Programs with one or more of the following foci – community building, providing information, and providing services;
ii) Health as one, but not necessarily the only focus of a program;
iii) Programs with an established record of working with C-HWs;
iv) Programs working in *colonias*.

C-HWs, program staff, and service providers within each C-HW organization

i) One director or coordinator per C-HW organization; whenever the program had more than one distinctive site, then coordinators of each site were interviewed. Persons to be interviewed was selected by director of the program.
ii) A maximum of 10 C-HWs per program; whenever the program had more than one site, an attempt was made to select an equivalent number of C-HWs per site.
iii) Each director or coordinator of the participating organizations was asked to suggest the name of a service provider who worked with the program's C-HWs.

Community Residents

Program directors/coordinators were asked to select a maximum of 10 community residents to participate in focus groups. Commonly, program directors/ coordinators asked C-HWs to recruit from the community residents with whom they were working at the time of data collection, or with whom they had worked in the past. A predominant criterion for selection of participants was the need to represent within each focus group the variability of activities in which the C-HWs were involved with community residents.

Data collection.

What follows is an overview of each one of the data collection activities:

a. Individual Interviews. Semi-structured in-depth interviews were conducted with a total of 90 C-HWs. Sixty interviews were conducted in the Texas Lower Rio Grande Valley, and 30 were in New Mexico. This difference in the size of the samples is a reflection of the smaller size of the New Mexico participating programs. All interviewees, with the exception of one, were women.

   Semi-structured interviews were also conducted with service providers. A total of ten service providers were interviewed.

b. Focus Group Interviews. Focus groups were conducted with community residents who were served by the case study programs. A total of 15 focus groups were conducted, with a total of 123 participants. These focus groups provided the point of view of community residents regarding the impact of C-HWs and their programs in the life of individuals, families, and communities.

c. Observations. A total of 57 activities were observed. These activities included observations of:
   - home visits by the C-HWs
   - training activities in which the C-HWs participated as trainees
   - educational activities taught by C-HWs
   - community activities planned and coordinated by C-HWs, such as colonia celebrations and parties.

Activities were observed through a non-participant procedure. Observation allowed the researchers to examine the C-HWs' practice within the context of real-time settings, providing comparative data on the CHW experience as told by the C-HWs and the community residents and as directly observed. Field notes were taken during each activity.

Data Analysis.

- Organization of data: Data were organized and prepared for analysis, including the transcription of tape-recorded interviews and focus groups and the writing up of the observational field notes.

- Description and classification: The data were described and classified using Atlas.ti, a qualitative analysis software. From this initial description and classification, a set of master codes and sub-codes were derived. Each research team member then reviewed and categorized the sub-codes, after which a reduced set of codes was accepted based on inter-coder reliability. These codes then became the basis for integrating specific data from the interviews under each code, after which the researchers began the process of analyzing the data collected through Atlas.ti. From this process emerged the analytical framework included in this report.

- Interpretation: Data were interpreted in the context of the research questions and the analytical framework.

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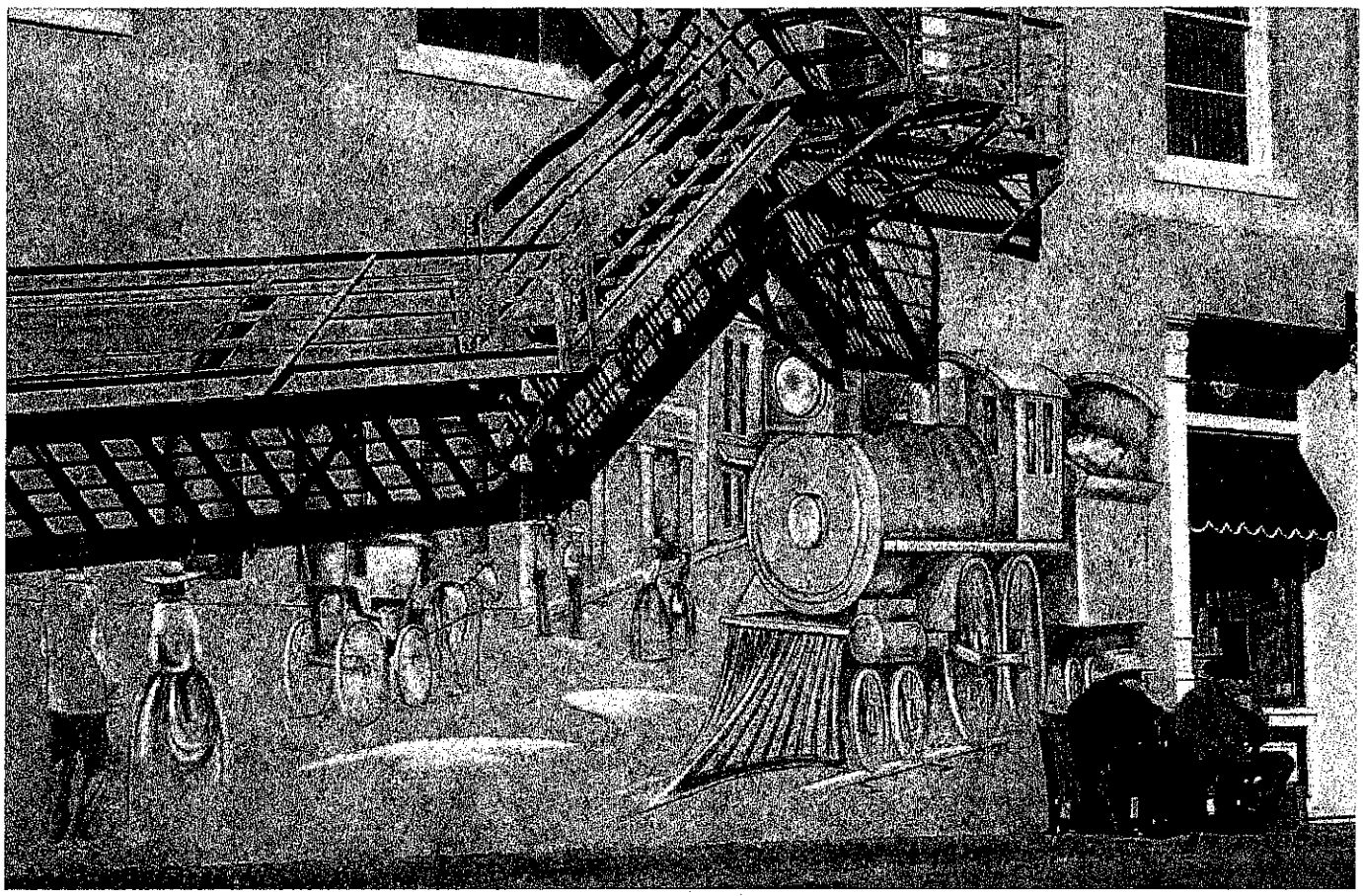

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