Laboring With the Heart

Promotoras' *Transformations, Professional Challenges, and Relationships With Communities*

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Little is known about *promotoras'* professional experiences engaging in Latinx health promotion. In this *promotora*-led community-based participatory study, we purposively recruited and interviewed 30 Spanish-speaking *promotoras* who worked in Los Angeles County and who had at least 5 years of experience as *promotoras*. Using a constructivist grounded theory approach, findings revealed *promotoras* self-identified as health professionals who offered unique, insider perspectives. Challenges arose as employers viewed *promotoras* as volunteer lay health workers, while *promotoras* desired opportunities for professional growth. Motivation to continue working as *promotoras* stemmed from their commitment to Latinx communities. We provide recommendations to strengthen community-based capacity for advancing Latinx health.

Key words: community-based research, Latinx, *promotoras*

PROMOTORAS are trusted members of underserved Latinx communities. *Promotoras* engage in community outreach and public health efforts that follow the community health worker (CHW) model. They usually share similar socioeconomic, racial or ethnic, cultural, language, and life experiences with members of the communities they serve.[1,2] In their traditional roles engaging in outreach, health screening, and health education, *promotoras* have effectively contributed to improving health behaviors and health outcomes among individuals contending with a diverse array of health issues.[1,3-7] *Promotoras* are valued members in health promotion and disease prevention efforts for their unique access to the most vulnerable and "hard-to-reach" populations, including individuals who are undocumented, have limited English proficiency, or have limited literacy skills and racial and ethnic minorities.[8] *Promotoras* are also valued for their diverse roles in reducing health disparities through cost-effective, sustainable programs and interventions.[9] Prior research has documented *promotoras'* roles in numerous intervention programs that address health-related topics, such as domestic violence,[10] cardiovascular disease,[11] nutrition,[12] and diabetes self-management programs.[13]

Although prior research has documented the role of *promotoras* in health promotion and disease prevention efforts, these studies have primarily focused on evaluating *promotora*-led or *promotora*-involved health promotion programs[13-17] or measuring a return on investment on *promotoras'* efforts.[18] Far less is known about the professional circumstances of *promotoras* themselves—as members of the health workforce—and factors that motivate or discourage them from engaging in community-based health promotion.[11,16,19] For instance, one study examined *promotoras'* experiences in delivering health interventions to Latinx communities by examining how *promotoras* undergo personal development while serving as change agents.[20]

Promotoras work at the intersection of community health agencies and underserved communities, placing them in a unique position that merits a better understanding of their workforce experiences. A content analysis of CHW and *promotora* peer-reviewed publications suggests that *promotoras* face limited professional training and financial compensation opportunities and that *promotoras* often work as volunteers for various organizations.[21] The attention on *promotoras* as members of the workforce, however, has primarily centered on issues of training, credentialing, developing standards for training, and hiring.[22-24] In combination, these trends suggest that while there is evidence

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highlighting the value of *promotoras* for health promotion efforts among underserved communities, increased knowledge is needed on *promotoras'* workforce development experiences, how to maximize their health promotion efforts, and their own well-being. This improved understanding may help maximize the quality of life among aging minority populations in the United States, particularly Latinx, by improving the ways in which *promotoras* are able to promote health equity. As diverse organizations collaborate with *promotoras* to reduce health disparities among underserved communities, it is important to understand the experiences of *promotoras* as they engage with members of the community and community-based organizations in health promotion efforts. Thus, the purpose of this study was to document *promotoras'* self-perceptions of their role, position, and impact on the communities they serve and the organizations for which they work to gain insight into the personal and professional experiences they undergo as they work to reduce health disparities. By drawing on their experiences and voices, *promotoras* and their employers can work to more strategically promote health equity for all populations.

METHODS: A COMMUNITY-BASED PARTICIPATORY RESEARCH APPROACH

This qualitative methodological study used a community-based participatory research (CBPR) study design. CBPR is an orientation and approach to conducting research based on principles of fostering community strengths, creating equitable partnerships, and engaging in co-learning between partners.[25] This approach has particular strengths for understanding the experiences of *promotoras* as it values community knowledge and ensures that research is conducted *with* community members, not *on* them.[26] This CBPR study design involved community and academic partners. Community partners were members of *Corazón y Carácter* (CyC), a grassroots *promotora* organization in Los Angeles. Academic partners were affiliated with the University of California, Los Angeles (UCLA) during the time of data collection.

The study was motivated by CyC members' experiences working as *promotoras* in both health promotion interventions and data collection for research studies. The CyC members had extensive experience implementing the outreach or education components of health promotion efforts and conducted data collection for various community-based studies, but they had rarely been asked to participate or contribute to program planning or research design development. Critical to a CBPR approach is shared power and decision-making[27] between academic and community partners. Consistent with this principle,[25] the *promotora*-partners from CyC led the process of identifying the study objectives and research questions and collecting and analyzing the data. The academic partners provided technical guidance on the research process, offering the *promotora*-partners with workshops on topics, such as human subjects protection (eg, how to obtain informed consent), interviewing techniques (eg, how to ask open-ended questions, probing techniques), and grounded theory analysis. They then served as coresearchers during the implementation of each phase of the study. All research partners engaged in reflexivity and aimed to promote equitable power dynamics over the course of the study.[28]

First, the *promotora*-partners identified research objectives aimed at (1) investigating *promotoras'* perspectives on their role, position, and importance in their work; (2) identifying ways in which *promotoras* are acknowledged for their work; and (3) understanding the changes, transitions, or transformations *promotoras* may have experienced as a result of their work. Drawing from their personal experiences, the *promotora*-partners generated a list of interview questions to elicit narratives from study participants. Questions included participants' motivations for becoming a *promotora*; experiences in different types of *promotora* positions; activities and responsibilities associated with being a *promotora*; remuneration practices; perceptions regarding the function of *promotoras*; participants' perceived value of the *promotora* within the communities they serve and organizations for which they work; and their goals for the future of *promotora* work. The interview guide included 10 questions to guide semistructured interviews. We received approval to conduct this study from the UCLA Institutional Review Board.

Sampling and recruitment

Participants were recruited by the *promotora*-partners through their professional networks. This included recruitment at local *promotora* gatherings in Los Angeles (eg, training sessions, a conference, and health promotion sessions) and by calling or texting *promotora* colleagues to invite them to participate. Participants were eligible to participate if they were currently or had previously worked in Los Angeles County, had at least 5 years working as a *promotora*, and spoke Spanish. In total, 30 *promotoras* were recruited to participate in interviews. Prior to the interview, we asked participants to provide a pseudonym. Furthermore, during the

interview, we did not collect any of their identifying information to protect their anonymity.

Data Collection

Interviews were conducted in the participants' preferred location to increase participants' level of comfort and trust. These locations included participants' private homes or public spaces such as coffee shops and parks. Interview length ranged from 45 minutes to 1.5 hours, with the average length of the interview being 1 hour. Interviews were conducted in Spanish, audio recorded, and transcribed in their original language by one team member to maintain content fidelity. Researchers conducted interviews until reaching saturation, fully eliciting all variations of the *promotoras*' experiences.[29]

Participants were foreign-born, predominantly middle-aged (mean age = 46.5 years; range, 37-60 years) Latinx adults from Mexico (53%) or other Latin American countries (47%). On average, participants had 16 years of experience working as *promotoras* (range, 5-20 years). More than half of participants had less than a U.S.-based high school education.

Data analysis

We used a constructivist grounded theory approach to inductively identify codes, subcategories, categories, and themes (Figure).[30] All analyses were conducted in Spanish. Excerpts presented in the "Results" section were translated into English. In line with grounded theory principles, all interviewers were involved in all levels of the analytic process. Throughout the data collection and analytic processes (open, axial, and selective coding), researchers engaged in constant comparative analysis.[31,32]

First, following each interview, we wrote interview summaries of high-level impressions and transcribed the interview in Spanish. In addition, team members completed memos of emerging concepts and, during the data collection phase, the research team met biweekly to discuss these. We then used the initial 5 transcripts to identify the first set of codes to include in the codebook. The full team engaged in a multistep process of open coding using line-by-line in vivo codes, axial coding for identification of subcategories and refinement of categories, and, finally, selective coding to further condense the findings.[31-33] Each team member reviewed the same 5 transcripts and developed an independent list of codes that was constantly refined with the emergence of a new event and circumstance. After developing the initial set of defined 74 codes, the transcripts were systematically rotated among the coders to ensure each interview was reviewed, coded, and analyzed by a separate team member. This process served to increase rigor of the analyses and to ensure coder agreement, which ultimately aimed to increase dependability and minimize the influences of biases and positionality during data analysis. This approach also

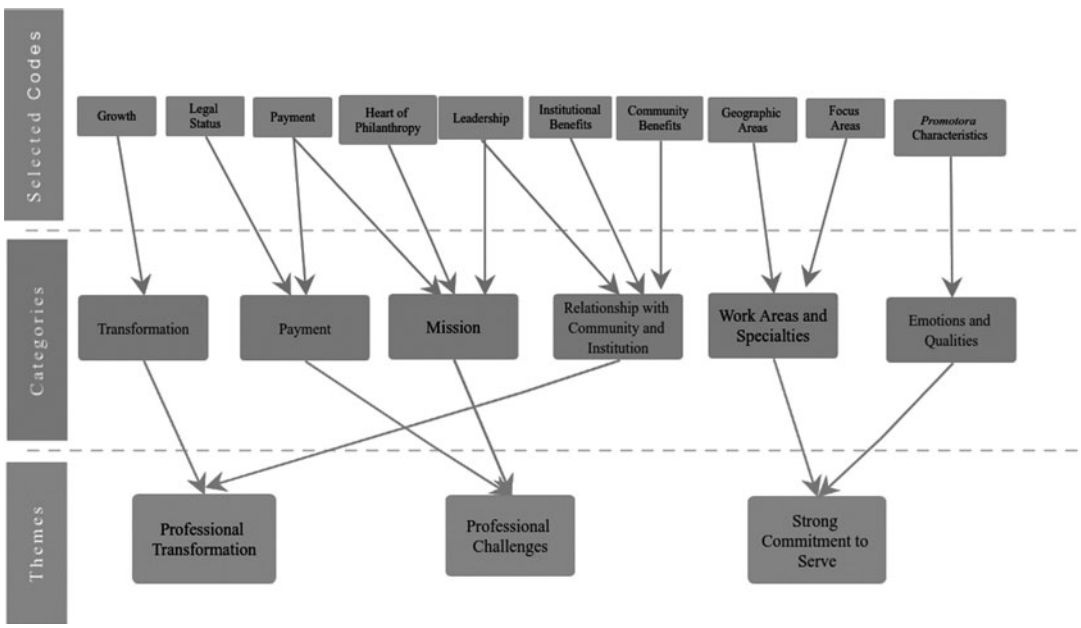

Figure. *Corazón y Carácter* analytic pathway from identification of codes to overall themes.

guaranteed that each member of the team had exposure to the content of each interview, ensuring that there was agreement regarding saturation of codes and comprehensiveness of themes. The study team then engaged in the axial coding—a process of relating codes to one another to establish a focused set of codes, also referred to here as subcategories. As coding continued, the constant comparative analysis allowed for comparison of categories with data collected and broadening the definition of our categories by describing its properties and dimensions, therefore reducing the number of codes while increasing the inclusivity of concepts (see the Figure).[33] The constant comparative analysis also permitted researchers to compare research notes and codes and discuss emerging topics and circumstances that applied to *promotoras'* professional transformation, challenges, and their commitment to the community.[31]

All stages of the analysis were conducted using manual methods, which followed principles of grounded theory. This approach created an open format in which all members of the research team could view, share, and comment on transcripts and other documents (eg, draft codebooks), regardless of availability of computers, level of computer skill, or availability of Internet connection.

RESULTS

Three major themes related to *promotoras'* role in health promotion efforts emerged: (1) a professional transformation; (2) challenges with employers, particularly related to compensation and limited professional development opportunities; and (3) a strong commitment to the communities they serve. Over the course of being recruited and trained as *promotoras*, and in their time working as *promotoras,* participants reported experiencing a process of professional transformation. This experience resulted in not only career satisfaction but also challenges as they navigated their relationship with community-based organizations and their sense of commitment to the communities they served. In the following text, we describe the professional transformation and the professional challenges that arose during the years *promotoras* engaged in a broad array of health promotion efforts.

Professional transformation

Participants were primarily recruited as *promotoras* directly from their local communities. Participants, such as Paulina, were recruited from schools or public programs where their children received services, such as Head Start. Paulina recalls,

> Coincidentally, an agency came to the school and invited us to be *promotoras* against violence. Thanks to this person who came one day to the school to invite us moms, my life changed. I trained, was able to go to events, was able to give classes in the community.

Participants reported that the local *promotora* program initially provided a way of advancing their own learning about health and related issues and then led to an ongoing commitment to the community. Paulina states, "I continue to give classes in the community. I have not left my group of parent leaders and I remain in the community, working as a volunteer. My work has improved because I've acquired new skills."

Some *promotoras* were health professionals (eg, doctors, nurses, teachers) in their home countries. Among these, some began their *promotora* training in their home country, where they reported that the *promotora* concept is also perceived as a service for underserved and impoverished communities. Laura described being surprised to learn that there were *promotora* programs in the United States, a country often perceived as wealthy. Laura stated,

> I didn't think there were *promotoras* in this country that's so rich. I didn't think they had a need for *promotoras*. I came to South Los Angeles and saw this community so affected and in need. There were many problems and they needed information. In seeing all this—that's what awoke [my] motivation to be a *promotora*.

Many *promotoras* shared similar lived experiences as the individuals they served in health promotion efforts. *Promotoras*' lived experiences served as motivation to help others through similar problems. For instance, Luz shared that her personal struggles motivated her to pursue *promotora* training. She recalls benefiting from community-based domestic violence support programs and ultimately deciding to pursue *promotora* training despite numerous challenges. Luz described the domestic and career struggles she faced and how, being a source of health information among her community, led her to become a *promotora*. Luz stated,

> I was a victim of domestic violence ... at school, the mothers of the children would ask me about health resources they needed.... I then decided to take the *promotora* course. I graduated in 2000 and had the opportunity to do my social service in a hospital.

Through their *promotora* trainings, participants engaged in professional development activities, such as workshops and training sessions, and they acquired multiple certificates in diverse areas, such as mental health and domestic violence. Through this process, they underwent a journey—from being a community member to being a member of the public health workforce. Among all participants, this process resulted in a paradigm shift in their

self-identity, from a recipient of services to that of a health professional. Flor describes this process in the following way: "Well, I consider [being a *promotora*] a profession. At the beginning, you take it as helping the community, giving a service to others, but you develop, you become a professional." Paulina explained *promotoras* are professionals because of their ongoing development and growth in knowledge:

> I think that the position of *promotoras* is a profession because every day a *promotora* is learning with experience and is becoming better, because every day she has more skills, like public speaking, being persuasive, encouraging. More than anything, I feel it is something that I developed and that it is like a career that I am pursuing.

Compensation and limited professional development opportunities

In their role as *promotoras*, participants engaged with a diverse group of employers, such as community-based organizations and academic institutions. The organizations focused on a wide range of community-based health and social services. Participants described complex relationships with the organizations for which they worked and/or volunteered. As such, numerous challenges arose related to the *promotoras'* employment. Despite these challenges, several participants also noted that employers validated their contributions. In the following text, we describe these participants' complex relationships.

Participants faced several challenges related to the compensation and funding of their work. Participants reported that the primary career trajectory among *promotoras* was to serve as a volunteer before being offered a position that was financially compensated for part-time or activity-based (eg, per group session or workshop) work. They considered the compensation to be low and the compensation often did not cover all aspects of their work (eg, workshop supplies). A common experience among participants was to receive financial compensation only for the hours worked to conduct a community workshop but not for other related efforts, such recruitment or preparation time, that were critical to the success of a workshop. Idalia discussed the compensation she had received and why she had continued in her work as a *promotora*:

> In the beginning, it would be three or four hours of community training and they would give us fifteen or twenty dollars, which was nothing. Or they would pay for gasoline. At times, they wouldn't even say thank you. Currently, they pay me by the hour. Despite this, I keep helping, training in mental health. Although they don't pay, one takes this to be able to bring [information] to the community, to help.

Participants also experienced issues related to the burden of out-of-pocket costs. For example, after completing their *promotora* training, participants were responsible for conducting classes, group sessions, and workshops in the community. However, participants described a lack of funding available for the supplies that were needed to lead the various community trainings. Rosa Blanca described a common experience,

> It's something voluntary but I immersed myself more into this job. I used more gasoline, I purchased more materials—those of which nobody helped me purchase. I saw that it wasn't just one hour or two, but many more. That's when I felt that I needed more support from the organization.

In a few cases, depending on the organization or the specific health promotion initiative (eg, level of funding or program model), compensation was not offered in the form of money. Participants noted they did not feel it was fair to receive gift cards or other alternatives (eg, food vouchers) to nonmonetary compensation.

Participants described challenges in relation to professional development and career advancement. Beyond compensation, participants described a lack of infrastructure for supporting *promotoras'* professional development that lead to professional advancement, such as promotion to leadership or coordinator roles. Participants experienced ample opportunities for trainings on different health promotion topics, which generally resulted in being given subject matter certificates. These training opportunities, however, seldom led to career advancement opportunities. All participants reported desiring, but rarely finding available, employment positions beyond serving as a *promotora*. Alma described the limited leadership opportunities she experienced while working as a *promotora*, "In this job, I have only been working as a *promotora*. I think that there aren't many opportunities in this organization to advance beyond being a leader or a coordinator."

In combination, the financial burden participants took on to implement community programs, coupled with the deficiencies in professional development and career advancement, resulted in a range of challenges and stressors related to participants' continued role as *promotoras*. Many participants described feeling undervalued by their employers, many of which were community-based organizations. Alma shared, "The reality is that I feel that sometimes these organizations, more than anything, don't give you the value that you have as a *promotora*." Similarly, Samantha stated, "I felt forgotten.

They didn't talk to us continuously and they took a long time to pay us." Luz describes that undervaluing and underpaying *promotoras* were persistent problems:

> Unfortunately, it is a wrongdoing of many organizations … and I've been with three [organizations]. They have the *promotora*, as she is the one who informs the community. The stipend is for her. It's not a compensation that really is of value to her. I don't know why they have the *promotora* at such a low level, at the lowest level of the ladder in terms of employment. They don't consider it a job. They just tell us, "Go and inform." They view it like the ones who provide information, but they cannot see the impact that the *promotora* has when they do their job. They cannot see that, thanks to that job, the rest is sustained.

Other participants felt that, despite these financial and professional development challenges, their wealth of knowledge as *promotoras* was recognized by their employers. For example, Rosa Blanca described several ways in which her employers validated her efforts and contributions as a *promotora*:

> They always tell me "thank you." Sometimes they call me to ask my opinion, how I'm feeling, which questions the patients are asking. They have meetings and they call me, ask my opinion and listen. Yes, the truth is, they make me feel important and that I matter.

Overall, these experiences highlight the complex relationships and the distinct ways participants were engaged and supported by various community-based institutions.

A strong commitment to the communities promotoras *serve*

In serving members of the community, *promotoras* recognized that they worked as bridges between health-serving agencies and community members. Participants described that members of the communities they served lacked awareness and knowledge on a range of available resources, such as health services and social service assistance. For instance, Idalia first learned about *promotoras* when one of her children became ill. She began looking for resources and realized that, while resources did exist, it was tremendous work to find them. This was the spark that motivated her to help bring resources to her own community.

Participants also described having a unique role in advancing health. Participants were able to build a strong rapport with those they served, which ultimately helped advance their health promotion efforts. Flor stated, "I think that the people who engage with us a lot … open up a little more to share their experiences." Participants also described a pattern where community members were more comfortable with them than with other professionals. For instance, Alma stated,

> Perhaps community members can feel timid, but then they see a *promotora*. I always tell them, "I am a mother like you. I was sitting there like you. I took the classes like you. I am a woman from the community." And I feel that they identify greatly with us and I feel that they trust us more.

As a result of this role, *promotoras* recognized the unique contributions they had in promoting health among underserved communities—a role that other health professionals could not take. For instance, Lilian described that *promotoras* are agents of change for the community:

> The *promotora* makes changes. However small you see them, those changes push others and have reactions. At the end, they are big and can be seen throughout the community. I am happy with my participation as an agent of change.

The desire to make positive contributions among underserved communities, however, also resulted in tension as *promotoras* navigated and balanced the financial and professional challenges related to their role. Overall, the participants not only expressed their commitment to serving but also acknowledged that the work required emotional and financial sacrifices—uncompensated emotional labor. For example, Isabella described how being a *promotora* is a labor of love: "They are doing the labor with the heart, putting in the extra mile."

For many, the opportunity to give back to the community served as a form of recognition and fulfillment that compensated for the low pay. Samantha described,

> It's a job because they pay me. However, I always give more time, before and after the class. This isn't a problem for me since I know that I am helping the community, just like I was helped at times. It makes me happy to help.

Similarly, Idalia shared:

> If you view [the *promotora* position] by pay, it's a job. When I collaborate with other organizations, it's a profession. It is my passion and there's no need for them to pay me. I learn so many things and put on the table all of the necessities of my community. I advocate against violence, that there may be more health centers, when there is a community event. It's important to see all that is offered so that people can take advantage of everything available to them. I always advocate and they don't pay me to do that.

Overall, participants discuss an unwavering commitment to serve the communities they come from—the communities in need. However, participants' experiences highlight the tensions that they

experienced in their desire to pursue the work of a *promotora* in an environment where they often lacked financial support and recognition as professionals.

DISCUSSION

This community-based participatory study provides insights into the experiences of *promotoras* as they enter and gain experience working across a range of health promotion efforts. Several findings are notable. First, we found that *promotoras* experience a process by which they come to see themselves as health professionals. Second, *promotoras* face professional challenges with agencies that train and employ them. Third, despite the professional challenges, *promotoras* reported a strong commitment to serve communities in need. We found that *promotoras* described their role as having a foot in both worlds—one foot in the community and one foot working with community-based organizations. During their process of training and gaining health promotion skills, they become experts in navigating both professional and lay worlds. During the process of becoming experts at navigating both worlds, they were personally and professionally transformed.

This transformation, however, is not without challenges. Among participants, there was a disparity between the way *promotoras* perceived themselves as health professionals and the way they felt that they were perceived by the institutions for which they worked. Our findings indicate that *promotoras* work at the intersection of two contexts: the community level and the health organization level. At the community level, they provide health information to hard-to-reach populations—populations that *promotoras* ultimately feel an obligation and commitment to continue serving. At the health organization level, the *promotoras* were commonly engaged by community-based organizations under a "volunteer"-based model or a model that did not compensate the full range of their work-related activities (eg, recruitment, class preparation). Overall, in the context of their relationships with communities and organizations, *promotoras* felt a personal desire and need for professional recognition and financial stability.

This study is one of the first in which *promotoras* led the research to examine the experiences of *promotoras*. Our findings are consistent with previous studies of the assets that *promotoras* not only bring to health promotion efforts but also expand on this research to highlight the personal costs and challenges faced by this effective sector of the health workforce. The *promotora* model in research and practice is generally considered under the CHW umbrella and is often implicitly or explicitly described as a "volunteer" model.[24,34] One assumption in many *promotora* programs is that the trainings and health promotion activities serve as an empowerment model. For example, one study examined compensation philosophies of *promotoras* through the perspectives of program planners. Program planners reported a broad range of viewpoints regarding *promotoras* being financially compensated for their work or serving as volunteers.[34] Program planners came to a consensus that *promotoras* provide patience, love, and dedication and thus deserve some form of compensation; however, there was no consensus on *promotoras* being provided with salaries.[34] Other scholars have documented how *promotoras* are purposefully compensated with low wages, as a way to ensure *promotoras* continue to relate to the underserved communities in which they work.[21] Our findings indicate that participants gain empowerment through their experiences as *promotoras*, but this empowerment leads to a professional transformation as much, if not more, than a personal one. These findings provide some insights into an ongoing debate regarding *promotoras* as community advocates or paraprofessioals[35] and the tensions between *promotoras* working between two opposite categories: volunteers and public health professionals.[21] *Promotoras* themselves self-identified as professionals—not paraprofessionals. *Promotoras* did not perceive their work exclusively as volunteer efforts. They viewed themselves as professionals, understood the value in their work for minimizing health disparities, and aspired to be recognized and compensated for their contributions. This points to the importance of understanding and addressing *promotoras'* perspectives and understanding of their role.

Limitations, future research, and recommendations

This study highlights the importance of engaging *promotoras* in research through approaches such as CBPR. The study, however, also presents some limitations. First, this qualitative study is not designed to provide representative, population-level estimates of the frequency of *promotoras'* various experiences. Future research and evaluation, however, can draw from this research to incorporate concepts into surveys or other data collection regarding *promotora* programs. For example, there could be a systematic effort to collect data related to *promotoras'* concerns about compensation. Evaluations of the impact or return on investment of *promotora* programs can (and should) include measures of job satisfaction, professional development needs, and other professional indicators.

Second, because the sample was recruited from Los Angeles County, some of the experiences that *promotoras* described may be unique to the region. Los Angeles County and its health-serving agencies have a long history of engaging *promotoras* and have well-established programs. Regions with newer *promotora*-based programs or fewer *promotoras* may see different dynamics. Studies such as this should be replicated in different settings, particularly for the opportunity to engage *promotoras* in research. The transferability of these findings to other populations of *promotoras* may be limited. Third, our positionality as a team of public health researchers and *promotoras* may have introduced bias during data collection (in the questions we asked or did not ask during interviews) and data analysis. However, as described in the methodology, we took several rigorous measures to reduce the threat or effects of bias.

On the basis of findings from this study, we identified several recommendations aimed at improving the workforce experiences of *promotoras*, to ultimately maximize health promotion efforts among Latinx communities. First, our findings go beyond the current literature's focus on *promotora* skill sets and training to identify the lived professional experiences of largely low-paid, low-income immigrant workers and help shed light on their experiences contending with the structural context of the *promotora* model and the needs of their communities. Research on *promotoras* can build from our findings to further examine the broader economic and social context in which *promotoras* work. *Promotoras* should continue to be at the center of research, as opposed to simply components of an intervention or program. Our findings also highlight how the *promotora* model has moved beyond being a volunteer model and is now a health workforce model. The *promotora* model continues to be different from some of the more established CHW models, which have moved to a more professionalized workforce model. For instance, in 2010, the Office of Management and Budget revised the Standard Occupational Classification to recognize a new division: community health workers.[36] Similarly, however, to the CHW model, our findings indicate that *promotoras* are engaging in work that goes beyond volunteer and peer support and that constitutes professionalized, community-based health services. The *promotora* model should be reconsidered to reflect and recognize *promotoras* as an established part of the health workforce. Doing so may not only advance fairness within health-serving organizations but can also ensure that organizations are fully tapping into the wealth of professional experience that *promotoras* possess after many years of experience. Finally, our findings point to the need to appropriately compensate *promotoras* for all aspects of their work. In particular, this includes their preparation time, transportation, purchase of materials, and attendance at professional development events. Ultimately, *promotoras* serve as the link between numerous organizations (eg, community-based organizations, research institutions) and underserved communities—communities that they themselves come from. It is imperative that the public health workforce effectively and equitably work with *promotoras* to more effectively minimize health disparities and promote health equity among disadvantaged groups.

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