Published in final edited form as:

J Immigr Minor Health. 2010 June ; 12(3): 398–407. doi:10.1007/s10903-008-9127-5.

Institutional Barriers and Strategies to Health Promotion: Perspectives and Experiences of Cape Verdean Women Health Promoters

Maria De Jesus

Harvard School of Public Health, Department of Society, Human Development, and Health and Dana Farber Cancer Institute, Center for Community-Based Research, Boston, MA, USA

44 Binney Street-LW 703, Boston, MA 02115, USA

Maria De Jesus: Maria_dejesus@dfci.harvard.edu

Abstract

Background—Health promoters are critical resources in improving health care access and in providing culturally-responsive health education and interventions to members of medically underserved communities. Little is known about the barriers that impede their health-promoting practices and the strategies used to overcome these barriers.

Methods—In-depth, semi-structured interviews were conducted with nine Cape Verdean women health promoters to examine their perspectives on barriers and strategies to health promotion.

Results—Findings revealed how their health promotion practice is influenced by a host of institutional barriers, including insufficient program funding, restrictive institutional policies, and a lack of culturally and linguistically appropriate health resources. Adaptive and resistant strategies used to counterbalance these barriers included forming supportive internal and external alliances, having a good mentor, and “making noise.”

Discussion—A complete and effective model of health promotion must embrace not only individual-level factors, but also macro-level factors, thus emphasizing the need for institutional change to enhance health-promoting practices.

Keywords

Health promotion; Cape Verdean immigrant women; Health promoters; Barriers; Strategies

Introduction

Health promoters—also known as community health advisors, lay health advocates, outreach educators, community health representatives, peer health promoters, peer health educators, and frontline health workers—are critical resources in improving health care access and patient communication, as well as in providing health education and culturally-responsive interventions to members of medically underserved communities [1]. Moreover,

they facilitate appropriate use of health resources by providing outreach and cultural linkages between community members and health service delivery systems. A 2007 National Workforce Study of Community Health Workers confirms that they are particularly effective in reaching hard-to-reach populations such as immigrants, the uninsured, the homeless, isolated rural residents, migrant workers, and members of ethnic and racial groups [2]. In part, their effectiveness with these populations is due to their abilities to understand community problems in context, to develop innovative health interventions appropriate to the context, and to translate these interventions into practice, thus, responding creatively to local needs [3].

Although there is a bevy of research on patient barriers to health promotion (e.g., lack of knowledge) and immigrant-specific barriers (e.g., limited English), little, if any, research to date has examined the barriers faced by *health promoters* who work with immigrant women and serve as liaisons with the health care system [4–6]. In light of current increased efforts to institutionalize the community health worker field in the U.S. health system, it is crucial to consider the barriers encountered and strategies adopted by health promoters in carrying out their health-promoting practices. Moreover, there have been no published public health journal articles to date examining health promotion with Cape Verdean immigrant women. Cape Verdean women health promoters play a critical role in promoting the health of women in their community and in creating a bridge between the women and the health sector [7]. The present study fills a gap in public health literature by examining the perspectives and experiences of Cape Verdean women health promoters to identify both the barriers that impede their health-promoting practices and the strategies used to overcome these barriers.

Between Two Cultures: Cape Verdean Immigrant Women

It is estimated that the number of people with Cape Verdean ancestry in the U.S., including both migrants and their descendants, is higher than in any other country [8]. The U.S. contains an estimated 77,000 Cape Verdeans, most of whom are living in major cities in New England [9]. Immigrant Cape Verdean women have migrated from rural communities of Cape Verde to the urban ethnic enclaves of Boston (40,000), Brocton (9,000), and New Bedford (9,000) in Massachusetts and Providence (7,000) and Pawtucket (6,000) in Rhode Island [10]. The majority of these women have resided in these urban centers for less than ten years and live their lives mostly encapsulated in segregated immigrant communities. Difficulty in speaking English (i.e., the language of the host country) is a factor in the apparent lack of integration of these women in other sectors of the community.

Most Cape Verdean women have immigrated to the U.S. to support their families [11]. Immigration patterns indicate that women are not simply following men to the United States, nor is their transition attached completely to kin immigration. Other societal conditions, such as an increase in the availability of low-wage jobs tailored for women, attract Cape Verdean women to the U.S. [12]. The process of these women's transition from the country of origin to the host country is stressful, creating many competing roles that they must enact and for which they have limited supportive resources [13]. Most of them face social, economic, language, and health care barriers, and are affected by the violence that

they experience or witness in the community. In fact, many have experienced the loss of a son or daughter due to community violence. Given these stressors, Cape Verdean immigrant women are at high risk for physical and mental distress [14]. Women health promoters therefore are important in helping these women to access and navigate the U.S. healthcare system.

Methods

Participants

The research study was reviewed and approved by the university's Institutional Review Board (IRB). Agencies that met all of the inclusion criteria were selected: (1) employed health promoters; (2) served Cape Verdean immigrant women, and (3) were health organizations situated in Boston neighborhoods. Local health organizations that did not serve Cape Verdean immigrant women were excluded. Nine Cape Verdean women health promoters served as key informants for the study. Key informants were identified using the snowball sampling technique whereby individuals initially identified through previous research [15] as being knowledgeable about health promotion with Cape Verdean immigrant women provided recommendations for additional informants. Inclusion criteria for participants were as follows: (1) they self-identified as Cape Verdean, (2) were working with Cape Verdean immigrant women on health promotion issues, and (3) were employed as health promoters by local health organizations situated in Boston neighborhoods containing high proportions of Cape Verdean women. Health promoters were excluded if they did not work with Cape Verdean immigrant women in Boston neighborhoods. Health promoters received a phone call describing the study goals and procedures, and were asked whether they wanted to participate in the study.

The health promoters possessed the skills and knowledge needed to inform and educate women in their community about various health, educational, and legal issues, as well as to offer relevant resources or informed referrals. They had extensive training that covered issues such as cultural awareness, interpersonal communication, client advocacy, leadership skills, team-building skills, and professional development. They also had knowledge about the various local medical and social services, and how to coordinate access to services, outreach, home visiting, and patient "navigation." As health promoters, they were also required to learn special competencies for addressing specific diseases such as asthma, cardiovascular disease (CVD), cancer, and HIV/AIDS, as well as other relevant health issues including substance abuse and domestic violence. Equally important, these health promoters had a rich combination of practical life skills and experiences, personal qualities, and knowledge about the community that allowed them to effectively address health challenges.

The health promoters were between the ages of 25 to 38. Five of them were born in Cape Verde and the others were born in the U.S. Those who immigrated had been in the U.S. for 15 years or more. They all spoke both English and Kriolu, which is a mixture of West African languages and Portuguese and is the language of everyday communication in Cape Verde at all levels of society. In addition, six health promoters also spoke at least another language (e.g., Portuguese, French). On average, they had been health promoters for six years, and most had some postgraduate education. Overall, they were younger, more stably

employed, more proficient in English and other languages, more formally educated, and had been in the U.S. for a longer period than the women they served. They served as “cultural mediators” who are immersed in the context of their culture of origin while simultaneously creating a bridge for immigrant women in their community to the U.S. health care system.

Data Collection

Twelve months of fieldwork on an earlier project conducted in this community allowed for much more rapid start-up on this research than would normally be the case for community-based qualitative research [16]. A qualitative, inductive research design is concerned with an emic, idiographic approach to research [17]. This approach is focused on the experiences of specific participants (i.e., Cape Verdean health promoters) and the unique richness of a phenomenon (i.e., barriers and strategies to health promotion). This was the design of choice given the paucity of information about this research topic and this community.

Ethnographic participant observations at weekly women’s support group meetings served as a context for interaction with Cape Verdean women health promoters and community women. Data were collected through ethnographic observations, community mapping exercises, open-ended semi-structured interviews and a focus group with local health promoters from September 2004 to January 2006. The data gathered through these multiple and diverse sources increase internal validity, in part, by a process of triangulation that provided a more complete picture of health promotion with Cape Verdean immigrant women. Data from the interviews will be discussed in this report.

The data collection process was comprised of three phases. The first phase served to describe to the participants in more detail the nature of the research and its goals, to explain the informed consent process, to collect demographic information, to conduct a mapping exercise, and to ask open-ended semi-structured questions about their health promotion practice. Participants were asked to visually represent the different community partners whom they viewed as important resources in their health promotion practices. These “maps” served as contextual data during the data analysis process. In-depth, open-ended, semi-structured interviews were useful to gather “thick description” [18] through the stories that emerged. Participants chose a time and place convenient to them for the interviews, which were all conducted in English. Signed informed consent was obtained from all participants and pseudonyms were selected.

The second phase of data collection involved another round of individual interviews. These interviews focused on open-ended semi-structured questions related to their training and the impact, if any, of these experiences on their work. These interviews also served to probe further and to test ongoing theory and mini-hypotheses. Each interview lasted between 1.5 to 2 hours. The last phase of the data collection process was a focus group with participants. This opportunity allowed for member-checking (i.e., presenting the findings to the participants who then commented on the representation of the findings). These focus group discussions served to deepen the analysis.

Data Analysis

Data analysis of the transcribed interviews relied on a grounded theory approach [19–20]. Grounded theory is an inductive and systematic approach to data analysis, meaning that analysis proceeds from making specific observations to developing more abstract concepts and theories [21]. A grounded theory method was useful for developing an understanding of participants' experiences from their standpoint and was suited for studying a topic on which there has been little research [22]. Data collection was open-ended and minimally shaped by a priori theory rather than close-ended and predetermined. The meanings and the issues of salience as expressed by the participants shaped the process of data collection and analysis.

In this study as with other grounded theory studies, data analysis and the later stages of data reduction operated iteratively. Coding is a process of simultaneously reducing the data by dividing it into units of analysis and coding each unit. Theoretical sampling guided what other data were needed and where to find it [23]. The idea was to refine and sample ideas, not simply to add more participants to the sample [24]. Saturation, that is, when more interviews were no longer adding any new themes or concepts to what was already known, was achieved with nine Cape Verdean women health promoters [25].

Memo-writing (i.e., the write-up of theoretical ideas about substantive concepts and their theoretically coded relationships as they emerge during data collection and analysis) throughout the research process shaped aspects of subsequent data collection, pointing to areas of further exploration [26]. Memos included code notes (i.e., properties and potential relationships among the codes), operational notes (i.e., speculating about future directions for theoretical sampling), and theoretical notes (i.e., any ideas about interpreting data) [27]. As data were gathered, patterns and relationships in memos were noted, and hypotheses were either confirmed or refuted through gathering more data. The interviews and data analysis occurred concurrently in a dynamic interaction and iterative process.

Results

Institutional Barriers to Health Promotion

The health promoter interview data revealed different institutional barriers that hindered health promotion practices with immigrant women. Figure 1 depicts these barriers in the form of a brick wall. The main factors identified included: the lack of administrators' understanding of the importance of relationship-building as a prerequisite for undertaking health promotion, insufficient resources and funding for needed health promotion programs, the lack of linguistically and culturally appropriate health personnel, and ineffective institutional policies restricting health care services for clients.

Health promoters reported how administrators of the health organization had different understandings of how to measure effectiveness of health-promoting practice. Ana (a 38-year-old health promoter from Cape Verde with 16 years of experience) stated how she felt that administrators undervalued health promotion activities: "The executive directors do not always know or care about the type of work that we do with the women. This is the major constraint that I see. You cannot always measure the work with numbers like you can when you are in another field such as finance. In our work as health promoters, we are dealing

with people's lives." She regarded helping the women to whatever extent possible as the most important aspect of her work: "I can spend a full day just trying to find some information if it is going to change someone's life. We are dealing with people's lives, not numbers. Nowadays everything revolves around numbers. Numbers count, but we are still touching people's lives and that is what is most important for me."

In addition, health promoters indicated that there was a lack of essential resources and funding for health-promoting activities. Rosie (a 33-year-old health promoter who was born in the U.S. and has 5 years of experience) explained:

We never have enough resources, especially now with the funding that is being cut left and right. It is hard to get interpreters everywhere they need to go and to get transportation. There are always insufficient resources and unfortunately so much funding has been cut on the services that we need most. Again, they [health administrators and policymakers] are looking only at the numbers. Whatever can bring dollar signs in front of it, that is where they are willing to put the money and not necessarily in what will work with immigrant women.

Another major obstacle reported by health promoters was a shortage of health workers. In Marlene's (a 28-year-old health promoter from Cape Verde with 4 years of experience) words:

We do not have enough staff as an organization to meet all of the needs and demands that are out there for the women with whom we work ... there are part time positions, reduced hours, and more casework, yet more and more issues, more and more women with problems, especially as the economy worsens. We have an increase in caseload but a decrease in funding, positions, and staff.

Similarly, Alice (a 36-year-old health promoter who was born in the U.S. and is in her fourth year of practice) explained, "My biggest struggle for the past three years is not having enough health workers out there who could provide services for Cape Verdean women and who speak their language."

Furthermore, Alice explained how certain policy restrictions of the health organization created barriers to health promotion: "Before women could see anyone they wanted in the clinic. Now if a woman is not an in-network patient of the health center, then she cannot go there. She has to be a patient there in order to get help." Sandra (a 25-year-old health promoter who was born in the U.S. and is in her second year of practice) also recounted how the policies of the faith-based health center where she worked created barriers to health promotion with the women:

Our organization started setting more rules and stricter policies about what information we could offer the women and which services we could provide. They began reinforcing the rules just to be on the safe side. And all these other things that were going on with the church affected our work. What is hard is to tell women, "I am here for whatever you need," but in actuality all you can do is refer them out.

Sandra went on to explain how these strict organizational policies had negative repercussions on her health-promoting practices:

I have to watch what I say to community women with whom I work. A lot of women who have that trust in me and with whom I have been working for a long period of time, for example, one woman confided in me and told me things that she had not told anybody in 15 years, I now have to refer elsewhere. It changes the relationship. When I visit them, they brush me off now... And then I am not really working on the health issues with them anymore because they do not trust me as much anymore given that they have lost the ability to confide in me. With Cape Verdeans, trust in relationships is a very important thing.

Adaptive and Resistance Strategies Adopted by Health Promoters

The health promoters indicated that they used different strategies to counterbalance some of the institutional barriers described above. Figure 2 illustrates these adaptive and resistance strategies. Adaptive and resistance strategies included: being passionate about health promotion, taking care of oneself and finding a sense of balance, forming supportive internal and external alliances, collaborating and building a referral network, learning from each other, sharing challenges and compromising, having a good mentor, and “making noise.”

The health promoters described how a sense of passion fueled their health-promoting practice. For example, Lucia shared how what she learned from her own parents’ struggles as immigrants in the U.S. contributed to her sense of passion about her work in the community:

Although I was born here, just seeing the struggles that my parents went through guides my work with the women ... My parents immigrated from Cape Verde and I have a passion for Cape Verde. I’m proud to be Cape Verdean and I love my community. And because there are such limited resources in the community, it’s hard to walk away and say, “I’m not going to do this anymore.” Sometimes we get frustrated doing this kind of work. In the end there are more good days than bad days, so it just keeps fueling your fire, especially when you know you’ve made a difference in a woman’s life, then that keeps you going.

Sandra also shared a similar understanding of health promotion: “It is that kind of work where sometimes you just have to go past your work hours.” Similarly, Natalia (a 34-year-old health promoter from Cape Verde who is in her sixth year of practice) described her health promotion practice as “much more than simply a 9 to 5 job. She explained, “I don’t work for the agency. I work with and for the women in my community.” Echoing these words, Alice, gave an example of how health promoters have a similar vision in carrying out their work with women in the community. She stated:

I think it’s the passion that drives us. We see health promotion work not as a profession but as a mission. I work very closely, for example, with the health promoter who helps women with domestic violence issues in a different department. But she can help me with a lot of the women’s issues. And I can help her too. We can serve the same person in different capacities and in terms of that

work relationship, the beauty of it is that we are all on the same page. We are all here and we all feel that we are on a mission.

Ana also prioritized helping community women in any way that she could, regardless of the barriers. As she described:

I made it very clear to my executive director that this work is not about me. It's about the person in front of me. And it is my job, my duty, my morals, my mission that is telling me that I need to find a way to help this person. It's not about me ... I take it upon myself personally to find the help for this person ... and I tell her, "Someday if you see another woman in the same predicament, don't turn your back. Go to her if she's not coming to you because chances are she's either too embarrassed or too shy to come to you."

Although these health promoters described their passion in working with women in the community, they also reported how they needed to take care of themselves too. Lucia explained:

But then at the same time, there are challenges and there's only so much we can do because I have a family of my own. So I can't do this on weekends because my kids are teens and they need me too. And I feel like I take enough time during the week from them in order to do this work. So as health promoters, we have to sit down and think of more clever ways to do it all ... We need to take care of ourselves too, even though we see that so much still needs to happen.

Alice shared how it was important to keep a sense of balance in her work: "We have to keep some kind of balance too."

Other adaptive strategies included seeking support from fellow health workers, as Ana described: "When things get very intense, we [health promoters] kind of bounce off each other...my colleagues are my major support system. If you have a good department that is supportive of each other, you're battle is half won..."

Beyond forming supportive internal alliances, forming external alliances, collaborating with others, and building a referral network were also adaptive strategies used by some of the health promoters. Marlene explained:

I think it's important that you're connected with other people who are working with the Cape Verdean community...When you have the opportunity to meet someone who is working with the community, remember their name, remember where they worked, and call there. Keep all the business cards you get and use them. That's what I do. Everywhere I go, I meet people, and I take business cards. I call organizations where I remember having met someone. I take the information down and I put it in my Rolodex, and I use it again.

Collaborating is also important. As Lucia described:

I think that for the most part we all know each other. Collaborating is a big thing and I think it's very important to collaborate because there are so few of us. It's the same people doing the same thing over and over again. So I think that's where

collaboration comes in. I could call somebody at the health center and they could call me too for help or just to know what we're all doing. I think that we depend on each other that way.

Gabriela mentioned how building a list of referrals is an important strategy, "You build a list of people, of networks, and of contacts that you use. I think that this strategy has helped me because I found out about other resources." Alice also mentioned using existing contacts as a way to obtain information. "We have one another and we're very creative. We use our contacts, the other people that are working in the field. For example, we send out an e-mail to the group asking, "Does anyone know about X, Y, Z?" or "Where can I get this?" And then you just kind of figure things out so I think that's a supportive strategy." She went on to explain how continuing to learn new information is also helpful.

There are always different things to attend too so that one keeps learning. For example, the Department of Education is doing workshops on how to integrate this or that and other community agencies have workshops and they ask you to participate. So then you learn about the different resources that are available and you bring it back to your clients.

Sandra mentioned that learning from each other's programs and experiences is important as well.

There are other programs that are similar to mine, just different in some minor ways. For example, with the Asian program and the Haitian program, we talk about how we would handle different situations and how we would do this, and how we would go about doing that or experiences that we've had, "This is what we've done in this situation." We learn from each other and we all support each other here.

Sharing challenges and compromising with other health workers was also described by these health promoters as an adaptive strategy. For instance, Natalia stated, "Just talking about the constraints and being honest and having everybody put what they need on the table is helpful. It's a give and take process. It is not about *me* taking from *you* or *you* taking from *me*. It is about us working together. There is a ton of work out there for everybody to do."

Having a good mentor or supervisor, especially one who is supportive and culturally sensitive was also an important way that health promoters dealt with some of the institutional barriers. As Marlene stated, "...having a good mentor has also been helpful. I learned a lot by watching how she handles certain situations." Sandra shared how her mentor who was not Cape Verdean understood the Cape Verdean culture and thus was able to offer helpful suggestions to her.

My mentor understood the Cape Verdean culture and so that made it easier for me, especially when we had supervision together. I would talk to him about things and he would give me suggestions. It made it a lot easier for me too because he is somebody who understands the culture and was able to give me good advice. I was able to say things that I was thinking and we could go ahead and help a client out in a culturally savvy way.

Alice also described how having a good relationship with a supervisor and peers counterbalanced some of the institutional barriers. She stated, “Fortunately, I love my boss. I have a very good boss. I told her, “I could see myself working for you for a long time. If you leave and go to another program, I want you to take me with you.” She’s excellent. And I think that having a good relationship with your peers and supervisor at work is important in dealing with some of the challenges.”

These health promoters also mentioned using strategies to resist some of the institutional barriers such as speaking out against a particular barrier or unjust situation. As Lucia described, “It has taken a lot of education on my part, learning to choose my battles, and making a lot of noise too. I tell other health promoters, ‘Make noise. That’s it, just make noise.’” In sum, the health promoters described different institutional barriers and strategies they used to either adapt or resist these barriers.

Discussion

The findings reported here suggest that health promotion activities by Cape Verdean women health promoters are neither static nor do they occur within a vacuum. Health promotion practice with Cape Verdean immigrant women unfolds within the U.S. host culture as well as a dominant state and federal U.S. medical system and its funded programs, which represent institutional and contextual entities that are linguistically and culturally different from the participants in this study. The findings of this study reveal that there are a host of institutional barriers that health promoters encounter in their practice, including insufficient funding for the development, expansion, and sustainability of needed health-promoting programs, policy restrictions in terms of where community women could go for assistance, as well as scarcity of culturally and linguistically appropriate health workers and resources.

Health promoters in this study described how their work with immigrant women in the community is undervalued and how administrators do not seem to care or want to learn about the community that is being served. These findings point to an institutional health context characterized by highly asymmetrical relations of power. Specifically, these health promoters who are in positions of less power relative to the medical system (i.e., administrators and policymakers), yet whose work is embedded in this health context, are constantly challenged to learn how best to navigate and overcome institutional barriers by utilizing both adaptive and resistant strategies, as revealed by the findings reported here. For example, there is a clash in understanding how to measure the effectiveness of health promotion. While administrators and policy-makers want to measure effectiveness with numbers, health promoters on the frontlines emphasize the importance of building rapport with community women. In fact, this finding is consistent with other studies that examine the perspectives of frontline health workers and reveal how these workers view a process of *creating relationships* as key to promoting immigrant women’s health [28–32].

These health promoters combine their unique skill set with an extraordinarily high level of passion for and commitment to the community in which they serve, and play a significant role in addressing some of the problems that exist in the present health system. They also develop strong internal and external alliances, and supportive mentorship and supervision

within the health organization to overcome the institutional barriers. These findings are consistent with literature that indicates how management and organizational support is key in facilitating health promoters' practices [33–34].

Health promoters are a significant asset not only to their communities, but also to inform the organizational as well as the advocacy and policy world of health [35]. Specifically, their firsthand knowledge about institutional barriers and useful strategies to overcome these barriers must be harnessed and expanded to ensure their capacity to affect institutional policies and inform decision-makers.

Recommendations for Overcoming Institutional Barriers and Strengthening the Use of Health Promoters

The current health care reform environment presents a unique opportunity to recognize and maximize on the contributions of health promoters. The adaptive and resistant strategies reported by the health promoters in this study provide valuable recommendations to overcome institutional barriers. Firstly, as more efforts are put towards institutionalizing their role within health systems, it is imperative that they be valued and understood by other health professionals as a critical component of integrated systems of health care and as advocates for the populations they serve [36–38]. Moreover, as members of the primary health care team, health promoters can prevent unnecessary reliance on costly emergency department and specialty services [39]. Institutional and systemic support are key factors to expanding and stabilizing this workforce.

Further research is needed to document the unique contribution of health promoters to the health system, and educate health providers and policy makers about this contribution. For a deeper understanding of how health promoters enhance health systems, it will be important to conduct follow-up longitudinal studies to determine the costs and benefits of employing health promoters, and to document their impact on access to health care, lowering health care costs, and improving health outcomes [40].

Secondly, cutbacks and the lack of funding for health promotion programs pose a continuous threat to health promoters effectively fulfilling their role. Thus, identifying stable, continuous, and flexible sources of funding that promote long-term program planning and strengthen health-promoting services will ensure that health promoter efforts can be sustained, be responsive to community needs, and be maximized across an ever-changing health care environment. Moreover, as reported in the findings here, most health promoters draw on their own life experience and communication skills, as well as training to remain effective on the job. They require formal training on an ongoing basis and consistent supportive supervision to ensure that they can meet the community's changing health care needs. Thus, more funding is needed to expand and train the health promoter workforce.

Thirdly, this study suggests that we need to expand models of individual-level health barriers and consider macro-level factors as well, thus emphasizing the need for institutional and structural change in order to effectively enhance health-promoting practices. Health promoters' perspectives on critical barriers to promoting women's health reinforced the fact that health promotion practice is multi-layered and that client-specific factors constitute only

one layer in health promotion. A complete and effective model of health promotion must embrace much more, including institutional and systemic factors. Furthermore, community-based and culturally savvy health promoters who serve as cultural mediators have a strong role to play not only in health promotion activities, but also in developing a comprehensive and multi-layered health promotion model.

Limitations and Future Directions

The study presented here was the first of its kind with Cape Verdean women health promoters. However, it is limited on a number of dimensions described below. The first limitation is the sample size, which was both small and restricted to a group of women health promoters in the Cape Verdean community of Boston. The number of Cape Verdean women health promoters who work in the community is quite small and these women constitute a close-knit community. Thus, saturation of the findings was achieved with a small sample size. It is unclear, however, whether the findings apply to other women health promoters' experiences in similar work settings. Despite the limitations of this study, however, understanding how this group viewed their health practice provides useful insights for understanding other health promoters' work, particularly those who strive to promote health in low-income immigrant ethnic communities.

Future research directions include an exploration of specific barriers to health promotion with other immigrant groups. Given the particularities within the Cape Verdean community and the history of the community's various waves of migration to New England, it would be informative to explore whether variations in the experiences and narratives of women health promoters of other ethnic or cultural backgrounds are reported. In part, this research would contribute to answering the question of whether the perspectives of Cape Verdean women health promoters reflect and extend to the practice of women health promoters of other ethnic and cultural groups.

In the absence of previous studies on the health promotion practice of Cape Verdean women health promoters, this study has helped shed light on the institutional barriers to health promotion. It thus serves as an important contribution to understanding Cape Verdean women's health promotion as a challenge to all those committed to promoting women's health who can then better engage and transform the barriers to health and well-being in collaboration with ethnically, culturally, and linguistically diverse communities in urban U.S. contexts.

References

1. Witmer A, Seifer SD, Finocchio L, et al. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–8. [PubMed: 7625495]
2. U.S. Department of Health and Human Services: Health Resources and Services Administration: Bureau of Health Professions. Community Health Workers National Workforce Study. San Antonio, TX: Regional Center for Health Workforce Studies of The University of Texas Health Science Center at San Antonio; Mar. 2007 HHS no. 230200432032C available at <ftp://ftp.hrsa.gov/bhpr/workforce/chw307.pdf>
3. Witmer A, Seifer SD, Finocchio L, et al. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–8. [PubMed: 7625495]

4. Ma GX, Fang CY, Shive SE, et al. Risk perceptions and barriers to Hepatitis B screening and vaccination among Vietnamese immigrants. *J Immigrant Minority Health*. 2007; 9:213–20.
5. Williams DP, Hampton A. Barriers to health services perceived by Marshallese immigrants. *J Immigrant Minority Health*. 2005; 7(4):317–26.
6. Gany F, Herrera AP, Avallone M, et al. Attitudes, knowledge, and health-seeking behaviors of five immigrant minority communities in the prevention and screening of cancer: a focus group approach. *Ethn Health*. 2006; 11(1):19–39. [PubMed: 16338753]
7. De Jesus M. HIV/AIDS and immigrant Cape Verdean women: contextualized perspectives of Cape Verdean community promoters. *Am J Community Psychol*. 2007; 39(1–2):121–31. [PubMed: 17340187]
8. Carling, J. Migration policy institute Cape Verde: towards the end of emigration?. Washington, DC: Nov. 2002 available at <http://www.migrationinformation.org/Profiles/print.cfm?ID=68>
9. US Census Bureau. United States Census 2000. 2000. available at <http://www.census.gov/main/www/cen2000.html>
10. US Census Bureau. United States Census 2000. 2000. available at <http://www.census.gov/main/www/cen2000.html>
11. Marques MM, Santos R, Araujo F, et al. Ariadne's thread: Cape Verdean women in transnational webs. *Global Networks*. 2001; 1(3):283–306.
12. Meleis AI, Rogers S. Women in transition: being versus becoming or being and becoming. *Health Care Women Int*. 1987; 8:199–217. [PubMed: 3650260]
13. Hondagneu-Sotelo, P. Gendered transitions: Mexican experiences of immigration. Berkeley, Calif: University of California Press; 1994.
14. Massachusetts Department of Public Health. Massachusetts Community Health Information Profile (MassCHIP): Breast Cancer Report 2003–2005. available at <http://www.nlm.nih.gov/nichsr/usestats/MassCHIP.htm>
15. De Jesus M. HIV/AIDS and immigrant Cape Verdean women: Contextualized perspectives of Cape Verdean community promoters. *Am J Community Psychol*. 2007; 39(1–2):121–31. [PubMed: 17340187]
16. De Jesus M. HIV/AIDS and immigrant Cape Verdean women: contextualized perspectives of Cape Verdean community promoters. *Am J Community Psychol*. 2007; 39(1–2):121–31. [PubMed: 17340187]
17. Watson, LC.; Watson-Franke, MB. Interpreting life histories: an anthropological inquiry. New Jersey: Rutgers University Press; 1985.
18. Geertz, C. The interpretation of cultures: selected essays. New York NY: Basic Books; 1973.
19. Glaser, BG.; Strauss, A. The discovery of grounded theory: strategies for qualitative research. Chicago, Ill: Aldine; 1967.
20. Strauss, A.; Corbin, J. Basics of qualitative research: grounded theory procedures and techniques. Newbury Park, Calif: Sage; 1990.
21. Glaser, BG.; Strauss, A. The discovery of grounded theory: strategies for qualitative research. Chicago, Ill: Aldine; 1967.
22. Charmaz K. 'Discovering' chronic illness: using grounded theory. *Soc Sci Med*. 1990; 30(11): 1161–72. [PubMed: 2360052]
23. Glaser, BG.; Strauss, A. The discovery of grounded theory: strategies for qualitative research. Chicago, Ill: Aldine; 1967.
24. Charmaz, K. Grounded theory: objectivist and constructivist methods. In: Denzin, NK.; Lincoln, YS., editors. *Handbook of qualitative research*. Thousand Oaks, Calif: Sage; 2000. p. 509–36.
25. Morse JM. The significance of saturation. *Qualitative Health Res*. 1995; 5:147–9.
26. Glaser, BG.; Strauss, A. The discovery of grounded theory: strategies for qualitative research. Chicago, Ill: Aldine; 1967.
27. Glaser, BG.; Strauss, A. The discovery of grounded theory: strategies for qualitative research. Chicago, Ill: Aldine; 1967.
28. De Jesus M. Mutuality at the center: health promotion with Cape Verdean immigrant women. *Ethn Health*.

29. Casey D. Nurses' perceptions, understanding and experiences of health promotion. *J Clin Nurs*. 2007; 16:1039–49. [PubMed: 17518880]
30. Richardson J. Health promotion in palliative care: the patients' perception of therapeutic interaction with the palliative nurse in the primary care setting. *Issues Interventions Nurs Pract*. 2002; 40:432–40.
31. Casey D. Nurses' perceptions, understanding and experiences of health promotion. *J Clin Nurs*. 2007; 16:1039–49. [PubMed: 17518880]
32. Ureda J, Yates S. A systems view of health promotion. *J Health Hum Serv Adm*. 2005; 28(1):5–38. [PubMed: 16521613]
33. Casey D. Nurses' perceptions, understanding and experiences of health promotion. *J Clin Nurs*. 2007; 16:1039–49. [PubMed: 17518880]
34. Witmer A, Seifer SD, Finocchio L, et al. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–8. [PubMed: 7625495]
35. Pérez LM, Martinez J. Community health workers: social justice and policy advocates for community health and well-being. *Am J Public Health*. 2008; 98(1):11–4. [PubMed: 18048789]
36. Witmer A, Seifer SD, Finocchio L, et al. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–8. [PubMed: 7625495]
37. Pérez LM, Martinez J. Community health workers: social justice and policy advocates for community health and well-being. *Am J of Public Health*. 2008; 98(1):11–4. [PubMed: 18048789]
38. Community health workers: essential to improving health in Massachusetts. Mar. 2005 available at: http://www.mass.gov/Eeohhs2/docs/dph/com_health/comm_health_workers_narrative.pdf
39. Witmer A, Seifer SD, Finocchio L, et al. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–8. [PubMed: 7625495]
40. Swider SM. Outcome effectiveness of community health workers: an integrative literature review. *Public Health Nurs*. 2002; 19(1):11–20. [PubMed: 11841678]

Fig. 1.
Institutional barriers encountered by Cape Verdean women health promoters

Fig. 2.

Adaptive and resistance strategies used by Cape Verdean women health promoters