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La Palabra es Salud: A Comparative Study of the Effectiveness of Popular Education vs. Traditional Education for Enhancing Health Knowledge and Skills and Increasing Empowerment Among Parish-Based Community Health Workers (CHWs)

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La Palabra es Salud:

A Comparative Study of the Effectiveness of Popular Education vs. Traditional
Education for Enhancing Health Knowledge and Skills and Increasing Empowerment
Among Parish-Based Community Health Workers (CHWs)

by

Noelle Wiggins

A dissertation submitted in partial fulfillment of the
requirements for the degree of

Doctor of Education
in
Educational Leadership: Curriculum and Instruction

Dissertation Committee:
Karen Noordhoff, Chair
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Portland State University
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ABSTRACT

Popular education is a mode of teaching and learning which seeks to bring about more equitable social conditions by creating settings in which people can identify and solve their own problems. While the public health literature offers evidence to suggest that popular education is an effective strategy for increasing empowerment and improving health, there have been no systematic attempts to compare the outcomes of popular education to those of traditional education. The goal of *La Palabra es Salud* was to conduct such a comparison among Latino, parish-based Community Health Workers (CHWs). The study employed a quasi-experimental design, mixed methods, and a community-based participatory research (CBPR) framework.

Results of a mixed factorial ANOVA revealed that both experimental groups made statistically significant gains in health knowledge when compared to a control group. Within-group comparisons showed that the popular education (PE) group made statistically significant improvements in self-reported ability to promote health, critical consciousness, and on a global measure of empowerment, while the traditional education (TE) group made significant gains in critical consciousness, control at the personal level, self-reported health status, and self-reported health behavior. Because the TE group was almost twice as large as the PE group, almost identical changes that achieved significance in the TE group did not achieve significance in the PE group. Results of the qualitative analysis validated the quantitative results, with members of the TE group reporting improvements in health knowledge and behavior while

members of the PE group reported increased empowerment and ability to empower others.

Our findings suggest that, when compared to traditional education, popular education can help participants develop a deeper sense of empowerment and community and more multi-faceted skills and understandings, with no accompanying sacrifice in the acquisition of knowledge. These results have their most direct implications for the education of adults from disempowered communities, where popular education shows promise for supporting community members to identify and organize around shared concerns. More broadly, the research suggests that wider use of popular education in mainstream educational settings could promote greater inclusion and increased success for students who have experienced marginalization, producing a more equitable society.

Dedication

When I began to think about all the people who have accompanied me on the journey of obtaining my doctoral degree and writing this dissertation, I realized that the word “acknowledgements” was far too parsimonious a word to recognize their contributions. Thus, I’ve chosen the word “dedication,” as it conveys my extreme gratitude and the awareness that this work would not have been possible without them. In that spirit, then, I’d like to dedicate this work first, to all the Community Health Workers and popular educators, both dead and living, whom I have had the honor to know since I began to do this work in a rural area of El Salvador 23 years ago. First among those is my *compañera, hermana*, and colleague Teresa Campos Rios, whom I first met in 1990 when I had been back in the U.S. for less than a year and Tere and her family had been here only two years. Despite our first impressions, we have forged a friendship and a working relationship that has sustained me through many struggles, both personal and professional. Tere, you are the consummate Community Health Worker and popular educator, the standard by whom all others are measured.

My thanks and appreciation go also to Karen Noordhoff, my doctoral program advisor and dissertation committee chair. Because she was at that time the Doctoral Program Director for PSU’s School of Education, Karen was the first person I met when I began to investigate the doctoral program. I remember well standing outside her office, waiting for my appointment, and seeing the sign on her door that said, “Breathe.” I suspected I might have found a kindred spirit, and after that first meeting my impression was confirmed. Though no disrespect to the program is intended, I

must admit that I chose the focus on Curriculum and Instruction solely so that Karen could be my advisor. Though she has always been the first to acknowledge her lack of background in popular education, Karen comprehended my passion and has unflaggingly supported me to follow that passion where it took me.

This work is dedicated also to the members of my committee: Ramin Farahmandpur, Samuel Henry, Carlos Crespo, and Cheryl Livneh. A special note of thanks to Ramin, who responded quickly and at length to my first exploratory e-mail despite the fact he was on sabbatical, providing an introduction to critical pedagogy and a list of readings that have guided me through the subsequent years. He has also had the great grace and humility, as a critical pedagogue and an academic, to appreciate and learn from a popular educator and a practitioner.

This dissertation is dedicated in a special way to the members of the *La Palabra es Salud* Project team. One of the primary reasons I chose to stay in Portland and study at PSU was my desire to be able to situate my academic work in contexts I knew well and make my work useful to the people and causes to which my professional career has been dedicated. I was nearing the end of my required coursework and thinking seriously about settings for my dissertation when I ran into Catherine Potter, the Director of the Parish Health Promoter Program (PHPP) on the east side of Portland. The route by which that conversation led eventually to La Palabra es Salud (LPES) is detailed later in the dissertation; suffice it to say for now that had Catherine not been willing to consider this partnership, LPES would not have existed and this particular dissertation would never have been written.

In very short order after that first conversation, Catherine's colleague Adele Hughes, PHPP Director for the west side of Portland, became absolutely central to this project. Due to the fact that the next PHPP course was scheduled for the west side, it was Adele who had to agree to host the research project. But there was more. As the research design developed, it became clear that for the project to happen, Adele was going to have to commit to doing something she had vowed never to do again: run two simultaneous training courses. She agreed to the idea with her customary grace, and bore up under the strain with remarkable equanimity. Running two courses at the same time was greatly facilitated by Adriana Rodriguez, who joined the project in the summer before the training began as Assistant Coordinator. As a CHW who had been trained in the program during the first "generation" on the west side, Adriana, who has since completed her BS in Community Health at PSU, was the ideal person to model the goals to which the CHWs could aspire. She was also an extremely apt student of popular education, and by mid-year was co-facilitating day-long popular education workshops. Adriana benefited from the mentoring of Teresa, who was also part of the Project Team and the principal trainer for the popular education classes.

It is impossible to do community-based participatory research (CBPR) without the community, and in this project the community was represented by an Advisory Board made up of experienced CHWs from the PHPP and leaders from some of the parishes that participate in the program. I'd like to express my gratitude to Zoraya, Delfina, María, Laura, Lydia, Deacon Bill, and Father David, all of whom shared unstintingly of their time, wisdom, and great compassion. As well as helping me to understand the

nuances of the qualitative data I was amassing, they also helped to prepare me for my dissertation defense by asking hard questions about quantitative data and suggesting the best ways to display the data for maximum understanding. I am also grateful to Sister Lynda and Rene Campagna, respective supervisors of Adele and Catherine, who gave their support as well as, in some cases, their funding to make this project possible.

A colleague who is contemplating doing a doctoral degree recently asked me if my supervisors at the Multnomah County Health Department had been supportive of my desire to further my education. They were; I'll say more about that momentarily. But my first thought when I heard the question was that the support I most needed to return to school was the support of my immediate colleagues at the Community Capacitation Center. That support began even before I began the program. During the time I was considering applying to the program, Teresa and my colleague Pam Hiller and I were driving along I-84 on our way back from a training course on the Umatilla Reservation. I was contemplating the daunting prospect of combining full time work with full time school, and not feeling very optimistic. But Pam and Tere, neither of whom ever lacks for an opinion, were adamant. I could do it, I would do it, and they would be there to cheer me on at graduation. Their support has been unswerving, even when it meant taking over bureaucratic tasks like monitoring contracts so that I could spend four months doing a fellowship in South America. In the intervening years, my list of supportive colleagues has grown to include Elizabeth Rees Morgan, Samantha Kaan, and Rujuta Gaonkar, all of whom have made this work possible with their own

unique contributions. Both Samantha and Rujuta brought their unique and valuable perspectives to the Project Team by attending meetings during different phases of the project. Elizabeth participated too, entering the data from the Participant Evaluation Forms into the database and preparing reports.

That all said, my dedication would certainly be incomplete without recognizing the support of Consuelo Saragoza, my immediate supervisor for the entire length of my doctoral program, and Lillian Shirley, the Director of the Multnomah County Health Dept. Consuelo barely batted an eye when I told her I wanted to take four months' leave to investigate how popular education had changed in Latin America since I returned to the U.S. in 1990. One could surmise that, by that time in our working relationship, nothing I could have said to Consuelo would have surprised her! But I would rather attribute her reaction to her own unceasing commitment to building capacity and improving health in the Latino community. Likewise, though she may never come to terms with the word, "capacitation," Lillian's support for the Capacitation Center and the work we do, through 10 years of consecutive budget cuts at the County, grows out of her own dedication to changing the unjust conditions that result in unequal health outcomes.

While co-workers, supervisors, professors, and advisors share important and meaningful parts of the journey of obtaining a doctoral degree, a unique part of that journey is shared and made possible by the family and friends who cook the food, water the garden, do the dishes, and withstand the bad moods so that another friend or family member can expend the effort that a doctoral degree requires. Along those

lines, my re-entry into academia was smoothed considerably by the presence of my longtime friend and colleague Carmen Gutierrez, who came back from El Salvador with me when I visited in 2003 and spent her first year in the U.S. living in my home. An expert popular educator and community organizer herself, Carmen made endless plates of *frijoles*, *crema*, *platanos fritos*, and a scrumptious dish of breaded broccoli while I read the required readings and wrote the required papers of the core curriculum. Carmen, I will never think of that first year in the doctoral program without thinking of that broccoli dish!

For the last three years, my academic passions as well as my need for food and diversion have been supported by my life partner, Marjorie McGee. These three years have also coincided with her first three years in PSU's doctoral program in Social Work and Social Research. While some might say that having both members of a couple in a doctoral program at the same time is a recipe for disaster, we have chosen to see it rather as an opportunity to learn from and support one another. Margie's shared passion for the models and methods that animate my own work – popular education, CHWs, CBPR – has served to renew my faith when it was lagging and reassure me that the effort I was expending was worthwhile. In a more concrete way, Margie's considerable skills in constructing databases for data entry and then exporting that information into SPSS saved me many frustrating hours and probably, money I would have spent on technical assistance!

Coming full circle, in closing I would like to dedicate this work to the *promotores de salud* of the Parish Health Promoter Program of the *promoción* of 2008. As Karen

and others well know, I had some severe misgivings early on about playing with other people's lives in the way that a quasi-experimental research design requires. My concerns were assuaged to a large degree through conversations with other academics whose ethics I trusted, and through the intervention of my colleagues on the Project Team, who helped assure that all participants would have a positive and empowering experience. Yet I continue to feel a huge debt of gratitude to the members of the two experimental groups, who participated in the training, completed the survey, and (in some cases) engaged in the in-depth interviews solely because of their desire to be of more use to their communities. They demonstrated the same optimistic spirit and purity of motivation that has characterized the great majority of *promotores de salud* I have known in my life. To all of you, in the hope it may strengthen *your* work, *this* work is dedicated.

Dedicatoria

Cuando yo comencé a pensar en todas las personas quienes me han acompañado en esta jornada de obtener mi calificación de doctora y de escribir este tesis, me di cuenta que la palabra “reconocimientos” era muy pobre para reconocer a sus contribuciones. Por eso, he escogido la palabra “dedicatoria,” porque esa palabra expresa mejor mi gratitud profunda y la realidad que este trabajo no hubiera sido posible sin ellos. En ese espíritu, entonces, me gustaría dedicar este trabajo primero a todos/as los/as promotores/as y educadores/as populares, tanto vivos como muertos, quienes he tenido el honor de conocer desde que comencé a hacer este trabajo en una área rural de El Salvador hace 23 años. La primera entre ellos es mi compañera, hermana y colega Teresa Ríos Campos, quien yo conocí por primera vez en 1990 cuando yo había estado de regreso a los EEUU por menos de un año y Tere y su familia había estado aquí por solo dos años. A pesar de nuestras impresiones iniciales, hemos construido una amistad y una relación de colegas que me ha sostenido durante muchas luchas, tanto personales como profesionales. Tere, eres la promotora y educadora popular completa, la ideal a quienes todos los demás se comparan.

Mis agradecimientos y aprecio también a Karen Noordhoff, mi asesora académica y la directora de mi comité de la tesis. Como ella era, en ese entonces, la Coordinadora del Programa del Doctorado de la Escuela Graduada de Educación de PSU, Karen era la primera persona que yo conocí cuando comencé a investigar el programa. Yo recuerdo muy bien el estar parada en frente de su puerta esperando mi cita, cuando vi el letrero en su puerta que decía, “Respirar.” Yo sospeché que había

encontrado una alma gemela, y la primera cita confirmó mi impresión. Aunque no quisiera faltar el debido respeto al programa, tengo que admitir que escogí el programa de Currículo e Instrucción solo para poder tener Karen como mi asesora. Aunque ella siempre ha sido la primera en decir que no es experta en educación popular, Karen captó mi pasión y me ha apoyado a seguir esa pasión por donde me llevaba.

Este trabajo está dedicado a los miembros de mi comité: Ramin Farahmandpur, Samuel Henry, Carlos Crespo, y Cheryl Livneh. Una nota de aprecio especial para Ramin, quien respondió rápidamente (¡siempre responde rápidamente!) y con esmero a mi primer correo electrónico a pesar de estar de sabático, y me dio una introducción a la pedagogía crítica y una lista de lecturas que me ha guiado desde entonces. También ha tenido la gran gracia e humildad, como pedagogo crítico y académico, de apreciar y aprender de una profesional práctica y una educadora popular.

Dedico esta tesis de una forma muy especial a los miembros del Equipo de Proyecto La Palabra es Salud. Una de las razones principales que decidí quedarme en Portland y estudiar en PSU era mi deseo de poder ubicar mi trabajo académico en contextos que conozco bien, y de hacer un trabajo que fuese útil para las personas y las causas a las cuales he dedicado mi carrera profesional. Estaba llegando al final de los cursos requeridos y pensando seriamente en contextos para mi tesis cuando me topé con Catherine Potter, la Directora del Programa de Promotores de Salud de la Iglesia (PPSI) para el lado este de Portland. La ruta por la cual esa plática se dirigió al final a La Palabra es Salud (LPES) se explica más tarde en esta tesis; decimos por ahorita

que, si Catherine no hubiera sido dispuesta a considerar esta colaboración, LPES nunca hubiera existido y este tesis en particular nunca hubiera sido escrito.

Muy rápidamente después de esa primera conversación, la colega de Catherine, Adela Hughes, la Directora para el PPSI para el lado oeste de Portland, se hizo central a este proyecto. Por el hecho de que el próximo curso del PPSI se iba a llevar a cabo en el lado del oeste, fue Adela que tenía que estar de acuerdo en participar en el proyecto de investigación. Y más. Mientras se fue diseñando la investigación, llegó a ser claro que, para que se llevara a cabo la investigación, Adela iba a tener que comprometerse a hacer algo que había dicho que jamás iba a volver a hacer: realizar dos cursos de capacitación simultaneas. Ella se comprometió a la idea con su gracia típica, y aguantó la presión con una ecuanimidad enorme. Conducir dos cursos a la misma vez se hizo mucho más fácil por la presencia de Adriana Rodríguez, quien se juntó al proyecto en el verano antes de comenzar la capacitación como Coordinadora Asistente. Como una promotora de la primera generación del programa del lado del oeste, Adriana, quien desde entonces ha obtenido su Licencia en Salud Comunitaria en PSU, fue la persona ideal para demostrar a los promotores las metas que ellos podrían obtener. También fue una estudiante muy apta de la educación popular, y para enero de este año ya estaba co-facilitando talleres de educación popular. Adriana aprovechó la más posible de la capacitación que le ofreció Teresa, quien era miembro también del Equipo del Proyecto y la facilitadora de la mayoría de las sesiones de educación popular.

Es imposible hacer investigación participativa basada en la comunidad sin la comunidad, y en este proyecto la comunidad se representó por una Mesa de Asesoría compuesto de promotoras del PPSI con experiencia y lideres de algunas de las parroquias que participan en el programa. Quisiera expresar mi gratitud a Zoraya, Delfina, María, Laura, Lydia, el Diacono Bill y el Padre David, quienes todos compartieron de su tiempo, sabiduría, y compasión. En adición a ayudarme a entender lo complejo de los datos cualitativos que había colectado, también ellos me ayudaron a preparar para la defensa de mi tesis, haciéndome preguntas difíciles acerca de los datos cuantitativos y sugiriendo las mejores formas para exponer los datos para que fuesen entendibles. También estoy agradecida con la Hermana Lynda y Rene Campagna, las supervisoras respectivas de Adela y Catherine, quienes ofrecieron su apoyo tanto como, en algunos casos, sus fondos para hacer posible este proyecto.

Una colega quien está contemplando hacer su doctorado recién me preguntó si mis supervisoras en el Depto. de Salud del Condado de Multnomah habían apoyado mi deseo de seguir con mi educación. Lo hicieron; diré más acerca de eso en un momento. Pero mi primer pensamiento cuando me hizo la pregunta era que el apoyo que más necesitaba para volver a la escuela era el apoyo de mis colegas inmediatas en el Centro de Capacitación Comunitaria. Ese apoyo comenzó antes de que comencé el programa. Mientras yo estaba considerando aplicar al programa, Teresa y mi colega Pam Hiller y yo estábamos manejando en el I-84, regresando de un curso de capacitación en la Reserva Indígena de Umatilla. Yo estaba contemplando la posibilidad asombrosa de combinar mi trabajo de tiempo completo con estudios de

tiempo completo, y no estaba sintiendo muy valiente. Pero Pam y Tere, a quienes nunca les falta una opinión, no tenían dudas. Yo podía hacerlo, yo iba a hacerlo, y ellas estarían allí de porras en mi graduación. Su apoyo nunca ha faltado, aun cuando requería tomar la responsabilidad para algunas tareas burocráticas como por ejemplo monitorear a contratos para que yo pudiera aceptar una beca y pasar cuatro meses en América del Sur. Desde entonces, la lista de colegas que me han ofrecido su apoyo ha aumentado, y ahora incluye Elizabeth Rees Morgan, Samantha Kaan, y Rujuta Gaonkar, todas las cuales han hecho posible este trabajo con sus contribuciones especiales. Tanto Samantha como Rujuta trajeron sus perspectivas únicas y valiosas al Equipo del Proyecto, participando como miembros de este grupo en fases diferentes del proyecto. Elizabeth participó también, entrando los datos de las evaluaciones en la base de datos y preparando reportes.

Dicho todo eso, mi dedicatoria sería seriamente incompleta si no reconociera el apoyo de Consuelo Saragoza, mi supervisora inmediata durante todo el transcurso de mi programa del doctorado, y Lillian Shirley, la Directora del Depto. de Salud del Condado de Multnomah. Consuelo apenas hizo gesto cuando le dije que quería pasar cuatro meses en América Latina investigando como la educación popular había cambiado desde que yo regresé a los EEUU en 1990. Uno podría pensar que, ya a esas alturas de nuestra relación de colegas, ¡nada que yo podría decir hubiera sorprendido a Consuelo! Pero me gustaría más explicar su reacción haciendo referencia a su propio compromiso con aumentar la capacidad y mejorar la salud de la comunidad Latina. De la misma manera, aunque tal vez nunca se quede de acuerdo

con la palabra, “capacitación,” el apoyo de Lillian para el Centro de Capacitación y el trabajo que hacemos, durante 10 años consecutivos de cortes de fondos en el Condado, resulta de su propia dedicación a cambiar las condiciones injustas que producen las desigualdades de salud.

Mientras colegas, supervisoras, profesores y asesoras comparten partes importantes y significativos de la jornada de obtener el grado de doctora, una parte única de esa jornada se comparte con y es hecho posible por los familiares y amigos que cocinan la comida, riegan las plantas, lavan los trastos, y aguantan los berrinches para que otra familiar o amiga pueda gastar el esfuerzo requerido para ganar el grado. Mi regreso a la academia fue hecho más agradable por la presencia de mi amiga y colega de muchos años Carmen Gutiérrez, quien regresó conmigo de El Salvador cuando yo visité en el 2003 y paso su primer año en los EEUU viviendo en mi casa. Un educadora popular y organizadora comunitaria experta, Carmen hizo muchos platos de plátanos fritos con frijoles y crema y un plato exquisito de brócoli mientras yo leí las lecturas requeridas y escribí los ensayos requeridos por el currículo central. Carmen, ¡nunca pensaré en mi primer año en el programa sin pensar en ese plato de brócoli!

Durante los últimos tres años, mis pasiones académicas tanto como mi necesidad de comida y diversión han sido apoyadas por mi compañera de vida, Marjorie McGee. Estos tres años también han coincidido con sus primeros tres años en el programa del doctorado en Trabajo Social e Investigación Social en PSU. Mientras algunos podrían decir que el tener dos miembros de una pareja haciendo sus doctorados al mismo tiempo es una receta para derrota, nosotras hemos escogido verla como una

oportunidad para aprender y apoyar la una a la otra. Su pasión de Marjorie para los mismos modelos y métodos que animan a mi trabajo – educación popular, promotores de salud, investigación participativa – ha servido para renovar mi fé cuando comenzaba a tambalear, y asegurarme que el esfuerzo que yo estaba gastando valía la pena. De una forma más concreta, las habilidades de Margie de crear bases de datos para entrar datos y luego exportar los datos a SPSS me ahorraron muchas horas de frustración y probablemente, ¡dinero que hubiera gastado en asistencia técnica!

Regresando a donde yo comencé, me gustaría dedicar este trabajo a los promotores y las promotoras de salud del Programa de Promotores de Salud de la Iglesia de la promoción del 2008. Como saben Karen y otros colegas, yo tenía al principio algunas dudas grandes con la idea de intervenir en las vidas de otra gente en la forma que requiere un diseño de investigación cuasi-experimental. Mis inquietudes se calmaron por medio de pláticas con otros académicos en cuya ética yo tenía confianza, y por medio de mis colegas en el Equipo de Proyecto, quienes ayudaron a asegurar que todos los participantes tendrían una experiencia positiva y empoderadora. Aun así, siento una deuda grande con los miembros de los dos grupos experimentales, quienes participaron en la capacitación, llenaron las encuestas, y (en algunos casos) participaron en la entrevistas solamente porque desearon ser más útiles a sus comunidades. Ellos demostraron el mismo espíritu optimista y pureza de motivación que han poseído la gran mayoría de los promotores que yo he conocido en mi vida. A todos/as ustedes, con la esperanza que pueda fortalecer tu trabajo, ofrezco este trabajo.

Pues que le doy gracias a Dios que me puso en ese camino y que si Dios quiere vamos a sacarle mucho provecho a ese curso, a esas pláticas, a esas entrevistas, a todo lo que tuvimos, le vamos a sacar el jugo, como le dicen por ahí.

Well, I give thanks to God for putting me in this path, and God willing we are going to get a lot of benefit out of this course, out of these discussions, out of these interviews, out of everything we had, we are going to “get the juice out,” as they say over there.

- Lupe, participant in the popular education course

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Frontispiece: The Meaning of the Name

I love the double, triple and even quadruple meanings to which the Spanish language seems to lend itself. Take the title of this project, *La Palabra es Salud* (The Word is Health). In the context of the Catholic parishes where the project was carried out, “La Palabra” means the Word of God, which according to Saint John was in the beginning, both with God and God him- (or her- and it-) self. Then there’s the more colloquial sense, “the word” as “the word on the street”; *eh chavo, carnal, pay attention to this, this is important*. Also, in the context of the larger health literacy study within which this study was first conceived, “la palabra” makes reference to the value of the ability to read and understand and act on health information, which is connected to the larger task of being able to negotiate our incredibly complex health care system.

But there’s a deeper meaning, one I only understood intuitively until I had a talk with my colleague Olivia Quiroz, who is both a Community Health Worker and a leader of MECHA, the Movimiento Estudiantil Chicano de Aztlán, the Chicano student movement that grew out of the Brown Berets’ activism in the 1960s. According to Olivia, for members of indigenous communities in Latin America, *la palabra* is something that special people have, community leaders, and only they are able to pass this knowledge and leadership on to the next generation, who will keep it alive and use it to the benefit of their communities. Like many aspects of indigenous culture, this meaning is passed on in the context of Latin American leftist movements

(many of which use popular education), where one asks for the right to speak by saying, *Pido la palabra*, “I request the word.”

Finally, the title *La Palabra es Salud* is an *homage* to an earlier program, *Poder es Salud*/Power for Health, on which this program builds. That program sought to improve health and decrease health disparities among African Americans and Latinos through the intervention of Community Health Workers who used popular education. The title took advantage of the double meaning of the word *poder*, which as a noun means *power* and as a verb means *to be able*.

So, *la palabra es salud*. Maintaining your connection to God and the spirit keeps you healthy. Knowing where you came from makes you healthy. Keeping traditions alive keeps you healthy. Sometimes, appropriating the knowledge of the dominant culture, including its language and the secrets of its priesthoods, keeps you healthy. Especially if you use it to help the community. Especially if you pass it on.

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CHAPTER I: INTRODUCTION

Es posible conceptualizar la metodología de la educación popular aplicada a la educación para la salud como un proceso de formación y capacitación que se vincula a la acción organizada de la población con el objetivo de construir una sociedad de acuerdo a sus intereses (Arenas-Monreal, Paulo-Maya, & Lopez-Gonzalez, 1999, p. 115).

It is possible to conceptualize the methodology of popular education applied to health education as a process of formation and capacity-building that is linked to the organized action of the population with the objective of constructing a society that is in line with their interests.¹

Background and Significance

Popular education, from the Spanish “educación popular,”² is a mode of teaching and learning which seeks to bring about more just and equitable social, political, and economic relations. Consistent with the Spanish and Portuguese definitions of “popular” as “of the common people,” popular education emphasizes the value of the knowledge that common people gain through life experience and seeks to create situations in which common people can discover and expand their knowledge and become active subjects in the construction of history. Through the use of interactive

¹ Translations from the Spanish and Portuguese throughout this paper are by the author.

² The Portuguese equivalent is similar: *educação popular*.

techniques such as *dinámicas* (social learning games), *sociodramas* (social skits), brainstorming, simulations, and problem-posing, popular education draws out and validates what participants already know and do, connects their personal experience to larger social realities, and then supports participants to work collectively to change their reality. Unlike traditional or conventional education, where the teacher is considered to be the expert, in popular education students are regarded as having their own expertise. Popular educators are encouraged to create educational settings that prefigure the society they are attempting to create, by treating students as equals and embodying values such as compassion, humility, and commitment to the cause of the people.

Because of its emphasis on the capacity of members of oppressed groups to author their own destiny, popular education eschews political and pedagogical dogmatism (Gómez and Puiggrós, 1986) and maintains a shifting, sometimes uneasy relation to hierarchical political parties and organizations. However, popular education has played a critical role in social movements as diverse as the Landless Rural Workers' Movement in Brazil, the Frente Faribundo Martí revolutionary movement in El Salvador, and movements for women's and indigenous rights throughout Latin America. Popular education is arguably the most important educational philosophy and methodology indigenous to Latin America; it has also been important to struggles for social justice in the U.S. Popular education's best known proponent, Paulo Freire, has been referred to as the most important educator in the world during the last half of the twentieth century (Kohl, 1997).

Despite its pivotal role in history, popular education is largely unknown in the United States, outside of a relatively small group of informal educators working mostly in Latino immigrant communities. As Donaldo Macedo (2003) points out in his introduction to the 30th anniversary edition of Freire's *Pedagogy of the Oppressed*, it is possible to get a doctoral degree from the Harvard Graduate School of Education, where Freire once taught, "without ever learning about, much less reading, Paulo Freire" (p. 16). When popular education is occasionally acknowledged by U.S. educators, it is largely relegated to the realm of educational foundations (Giroux, 1985).

If it were possible to bring popular education to a wider audience in the U.S., increased awareness about and use of popular education could benefit multiple groups. For public school teachers, popular education could provide concrete alternatives to current trends that encourage "teaching to the test" and could also assist them in resisting their own deskilling. For educators in a variety of settings, it could make the underlying philosophy and principles of critical pedagogy more accessible and offer practical examples of how to apply those principles in the classroom. Popular education has the potential to help students develop increased self-esteem and the critical thinking skills they will need to confront the challenges of a complex and globalized world. With deep theological and spiritual roots, popular education could help break down the false dichotomy between spirit and intellect in Western education and offer a mechanism for bringing spirituality into the classroom without introducing religious doctrine. This change is likely to produce particular benefits for members of

marginalized groups, who can feel alienated when asked to split their emotional and intellectual lives (hooks, 2003). The popular education practices of creating space for the expression of diverse values and beliefs, de-privileging philosophies and methods from dominant culture, and helping oppressed groups work for change could also benefit students who are not from the dominant culture. Perhaps most significantly, popular education offers community organizers and political activists effective strategies for organizing across lines of race/ethnicity, class, gender, and sexual orientation to oppose neoliberalism³ and corporate globalization and create a more just and equitable world.

With the election of Barack Obama as President of the United States and the nomination of Sonia Sotomayor to the nation's highest court, it is tempting to think that the philosophy and methods of popular education are no longer as urgently needed as they were during the presidency of George Bush. However, nothing could be further from the truth.

So-called "free trade" agreements negotiated under previous administrations still force small farmers in many parts of the developing world to abandon their land and move to the cities to find work (Asociación Equipo Maíz, 2003). Democratically-elected presidents like Manuel Zelaya of Honduras are still being deposed in armed

³ The term "neoliberalism" refers to an economic and political philosophy which developed in the 1970s. Its most prominent advocates are Milton Friedman, Friedrich Hayek, and the so-called "Chicago School." Proponents of this philosophy believe that, far from preserving the capitalist system, the massive government intervention in the economy which took place after the Great Depression of 1929 actually caused greater problems. They believe that "liberal," free markets work perfectly. Thus, they seek to resurrect the laissez faire policies of the 19th century, without, however, resurrecting the original liberals' concern for the general welfare of the populace (Aguilar, 1992; Stiglitz, 2003).

coups, which are then justified based on the leader's supposedly undemocratic actions (Thompson, 2009). In order to save jobs in their districts, "liberal" U.S. members of Congress restore unnecessary weapons to defense appropriations, despite the principled opposition of the Secretary of Defense (Bumiller, 2009). Undocumented immigrants detained in raids at the twilight of the Bush Administration remain caught in legal limbo, unable to work to support their families and with no immediate hope of immigration reform (Rios, personal communication, May, 2009). Major banks like Goldman Sachs return to profitability and to the practice of giving huge bonuses to their employees, unfazed by their responsibility for the global economic recession and untrammelled by any substantive new regulations (Krugman, 2009). From Multnomah County, Oregon, to the state of California (Steinhauer, 2009), local and state governments, faced with budget shortfalls in the billions of dollars, are being forced to make ever deeper cuts in essential public services. As always, those most affected by these cuts are those at the bottom of the economic ladder.

Also, while the election of President Obama and the nomination of Judge Sotomayor can serve to renew our faith that change is indeed possible, we should also remember that these recent, bracing events are the result of long political struggles, some of them animated by popular education. Like almost all Latin American countries, Judge Sotomayor's Puerto Rican homeland has its own tradition of popular education (Serrano-Garcia, 1984). The Civil Rights Movement that paved the way for the accession of President Obama was likewise nurtured by a uniquely American version of popular education (see below, "Myles Horton.") In a more general way,

President Obama's background as a community organizer reinforces the importance of the kind of slow, steady, political consciousness-raising and community development for which popular education is extremely effective.

Public health education and promotion offers a particularly propitious setting in which to bring popular education to a wider U.S. audience. In contrast to its relative absence in the academic literature of other disciplines, popular education (also referred to as Freirian and empowerment education) in its Latin American form has been used and documented in public health since the early 1980s (Minkler & Cox, 1980).

The use of popular education in public health has been integrally connected to the development of what Robertson and Minkler (1986) term the "new health promotion movement." This movement has sought to take public health back to the focus on the social causes of illness which engaged some of the earliest public health practitioners (Eisenberg, 1984). Throughout most of the 20th century, the development of the medical profession and discoveries about links between individual behavior and health shifted the focus towards preventing and curing disease in individuals, as opposed to changing the conditions that make whole communities ill. However, in its 1986 Ottawa Charter on Health Promotion, the World Health Organization (WHO) took a new direction, defining health promotion as "the process of enabling people to increase control over, and to improve their health" (Nutbeam, 1998, p.351). While the new health promotion movement generally encourages a focus on the social determinants of health, particular theorist/practitioners caution against exchanging biological determinism for social determinism. Consistent with interpretations of

Marxism that stress human volition, they emphasize the power that people in communities possess to change their situation and improve their health (Robertson & Minkler, 1986).

Popular education and the new health promotion movement share many theoretical foundations and some of the most respected proponents of the new movement have been strongly influenced by Paulo Freire (Minkler & Cox, 1980; Wallerstein & Bernstein, 1988). Popular education and health promotion also share historical and theoretical roots and proponents with the approach to knowledge production that I employed for this study, namely, community-based participatory research (CBPR) (Wallerstein & Duran, 2003).

Focusing on the use of popular education in health promotion is particularly appropriate for me, since public health is the context in which I first learned to use popular education and the context in which I have used it for more than 20 years. In order to provide a basis for assessing the claims I will make in this dissertation, in the following section I will locate myself relative to my topic and reflect on how my positionality affects the way I view and practice popular education.

Student's Interests Relevant to This Issue

I was born into a middle class family of Anglo-European descent living in a mid-sized city in Texas in the early 1960s. Due to the extreme racial/ethnic segregation that was prevalent, I had little contact with the large Latino (primarily Mexican-American) community in my hometown until I was 18, when, in the context of a summer job, I began to develop personal relationships with members of the

community and learn Spanish. Thanks to financial aid, I was able to step fairly far outside the expectations and experience of my family and attend an Ivy League university, from which I graduated with a B.A. in History in 1983.

After moving to Oregon where I obtained a bilingual elementary teaching certificate, I spent the years 1986-1990 living and working in the poorest department (state) in El Salvador. As a volunteer with a U.S.-based non-governmental organization, I was assigned to a Catholic pastoral team that served a parish in a contested border zone just south of the Torola River in Morazán. Unlike the pastoral teams in Northern Morazán, the team with which I worked was not allied with the FMLN, the coalition of guerilla groups at war with the Salvadoran government and military; however, it was strongly influenced by Liberation Theology (see below) and generally supported the goals of the revolution. My initial responsibility was to help train and support *promotores de salud* (known in English as Community Health Workers⁴). Later, we initiated a literacy program. Although I had begun to read Freire during college, it was from my Salvadoran (and a few North American) co-workers that I learned to use popular education. Thus, my conception of popular education is most strongly influenced by the particular expression of the philosophy/methodology developed by pastoral workers and popular organizations in Central America in the 1980s.

⁴ Community Health Workers are carefully chosen community members who promote health and social justice in their own communities. Their professionalism is based on their life experience rather than on formal training (Giblin, 1989).

While in El Salvador, I observed Salvadoran educators with only a second or third grade education perform absolute miracles of pedagogical practice, teaching 40 or 50 children to read quite effectively using only a stubby piece of chalk and a door painted black. I was strongly influenced by the idea that one's actual usefulness to a social movement is inversely proportional to one's level of formal education. Thus, I returned to the U.S. in 1990 with a perhaps unhealthy degree of anti-intellectualism, but an extremely healthy awareness that there is absolutely no inherent relation between the level of one's formal education and one's knowledge and ability. By 1995, I had overcome my disregard for formal education sufficiently to move to Boston to obtain a Master of Science degree in Public Health.

Since returning to the U.S., I have practiced popular education principally within the context of health promotion projects involving Community Health Workers (CHWs). Initially, I worked almost exclusively in Latino immigrant communities, although from the start my co-workers and I made conscious attempts to connect our practice to the practice of CHWs working in other communities and build alliances with them. Since moving to Boston and from there to Portland, Oregon, where I now work, I have practiced popular education in a variety of racial/ethnic communities, including the African American, American Indian, Anglo-European, Slavic, and African immigrant communities, as well as the disability community.

Currently, I direct the Community Capacitation Center (CCC), a health promotion program that is part of the Multnomah County Health Department (MCHD). My co-workers and I use popular education in our work in five primary ways. First, we use it

to assist CHWs to enhance their skills in a wide variety of areas, increase their knowledge of health issues and the health care system, and build their own personal and community power to identify and address issues and problems, including attacking the roots of these problems in the larger racist, classist, and sexist system. Second, we assist multiple groups to learn to use popular education in their own work. Third, we use popular education to conduct culturally-specific health promotion in a variety of communities. Fourth, we initiate and conduct community-based participatory research (CBPR) projects that use popular education and the CHW model as their primary strategies. Most recently, we have begun to use popular education as a strategy for organizational change, in the context of a major change management process intended to increase empowering health promotion throughout MCHD.

The nature of my life experience has several implications. My professional location for the last twelve years within a government bureaucracy means that, like Mayo (1999) and Freire (2002) before me, I have been attempting to use popular education within the existing system to change that system. As a non-Latin American, I speak and write from the position of “Other” vis-à-vis the particular version of popular education which has had the strongest influence on my own practice. As someone who has witnessed the power of popular education to transform individual lives and whole communities, I approach the phenomenon of popular education as an advocate. Because I concur with Lather (1983) that there is no such thing as an objective social science, I believe that as long as I declare my position and take steps

to protect my research from my “enthusiasms and incompetencies” (Lather, 1983, p. 67), my ideological commitments can strengthen rather than weaken the usefulness of my conclusions.

Support for my position that my experience can be an asset and some amount of guidance on how to use it as such comes from a variety of qualitative researchers and critical ethnographers. Maxwell (2005) proposes that the personal experience which has been viewed from a positivist perspective as “bias” can actually be “a major source of insights, hypotheses, and validity checks” (p. 38). This is true in my case, in the following way. Tashakkori and Teddlie (1998) describe the research cycle as leading from “observations, fact, [and] evidence,” through a process of inductive reasoning to “generalizations, abstraction, [and] theory,” from there to “prediction, expectation, [and] hypothesis” and finally, through deductive reasoning, back to further “observations, facts, [and] evidence.” In the process of using popular education for more than 20 years, I have gathered numerous observations, facts and evidence, which have led me to make certain predictions, expectations, and hypotheses. When I conduct research, I test these hypotheses through a process of deductive reasoning, producing yet more facts. This is the essence of the scientific method; the only difference is the source of my hypotheses, which are drawn from experience as well as literature. But because experience may be more compelling than literature, when I use qualitative methods where I am the instrument of the research, I must take particular care to practice “critical reflexivity,” which Anderson (1989), building on Lather (1986), defines as “self-reflective processes that keep [a] critical

framework from becoming the container into which the data are poured” (p. 254). A process through which we acknowledge our perspective and seek to interrogate it is, I believe, a substantial improvement over the classic positivist position since, according to Maxwell (2005), “any account is a view from some perspective, and therefore is shaped by the location (social and theoretical) and ‘lens’ of the observer” (p. 39). In Chapter III, I will explain how I sought to avoid bias, both in my choice of methods and my conduct of those methods. In Chapter V, I will practice critical reflexivity in the section titled, “My Positionality.”

Outline of the Dissertation

In Chapter I, I have provided an introduction to popular education and explained the potential benefits of wider use of popular education in the industrialized world. Additionally, I have provided a rationale for using public health as a venue and vehicle for bringing popular education to a wider U.S. audience and explored my own positionality vis-à-vis popular education.

In Chapter II, I will first review the historical events and theoretical foundations that underlie popular education, culminating in a list of popular education principles drawn from my research. This done, I will explicate some of the similarities and differences between popular education and adult education as practiced in the industrialized world and define the construct of “traditional education.” Next, I will assess the existing evidence about the effectiveness of popular education for increasing empowerment (which I will define later in the paper) and promoting health.

I will discuss what is known and not known, as well as identifying gaps, disagreements or conflicts in the literature.

Chapter III begins with a discussion of the research paradigm I employed in *La Palabra es Salud*, and provides background on the context of the study. The remainder of the chapter details the methodology I used to conduct the study and includes a description of the participant population at baseline and follow-up. In Chapter IV I report on the results of the study, and in Chapter V I summarize the findings and discuss their implications for a variety of groups. I also reflect on my own positionality and on doing research in the Latino immigrant community. The chapter closes with a discussion of the limitations of the study and my suggestions for future research.

Purpose of the Study and Research Questions

The purpose of *La Palabra es Salud* was to explore the potential of popular education for greater use in the U.S. and the industrialized world, by rigorously comparing the relative effectiveness of popular education and traditional education for increasing skills and knowledge and empowering participants. Additionally, this study sought to determine what elements of popular education may contribute to its effectiveness and what benefits and costs may accrue to a CHW training program as a result of being involved in research. Specifically, I sought to answer four primary research questions and two secondary research questions:

Primary Questions

1. Is type of instruction (popular education vs. traditional education) associated with any changes in health knowledge and skills, psychological empowerment, self-reported health status, and health behavior among participants in a parish-based Community Health Worker training program? If so, what is the nature and strength of the association?
2. Do any changes from baseline to follow-up among parish-based CHWs who participate in training differ systematically from temporal changes that may occur among members of a comparable parish community who do not participate in any type of training?
3. From the perspectives of the participants and the researcher, how does popular education work, if it does? What elements of popular education contribute to its differential effects, if indeed these exist?
4. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of the CHWs' participation in training? Do these self-reported outcomes differ as a result of the type of training that is used?

Secondary Questions

5. From the perspective of the researcher and the project team, what costs and benefits accrue to a CHW training program as a result of being involved in a research project?
6. From the perspective of the CHWs and the researcher, what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training?

CHAPTER II: THE LITERATURE

With the goal of exploring the potential of popular education as a tool to increase knowledge and skill and empower participants, I conducted a review of the published historical, theoretical/conceptual, and empirical literature in the field. Due to the nature of my topic, I took a different approach to the different sections of my review. It is not enough to understand the history of popular education in a U.S. public health context; rather, one needs to understand the broader world historical forces that produced the methodology. Therefore, my review of the historical literature will focus on the development of popular education in Latin America before closing with a brief consideration of its use in North America. Similarly, to fully understand the theoretical framework that underlies popular education as it is used for health promotion, it is necessary to understand the broad range of philosophical and theological currents that came together to produce popular education. Thus, my review of the theoretical/conceptual literature will address popular education generally, as well as providing some specific information (in the subsequent section) about theory that underlies popular education in a health promotion context. In my review of the empirical literature, I will focus on popular education as it has been used for health promotion, for two reasons. First, there is relatively little empirical literature in any language about popular education outside a health context. Second, there is so much empirical literature about popular education in a health context that expanding the review further was prohibitive. The arrangement of the three sections in my review is consistent with the popular education practice of beginning with

practice (the historical literature), adding theory (the theoretical literature), and then returning to practice (the empirical literature).

The Historical Literature

Lather (1983) states that one of the three characteristics of emancipatory theory is that it “seeks to historicize the present” by showing how what is came to be and identifying “both the beneficiaries of present arrangements and the unintended outcomes of human action” (p. 42).

In this section I will construct a theoretical argument about the origins of popular education. The heart of this argument is the assumption, characteristic of Lenin’s theory of imperialism (Wallace & Wolf, 2006), that the unequal conditions existing between the global North and the global South, and likewise between the upper classes in Latin America (and the U.S.) and the working classes, are the result of the systematic pillage of resources from the colonies by the colonialist countries to build the capitalist system. While it is my contention that some of the practices and values that characterize popular education – demonstration and practice, storytelling, sitting in circles rather than rows, an emphasis on communal rather than individual endeavor – were integral to pre-Columbian indigenous communities in Latin America, I propose that the majority of the practices and values of popular education developed as a direct response to the inequities and oppression that have dominated the history of the Americas since the Conquest.

During the Colonial period in Latin America, the imperative to quickly exploit the land, combined with the colonizers’ advantages such as horses, firearms, new diseases,

and an alliance with the Church, produced a vast gap between the poor (who tended to live in the countryside, be of indigenous or African heritage, and lack formal education) and the wealthy (who were generally well-educated city dwellers of European descent) (Galeano, 1973). With some exceptions (notably Jesuit and Dominican friars and priests), those in power systematically denied education and health care to the poor in order to maintain their control. Following the wars of independence in the early 19th century, some Liberal governments began to promote government-sponsored primary education for all (Bralich, 1994). These early experiments in “popular education” were heavily influenced by the desire to “Europeanize” Latin America which was common among even the most progressive Latin American leaders of the time (Burns, 1980). Universal primary education was viewed as a way to civilize the indigenous people, who were seen as totally lacking in culture (Bralich, 1994). Set up along European (primarily French) models, the education system embodied what Freire (2003) would later call “banking education” in that it created a strictly hierarchical relationship in which the student was expected to passively imbibe the learning proffered to him by the teacher.

A similar desire to civilize common people fueled some of the first attempts at “popular education” conducted by young Latin American socialists and Communists during the early part of the 20th century. For example, the “Popular University” established in El Salvador in the mid-1920s by the Regional Federation of Workers had as one of its goals to “elevate . . . the culture of the popular masses” (Gómez &

Puiggrós, 1986, p. 36). A high degree of dogmatism typical of the Communist parties of the time also influenced some of the teaching in the popular universities.

However, in other ways the experiments in popular education that took place during the 1920s and 1930s represented a radical departure from past practice and introduced some key elements of popular education that persist until today. Many of these efforts were influenced either directly or indirectly by the writing of José Carlos Mariátegui, a well-educated Peruvian who remains one of the most important interpreters of Marxism within a Latin American context. Unlike even the most sympathetic 19th century elites, Mariátegui (1981) traced the roots of Latin American underdevelopment to the destruction of indigenous communism and the decimation of the Indians by the colonizers. He believed that the Indians themselves had to be the authors of a solution to the so-called “Indian problem” (p. 33).

A desire to rescue and protect indigenous culture inspired programs of indigenous education such as the Instituto Bíblico Quiché, established in Guatemala in 1913, and the Escuela Ayllú, founded by the Bolivian Elizardo Perez in 1931 (Gómez & Puiggrós, 1986). Popular universities like those established in El Salvador in 1920 and Perú in 1921 had the clear aim of educating the common people for the project of liberation. In addition to providing instruction in a wide variety of subjects and exposure to socialist practices such as self-criticism, the popular universities also sponsored celebrations and excursions to tourist sites that were attended by entire communities and featured speeches, songs, and poetry. The importance of

convivencia (literally, “living together) which strengthens the social fabric of communities remains a key aspect of popular education today.

Latin Americans better known for their political and military leadership also made important contributions to the development of popular education. Motivated by his desire that all his soldiers should know how to read and write, Nicaraguan revolutionary leader Augusto Sandino established the Academy of El Chipote en 1926 (Gómez & Puiggrós, 1986). The Academy emphasized the importance of improving practice (in this case, military practice) through collective reflection in which officials and soldiers participated as equals, and the discovery of new methods through necessity. Mexican Lázaro Cárdenas promoted the development of socialist education during his presidency from 1934-1940 (Becker, 1995). The role that Cárdenas assigned to primary and secondary school teachers – to teach adults to read and write and mobilize them to take advantage of land reform – prefigured the role that Paulo Freire would envision for adult educators three decades later.

It was in this milieu of rapid social and religious change in Latin America that the Brazilian Paulo Freire began his work in adult literacy. Born in 1921, Freire grew up in an area of Northeastern Brazil that had been ravaged and left destitute by the production of sugar (Galeano, 1973). His middle class family fell on hard times during the economic crisis of the 1930s and Freire experienced hunger (Gadotti, 1994). Partly due to his family’s circumstances, Freire had difficulty in school; nonetheless, he began to teach while still in high school. An initial position as a teacher of Portuguese grammar led to positions with the Social Service of Industry

(SESI) and the Cultural Extension Service of the University of Recife. In 1964, Freire was in the midst of the first large-scale implementation of his literacy methods when a military coup forced him to flee the country. Freire lived and worked in Chile, Switzerland, the United States, and Africa and finally returned to Brazil in 1980. Before his death in 1997, Freire had served as Secretary of Education for the city of São Paulo and written over 20 books.

As the meaning of popular education in Latin American has changed from an anti-clerical, elitist effort to extend primary education to indigenous people as a means of civilizing them, to a specific methodology and philosophy which aims at creating a more just and equitable society, popular education has become intimately connected to a variety of social and revolutionary movements. Indeed, some authors assert that popular education cannot meaningfully exist outside the context of social movements (Wallerstein & Auerbach, 2004). Following the triumph of the Nicaraguan revolution in 1979, the Sandinista government launched a massive adult literacy campaign based on popular education principles. Popular education programs undertaken by El Salvador's Farabundo Martí Front for National Liberation (FMLN) recalled Augusto Sandino's efforts to teach his soldiers to read and write between battles (Hammond, 1998). More recently, Mexico's Zapatistas and Brazil's Landless Rural Workers' Movement have used popular education extensively in their efforts to raise consciousness and organize people to reclaim their rights.

Space precludes a full consideration of the historical factors which led to the creation of a uniquely North American version of popular education, as well as those

which motivated educators influenced by Latin American popular education to adapt it for use in the North American context. A history of progressive education in the U.S. is also far beyond the scope of the present study. However, it is possible to say that the North American form of popular education, best exemplified by Myles Horton and the Highlander Research and Education Center (previously, the Highlander Folk School), developed as a response to situations of oppression and inequity, just as in Latin America. Progressively during its 75 year history, the Highlander Center has served and been influenced by labor leaders fighting oppression of workers, civil rights leaders battling racism and denial of citizenship to African Americans, rural whites affected by the stigma and classism directed towards people from the Appalachian Mountains (Horton, 2003), and increasingly, undocumented immigrants from Latin America struggling against xenophobia and for their rights to remain and work in this country (Highlander Research and Education Center, 2008). Similarly, efforts to adapt and apply Latin American popular education in North America have been primarily conducted by people working with oppressed members of society: English as a Second Language and adult literacy instructors, labor organizers, community organizers, and high school and community college teachers in poor, urban areas (Wallerstein, 1988). Finally, applications of popular education in a health context have also taken place principally among people who experience marginalization, including migrant and seasonal farmworkers, American Indian and Latino youth (Wallerstein, 1988), homeless and formerly homeless women (Rivera, 2003), people with HIV (Williams

et al., 2005), and elderly residents of San Francisco's impoverished Tenderloin District (Minkler & Cox, 1980).

In both South and North America, popular education developed as a response to the systematic denial of authentic and effective education to members of marginalized communities, which in Latin America included the vast majority of society. It developed in opposition to the kind of traditional, authoritarian education that was implanted on both sides of the continent after the European Conquest. Finally, it developed as a philosophy and methodology to assist members of marginalized communities to change the distribution of power and resources within society and create a society that was in line with their interests.

The Theoretical/Conceptual Literature

Popular education makes some assumptions about the origins and purpose of theory which should be set out clearly before proceeding with a review of the theoretical and conceptual literature. First, it assumes with Youngman (1986) that, “. . . theory arises within the context of particular historical situations and contributes to changing them . . .” (p. 7). Thus, the particular historical conditions described above are seen to have produced popular education, and popular education is seen to have arisen partly with the goal of changing those conditions. Second, consistent with the emphasis in popular education on *praxis* or the practice-theory-practice spiral (Wallerstein & Auerbach, 2004), theory within popular education cannot stand on its own; it is only useful in so far as it provides guidance for action. Lather's (1983) statement about the role of theory in her project to create links between teacher

education and women's studies applies here as well: "Theory is a guide in our search for the intellectual tools relevant to our strategic task" (p. 42).

In pursuit of these intellectual tools, in the sections that follow I will identify some of the theorists who were most influential in shaping popular education, and provide an overview of the elements of their thought that most clearly influenced popular education. In the first section, I will briefly consider the political-philosophical grounding for popular education laid by Karl Marx and extended by Antonio Gramsci, as well as the political-religious underpinnings provided by Liberation Theology. In subsequent sections I will analyze in more depth the conceptual frameworks developed by Paulo Freire and Myles Horton and reflect on what the praxis of the Landless Rural Workers' Movement reveals about popular education theory in Latin America in the 21st century. At this point, I will present the intellectual tools culled from my search -- my own formulation of the basic principles of popular education -- before concluding with a discussion of similarities and differences between popular education and adult education and a definition of traditional education.

Early Influences

Karl Marx

The political theory that underlies popular education, as well as virtually all visions of radical change in Latin America, was and continues to be Marxism. In terms of the analysis of the problem, the Marxist line is clear and has been adopted with few changes by Latin American leftists and popular educators alike. This includes the analysis of oppression which states that people's individual experience of oppression

and injustice is the product of larger structural relations of oppression which uphold the capitalist system, and the interpretation of Latin American history that posits that Latin American underdevelopment is the result of the systematic pillage of the continent's natural resources in order to build the capitalist system in Europe and later in North America (Galeano, 1973). For popular educators (as well as other radical educators), the difficulty arises when one begins to consider the Marxist prescription for change. Here, the message is not nearly so clear, as I will explain further below.

Youngman (1986) provides a valuable summary of Marxist thought as it applies to radical adult education, though it should be noted that because Youngman is a radical adult educator, his summary is not, itself, free of ideology. As context for his analysis, he points out that the Marxist philosophical tradition is made up of various strains, some of which conflict with one another. "This is to be expected," he writes, "in a theory which regards contradiction as a source of development" (p. 47). Here, Youngman is referring to dialectics, a very old philosophical idea adopted by Marx and Engels which proposes that history progresses as apparent contradictions come together to produce a higher truth. The dialectical nature of Marxism explains, to a large degree, the controversies it has spawned. These controversies have clear implications for popular education.

The dialectical project at the heart of Marxism was the attempt to bring together the idealist philosophy of Hegel and the materialist philosophy of Feuerbach (Youngman, 1986). According to Hegel, there is a spiritual ideal which exists prior to phenomena. Materialism, conversely, holds that material things exist whether anyone thinks about

them or not and human consciousness occurs because of material factors like cells and neurons. Marx and Engels initially attacked Hegel using the philosophy of Feuerbach, accepting Feuerbach's conclusion that "thought arises from being – being does not arise from thought" (quoted in Youngman, p. 50). However, Marx also attacked Feuerbach for not taking into account "the active nature of human thinking" (Youngman, p. 51). Marx introduced the idea that consciousness results from the social and natural conditions of life *and* people's actions to change those conditions. According to Marx (1978), the alteration of nature (not simply nature itself) is the basis of human thought. In this case, nature refers to the world around us, as we find it (e.g. before we make any changes in it.) As Youngman writes, "Marx and Engels emphasized a materialist approach against the prevailing current of Hegelian idealism but they also criticized the materialism of Feuerbach for its reductionism and lack of social context" (p. 52). In summary, then, Marx's dialectical materialism does not posit that human beings are the passive recipients of sense impressions. Rather, while taking the material world as primary, it attributes to humans the capacity to interpret sense impressions based on their social position in the world. This belief undergirds Freire's social constructivist epistemology, as we will see below.

The related concept of praxis, which is central to popular education, is also derived from Marxism, though as Youngman (1986) points out, the word "praxis" can be traced back at least as far as Aristotle. Youngman defines praxis as "human activity through which people shape and are shaped by the world around them" (p. 55). He acknowledges that the importance of praxis in Marxism is contested, "raising as it

does the tension within Marxism between voluntarism and determinism” (p. 55). Gramsci, who was committed to the possibility of contesting the dominant ideology, equated Marxism with praxis (Youngman, p. 55). Youngman concludes that praxis is integral to Marxist thought and that the Marxist position is best summed up in the following passage from *The Eighteenth Brumaire*: “Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past” (Marx, quoted in Youngman, p. 57). Here again, we see Marx charting a middle course between idealism and determinism; people are active agents in the creation of history, but their activity is constrained by the circumstances around them.

According to Youngman (1986), the relationship between praxis and knowledge has three sides: praxis is the source of knowledge, the criterion for assessing whether knowledge is correct, and the objective of knowledge. Formulated slightly differently, all three ideas have become central to popular education. In popular education, educators are encouraged to begin with what people already know and do (their praxis). After supplementing praxis with theory and the knowledge of other participants, popular educators return to praxis, asking, “What will we do differently (how will our praxis change) based on what we have learned?” An example of how praxis provides the criterion for assessing whether knowledge is correct can be found in the ideology of Brazil’s Landless Rural Workers’ Movement (MST). Writing about the MST, Chilean sociologist Marta Harnecker (2002) states that, “it is in the

confrontation with practice that certain ideas are either incorporated or thrown away” (p. 219).

Marx’s conception of how ideology is produced and how it can be resisted has strongly influenced the conceptualization of popular education. According to Marx, the ruling class disseminates ideas that support and maintain its dominance, producing a state of false consciousness among members of the oppressed classes (Marx, 1978; Youngman, 1986). However, it is possible to resist the dominant ideology. In Youngman’s words:

The concept of ‘ruling ideas’ . . . does not suggest that individuals can achieve no critical distance from them. All it does imply is that the sheer social weight of these ideas transmitted through a variety of institutions makes a critical position difficult to achieve (pp. 67-68).

One way to achieve such a critical position is by making manifest the contradiction between the dominant ideology and the life experience of oppressed people. In my experience, this is one of the reasons popular educators seek to draw participants’ life experiences -- so that they can be used to achieve critical consciousness. Further, I would argue that the Marxist principle that “consciousness changes when the fundamental forms of social life change” (Youngman, p. 84), underlies the popular education principle that the social conditions of the classroom should prefigure the conditions of the society we are trying to construct, and the imperative to create horizontal relationships between teacher and students.

Marx's ideas about the effects of the mode of production on human development also have direct implications for popular education. In *The German Ideology*, Marx (1978) writes that while men can be distinguished from animals in any number of ways, it is when they begin to produce their means of subsistence that they begin to distinguish themselves from animals. In a much later work, Engels links human development to increasing manual dexterity and to the social intercourse which necessitated the development of language, both of which were the result of labor (Youngman, 1986). These ideas are clearly at the root of Freire's (1985) oft-repeated contention that by working, people change the world and produce cultural objects, and are thus cultured. However, just as labor can have a humanizing effect, it can also have a dehumanizing effect. According to Marx and Engels, the result of the increasing separation of manual and intellectual labor which accompanied the development of capitalism, along with the increasing specialization that accompanied industrialization, was the progressive deskilling and ultimate dehumanization of workers (Youngman, 1986). This state of affairs necessitated a form of education which could return to human beings the humanity that had been taken from them by capitalism. For Freire (2003), this is the ultimate purpose of what he refers to as "libertarian education."

Marxist conceptions about how knowledge is produced, the role of praxis, how ideology is created and can be resisted, and the effects of the mode of production on human development have all exercised a strong influence over the development of

popular education. In each case, popular educators have leaned away from materialism and towards an emphasis on human agency.

Antonio Gramsci

As Youngman (1986) suggests in the quotation on p. 27 above, Marxism in the early 21st century is by no means a unitary theory but rather a collection of philosophical strains created as successive generations of philosophers have interpreted Marx from their perspectives and for their times. One strain of Marxism which has had substantial influence on popular education is the strain created by the Italian Antonio Gramsci. Gramsci influenced popular education in two ways: directly, via his influence on Freire, and indirectly, via his influence on Latin American Marxists generally. Freire was introduced to Gramsci's *Literature and National Life* by Marcela Gajardo while he was in exile in Chile in 1968 (Mayo, 1999). He acknowledged his debt to Gramsci on various occasions; for example, in *The Politics of Education*, Freire (1985) writes that "Gramsci has profoundly influenced me with his keen insights into other cultures" (p. 182). The importance of Gramsci for popular education was his championing of a humanist Marxism which drew strongly on Hegel and his emphasis on the possibility of challenging and changing the dominant ideology.

The Marxist idea of base and superstructure – with economics at the base and politics and culture in the superstructure – has been interpreted by some Marxists to mean that work which occurs at the level of politics or culture (including education) is inherently less important. In the words of Lather (1983): "Those of us who work at

the educational level for social change have traditionally been regarded by Marxists as economically and politically impotent; our work has been dismissed as epiphenomena” (p. 38). Based on my own experience, taken to the level of practice, some community organizers adopt a similarly dismissive attitude towards the work of popular educators. Gramsci’s signal contribution in this regard was to “enormously raise the status of cultural/ideological struggle” with his concepts of hegemony and counter-hegemony (Lather, 1983, p. 39).

Mayo (1999) defines hegemony as “a social condition in which all aspects of social reality are dominated by dominant groups” (p. 35, drawing on Livingstone, 1976), while Lather (1983) calls it “the structures, activities, beliefs and ethics that interact to support the established order and the class, race and gendered interests which dominate” (p. 38). Hegemony can also be thought of as a process through which people are controlled without overt repression and influenced to act in ways that contradict their true interests. Freire’s (2003) idea that the oppressed carry the oppressor within them is another expression of hegemony. The hegemonic process of gaining consent is an educational process and schools play an important role in maintaining existing hegemony. However, hegemony is open to negotiation and therefore there is room for counter-hegemonic activity (Mayo, 1999).

Some resistance to hegemony is haphazard and ultimately “turns on itself” (Lather, 1983, p. 48). Counter-hegemony, conversely, is planned and conscious resistance. Like hegemony, it is “inherently educational work” (Lather, 1983, p.40). The starting point for counter-hegemonic work is the contradiction between what people have been

told about reality and their actual lived experience (Lather, 1983). This accounts, in part, for the emphasis placed within popular education on starting with people's lived experience. Not only does it make them feel more valued; it also produces the content to unmask the contradictions. According to the theory of counter-hegemony, social change depends on previously passive people becoming activated, since, "contrary to orthodox Marxists, the dynamic of social change is not the automatic crises produced by capitalism" but rather "the capacity of individuals to become aware of their situation and to work collectively for change" (Lather, 1983, p.40). Here, we see described virtually the entire popular education process of conscientization, which will be discussed further in the section on Freire.

How do intellectuals help people become conscious of themselves, overcome self-centeredness and "aspire toward a substantive democracy" (Lather, 1983, p. 40)? Gramsci's prescription strongly prefigures what Freire would write several decades later. According to Gramsci, intellectuals must also be open to learning as well as teaching. Liberating practice is based on the development of a reciprocal relationship where students are teachers and teachers are students (Lather, 1983). The creation of this relationship is not simply tactical; it is essential to producing emancipatory theory. In Lather's words:

Theory adequate to the task of changing not merely explaining the world must be open-ended, non-dogmatic, speaking to and grounded in the circumstances of everyday life and premised on a deep respect for the intellectual and political capacities of the dispossessed (p. 41).

I recognize principles such as resistance to dogmatism, openness to a variety of influences, and the importance of maintaining a strong connection to dispossessed people from my own experience of popular education; they can also be seen in action in organizations like Brazil's MST which are strongly influenced by popular education (Stédile & Fernandes, 1999). In their practice of setting up settlements infused with socialist principles throughout Brazil, the MST is also responding to Gramsci's call for "the establishment of the social-psychological underpinnings of socialism prior to resolving the question of state power" (Lather, 1983, p. 43).

An additional Gramscian idea has influenced the work of popular educators at the same time it has actually expanded the definition of popular education. This is his idea that the lower classes need to critically appropriate the knowledge of the upper classes and use it to their own benefit. The application of the latter idea can be clearly seen in the program of Brazil's MST, which emphasizes "todos os sem terra estudando" – "all the landless ones studying." Currently, MST militants are being trained as agronomists, physicians, historians and teachers, among other professions. The Movement has worked out agreements with public universities in Brazil through which MST militants can enter the university together and study as cohorts, supporting one another ideologically and socially (L. Pinheiro, personal communication, 2007). By opening professions previously limited to the upper classes to the sons and daughters of landless rural workers, the MST has given a new and even deeper meaning to the idea of "popular education."

In sum, by championing the idea that a change in consciousness must precede a change in the social relations of production, Gramsci provided what is essentially the *raison d'être* of popular education. With his concept of hegemony, he clarified the target of liberating educational efforts, while with the concept of counter-hegemony he worked out many of the processes and relationships essential to those efforts.

Gramsci's idea that the subaltern classes should critically appropriate the knowledge of the upper classes and use it to their benefit inspires popular educators today and continually expands the definition of "popular education."

Liberation Theology

Along with Marxism, the other current of thought that has exercised the strongest influence on popular education is Liberation Theology. The degree to which Marxism itself influenced the development of Liberation Theology is still a topic of debate; as recently as the spring of 2007 the Catholic Archbishop of São Paulo, Brazil, claimed that Liberation Theology uses a Marxist analytical method which is based on a materialist proposition, and therefore negates a basic principle of the Church – transcendence (*Brasil de fato*, 2007). Brazilian theologian Luiz Bassegio responded by saying that Liberation Theology only uses Marxist analysis in an instrumental way and its character is biblical and theological (*Brasil de fato*, 2007).

While Liberation Theology was certainly influenced by Marxism, like popular education it also grew out of the lived experience of the people of Latin America. Many of the same historical developments mentioned above, which led educators to seek new ways of helping oppressed people gain more control over their own lives, led

clergy and theologians throughout Latin America to begin to develop and practice a theology which sought to help the poor and marginalized achieve social, political, and economic as well as spiritual liberation (Smith, 1991). In the 1950s, social movements like Catholic Action, which had existed since the 1920s, began to take on a more radical character, inspired by the writings of European theologians such as Emmanuel Mounier and Teilhard de Chardin (de Kadt, 1970). These movements received affirmation and encouragement from the Second Vatican Council, which met from 1962 to 1965. Other signal events in the history of Liberation Theology included the first conference of Latin American Bishops at Medellín, Colombia, in 1968, and the publication of Peruvian theologian Gustavo Gutierrez' seminal work *A Theology of Liberation: History, Politics and Salvation* in 1971 (Smith, 1991).

A number of ideas central to Liberation Theology have become deeply woven into the fabric of popular education as I have experienced it. For example, unlike earlier theologies that told poor people they should wait patiently for the Kingdom of God to arrive, Liberation Theology teaches the poor that they must create the Kingdom of God here on earth (Gutierrez, 1988). Implicit in the directive to create the Kingdom of God are the ideas that the current situation is unjust and change is possible, ideas which were either never mentioned or directly contradicted in previous theological formulations and which I see reflected in popular education. Another core tenet of Liberation Theology is the *preferential option for the poor*. This doctrine, which was adopted by the bishops attending the conference in Medellín, teaches clergy and lay people that the first loyalty of Christians must be to the poor and to improving their lot

in life (Smith, 1991). The role of the poor in achieving not only their own liberation but also the liberation of their oppressors is a basic assumption of Freire's work. Further, Liberation Theology emphasizes the idea of *signs of the Kingdom*, a phrase which is used to describe both situations and institutions that announce the possibility of a future which is not yet fully realized (Smith, 1991). In a later section, we will hear this phrase used frequently to describe the MST and its members.

The melding of Marxism and Liberation Theology is one of the characteristics that sets popular education apart from other radical pedagogies, and it has drawn criticism from other radical educators. In his book *Adult Education and Socialist Pedagogy*, Youngman (1986) states that "a coherent synthesis of Marxism and Christian doctrine at the philosophical level is not possible" (p. 162) and criticizes Freire for combining the two elements. However, the long line of social movement leaders who have emerged from within radical Christian circles in Latin America attests to the powerful work which a combination of Marxism and radical Christianity can produce.

Paulo Freire

The enormous influence of Brazilian educator Paulo Freire on the development of popular and critical education can hardly be overstated; indeed, his contributions frequently obscure the important contributions made by others. Freire drew from a wide variety of thinkers including Fanon, Memmi, Fromm, Gramsci, Dewey, and Althusser (Austin, 1999; Mayo, 1999). However, Freire was preeminently a man of his time and context. As such, his predominant influences were a unique blend of Christian existentialism, populism and Marxism current among Latin American (and

particularly Brazilian) Catholic radicals of his time. For an understanding of popular education, the most significant aspects of this eclectic ideology were an emphasis on dialectical movement in history as explained by Hegel, a belief in the perfectibility of human beings as preached by Mounier, and a strong resistance to manipulation of the people by political leaders (de Kadt, 1970). From these influences, Freire constructed a theoretical framework for popular education and disseminated it globally. Nuñez (2004), a colleague of Freire and noted popular educator himself, has suggested that the theoretical-practical proposal of popular education is based on four pillars: an ethical framework, an epistemological framework, a socio-political framework, and a pedagogical framework. In this section, I will use these four frameworks to analyze the theoretical framework of popular education created by Freire.

The influence of existential Christianity and Liberation Theology is quite apparent in Freire's ethical framework, which posits that humanity's ultimate purpose is to become Subjects who transform the world. In the words of Giroux (1985), "central to Freire's politics and pedagogy is a philosophical vision of a liberated humanity" (p. xvii). This puts Freire at odds with all systems which would place some human beings in subjection to others and in favor of forms of knowledge and social relations that promote individual and collective liberation. Applied to education, this ethical principle means that the purpose of education is human liberation. Characterizing empowerment as an outcome of popular education, as I did in this study, is consistent with this ethical principle.

Other ethical values that inform Freire's theoretical framework are the importance of hope, the vision of an attainable utopia, and the value of both denunciation and annunciation. In Freire's (1985) words:

The pedagogy that we defend . . . is itself a utopian pedagogy. By this very fact it is full of hope, for to be utopian is not to be merely idealistic or impractical but rather to engage in denunciation and annunciation . . . denunciation and annunciation in this utopian pedagogy are not meant to be empty words, but an historic commitment (p. 57).

Another ethical value which comes through strongly in Freire's writings is his trust in common people. In *Pedagogy of the Oppressed* (2003), Freire castigates those who would seek to liberate the people with the tools of the oppressor. If we cannot trust the people, Freire asks, then why would we conduct a revolution intended to put them into power? While Freire saw a role for intellectuals, he consistently encouraged them to listen to the wisdom of common people.

Freire's epistemological framework bears strong similarities to the work of later social constructivists. Freire's epistemology is based on his ontology, which clearly reveals both the tensions within Marxism and the influence of Liberation Theology. On the one hand, Freire believed with the materialists that reality exists, regardless of whether anyone thinks about it or not. In his words, ". . . the radical is never a subjectivist" (2003, p.38). On the other hand, Freire was strongly influenced by the Hegelian, idealist strain of Marxism which emphasizes the role of human agency in the creation of history.

Hegel's influence is clear in Freire's dialectical view of the source of knowledge. According to Freire (2003), knowledge is both created and acquired by interacting with the world and then reflecting on the experience, in other words, through praxis. In Freire's view, praxis is responsible for transforming the world and making people fully human. "Apart from inquiry, apart from the praxis," he writes, "individuals cannot be truly human. Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other" (p. 72).

Freire (2003) also proposes a dialogical view of the creation of knowledge. Freire believed that learning is a conversation between two or more people. In between these people is the cognizable object, the thing known. As they dialogue about it, the thing becomes clearer. In Freire's words, "dialogue is the encounter between [people], mediated by the world, in order to name the world" (p. 88). Like praxis, dialogue is not *just* the way people learn; it is how we become human. Thus, it is "an existential necessity" (Freire, 2003, p. 88). Recalling Youngman's (1986) words about praxis, Freire states further that "dialogue authenticates both the act of knowing and the role of the knowing Subject in the midst of the act" (1978, p.39). However, dialogue alone is not enough; for example, Socratic intellectualism viewed the definition of the concept as knowledge, and "did not constitute a true pedagogy of knowing, even though it was dialogical" (Freire, 1985, p.55). To be a true act of knowing, dialogue must be authentic.

Freire's epistemology is also profoundly existential, emphasizing the importance of context in creating what we know and how we know it. A later generation would term this epistemological position "situated learning" (Driscoll, 2000). Freire (1985) highlighted the situated nature of his own knowledge and practice:

A critical view of my experience in Brazil requires an understanding of its context. My practice, while social, did not belong to me. Hence my difficulty in understanding my experience, not to mention in my applying it elsewhere without comprehending the historical climate when it originally took place (p.12).

Freire's method of teaching literacy, which involves identifying and using words that are familiar and evocative (so-called *generative words*), is a direct result of this principle, since it emphasizes that education should be based on people's contextual experience.

A tight link exists between Freire's epistemological framework and his socio-political framework, which is based on the Marxist assumption that the world is divided into oppressed and oppressors (Wallace & Wolf, 2006). According to Freire (2003), the oppressors have so dominated the argument over epistemology that they have been able to define what is knowledge and what is ignorance (Kane, 2001). While they themselves are ignorant "of the cultural world of the other classes" (Kane, 2001, p. 15), they have successfully equated being a *campesino* (poor farmer) with being ignorant, even in the minds of the *campesinos* themselves. The oppressors' success in controlling epistemology has put the oppressed into an unenviable position,

at least at the outset. Freire (2003) describes the oppressed as living in a state of duality in which they are both themselves and their oppressors. They possess a “naïve consciousness,” a “diffuse, magical belief in the invulnerability and power of the oppressor,” and an “unauthentic view of themselves and the world” (p. 64).

Such a conception of the oppressed could have posed a major contradiction for Freire who, at the same time he was emphasizing their naiveté, was also championing their wisdom. This potential contradiction is resolved through Freire’s emphasis on *concientization* (consciousness-raising). Despite Freire’s later distancing of himself from the term (Kane, 2001), *concientization* has remained one of popular education’s best known learning processes; it is, in fact, almost synonymous with learning. (de Kadt [1970] defines the Portuguese version of this word, *concientização*, as “learning.”) *Concientization* occurs via the process through which teachers (and revolutionary leaders) present the life experience of the oppressed back to them in the form of a problem. The problem may be represented in a text, a picture, a *sociodrama*, or some other form; Freire (2003) termed these representations *codifications*. This practice of *problematization* or problem-posing also serves to challenge some of the myths that the oppressors have used to maintain their control, such as the idea that the oppressed are ignorant or that their poverty is God’s will.

According to Freire, through *concientization*, the oppressed move from naïve consciousness to critical consciousness. They come to believe that there is a way out of their situation and that *utopia* is possible. Based on their new awareness, they become committed to work for change, fulfilling popular education’s theme that

learning is completed in action. Crucially, according to Freire, it is not only the oppressed who learn through conscientization. The teachers/leaders also learn through their encounter with the experience and worldview of the oppressed (Freire, 2003).

Many of Freire's political ideas changed markedly over time. For example, the role of social class became more and then less important, as he was criticized for downplaying it and then criticized for overstating its role to the exclusion of other axes of difference such as race/ethnicity and gender. His vision of the role of the upper class in particular changed significantly. In *Pedagogy of the Oppressed*, Freire (2003)⁵ assumed revolutionary leaders would come from the dominant classes and experience a conversion process that would result in their rebirth among the people. By the time he wrote *Pedagogy in Process* (1978) only a few years later, his vision of the ideal leader/educator had changed. "I would rather dedicate the necessarily longer time to train peasants who might become authentic educators of their comrades," he wrote, "than to use middle-class youth. The latter may be trained more rapidly but their commitment is less trustworthy" (p. 82).

Similarly, Freire's position vis-à-vis revolutionary parties and governments changed radically over time. In *Pedagogy of the Oppressed*, Freire (2003) advised leader/educators to maintain a safe distance from political parties, since they were likely to fall back on oppressive methods to try to ensure faithfulness to a party line. By the time he began his work with the revolutionary government of Amílcar Cabral

⁵ *Pedagogy of the Oppressed* was published in Portuguese in 1969. I am citing a version published in 2003.

in Guinea-Bissau, he had adopted the position that “. . . only as militants could we become true collaborators” (Freire, 1978, p. 8). At certain points in *Pedagogy in Process*, Freire’s (1978) expressed appreciation for the revolutionary process in Guinea-Bissau seems almost fawning; it appears his critical faculties have fallen asleep. This is probably due partly to the political reality; he and his team had been invited to work in Guinea-Bissau and were there as guests, so they had to tread very carefully when expressing dissatisfaction.

A final concept that is central to Freire’s political framework is the idea of the appropriation of the knowledge of the dominant classes by the oppressed classes. While Mayo (1999) claims that this idea was more important to Gramsci than to Freire, it is quite present in Freire’s work. In a dialogue with educators in Uruguay, Freire (1992) instructs them that, rather than immediately correcting the syntax of children from the popular classes, they should learn the children’s syntax. However, they should not stop there. “We have to make clear to the popular children,” he writes, “that even though they have the right to continue using their own syntax, they should learn the dominant syntax in order to be able to fight better against the dominators” (p.89).

Freire’s pedagogical framework grows directly out of the ethical, epistemological and socio-political commitments described above. Clearly, as well as being a political strategy, problem-posing is also a pedagogical method. Other aspects of Freire’s pedagogical framework are expressed in his writing on the role of the teacher and the relationship between the teacher and the student. Further, it is inspired by the idea that

the social relations of the educational setting should mirror the social relations of the new society we are trying to build. In his early work, Freire (2003) emphasized the need for horizontal relations between the teacher and the student, and the idea that learning occurred in dialogue between teachers and students. Critics charged that Freire was advocating a passive, non-directive role for the teacher. So in later works, Freire clarified his position. A long passage from *The Politics of Education* (1985) states his actual position eloquently:

It might seem as if some of our statements defend the principle that, whatever the level of the learners, they ought to reconstruct the process of human knowing in absolute terms. In fact, when we consider adult literacy learning or education in general as an act of knowing, *we are advocating a synthesis between the educator's maximally systematized knowing and the learners' minimally systematized knowing* – a synthesis achieved in dialogue. The educator's role is to propose problems about the codified existential situations in order to help the learners arrive at a more and more critical view of their reality. The educator's responsibility as conceived by the philosophy is thus greater in every way than that of his colleague whose duty is to transmit information that the learners memorize (p. 55, emphasis added).

In much of his later writing, Freire (1985, 1992) took pains to clarify that educators should correct misperceptions and errors. The question, however, was *how, when, and why* they should correct errors. Similarly, he confirmed that no matter what their aim, educators should always be present. “There is a radical difference, however, between being present and being the presence itself” (1985, p. 105).

Consistently throughout his writings, Freire encouraged teachers (and leaders) to give up their role as *the presence* and to replace it with a sense of radical humility. This humility, clearly influenced by Christianity, is completely necessary if popular educators hope to be consistent with their own philosophy. Freire expressed his own humility numerous times in his writings. He summarizes his position well in this passage from *The Politics of Education* (1985): “The crux here, I believe, is that I must constantly be open to criticism and sustain my curiosity, always ready for revision based on the results of my future experience and that of others” (p. 11).

From his vantage point as an educator, Freire also addressed the question of which comes first, the revolution or a change in people’s consciousness? According to Freire, while it is difficult to practice liberating education within an oppressive system, it is possible, since education is not the product of material conditions but rather “is constituted . . . in a close relationship with material conditions” (1992, p. 87). “When one perceives reality in this way,” Freire writes, “one also perceives that it is not necessary to wait for society to change in order to then create a different kind of school” (1992, p. 87). And while education alone is not enough, education can be an important driver behind broader societal changes.

It should be noted, as well, that Freire’s pedagogical framework left room for his methods to be used outside the realm of adult literacy in which he spent most of his life. He clearly saw literacy as connected to other aspects of life such as health. “We have never understood literacy education of adults as a thing in itself, as simply learning the mechanics of reading and writing, but, rather, as a political act, directly

related to production, to health, to the regular system of instruction, to the overall plan for the society still to be realized” (1978, p. 13). In *Pedagogy in Process*, Freire (1978) makes frequent references to the connections between education, health and agriculture, as the core disciplines of the new society. “Whatever activity gives rise to political consciousness raising – whether it be health education, means of production, or adult literacy efforts – there is a basic unity of approach,” he wrote (p. 55).

In summary, the theoretical framework constructed for popular education by Freire included an ethical system firmly grounded in hope which aims at human liberation, both personal and collective; an epistemology that we would now term critical and social constructivist; a socio-political vision in which formerly oppressed people emerge from oppression to become subjects of their own lives and creators of history; and a pedagogical system based on equality and dialogue between teachers and students. Many of these values and beliefs will reappear in the next section as we consider the philosophy and practice of Myles Horton.

Myles Horton

Myles Horton, founder of the Highlander Research and Education Center in New Market, Tennessee, is probably even less well known among mainstream U.S. educators than his Latin American counterpart Paulo Freire. Yet Horton also made substantial contributions to the development of popular education. Like Freire, Horton (2003) did not originally call his philosophy and methodology popular education, but later clearly linked his work to the “system of adult education based on what’s called popular education now, especially in Latin America” (p. 37).

Initially, Horton and Freire developed their ideas in isolation from one another; it was not until their later years that they collaborated on a dialogue book and made at least one video together. Yet the influences on them were remarkably similar. First among these was a connection to a particularly geographic place whose history and experience shaped them and their ideas. For Freire, the place was the ravaged northeastern region of Brazil. For Horton, the place was the Cumberland Mountains of Tennessee, where he was born and where, while teaching Bible classes during the summer before his senior year of college, he began to see and understand “the problems of the Great Depression that were already hitting the rural South in 1927” (Jacobs, 2003, p. xvii). Both Freire and Horton were strongly influenced by their parents; Horton’s parents were schoolteachers who taught him that “education is meant to help you do something for others” (Horton, Kohl & Kohl, 1990, pp. 2-3).

Radical Christianity was a decisive influence on both Freire and Horton; for Horton it also provided the context in which he conducted his first experiments in adult education. Freire developed his thinking amidst the ferment of Liberation Theology in Latin America. As a student at Union Theological Seminary from 1929-1930, Horton met and was deeply influenced by the theologian Reinhold Niebuhr, who attacked corporate capitalism and emphasized the relationship between material conditions and spiritual values (Jacobs, 2003). Niebuhr later became one of four signatories on a fund-raising letter to help establish the Highlander Center. As mentioned above, it was in the context of setting up vacation bible school programs in the Cumberland

Mountains of Tennessee that Horton first brought people together to reflect on their common problems.

Like Freire, who obtained his doctorate by submitting a dissertation despite the fact he had never attended classes (Wallerstein, 1988), Horton had a wide-ranging intellect that did not always fit easily into the formal education system. As an undergraduate, he quit playing football even though the college administration threatened to not let him graduate, because “it was interfering with my reading” and “learning was more important than graduating” (Horton, Kohl & Kohl, 1990, p. 14). After spending just one year at Union, Horton spent just one year at the University of Chicago, where he studied sociology with Robert Park and came to appreciate the importance of organizations for effecting social change (Jacobs, 2003). Freire and Horton shared many intellectual influences, including Marx, Lenin, Dewey, and Lindeman.

Horton’s final influence before establishing Highlander was a trip he made in 1931 to visit the Danish Folk High Schools, which he had learned about while at Union. The Folk Schools had been created by a Danish bishop in the 19th century in an effort to enlighten oppressed rural peasants through investigation of Danish history and Norse mythology (Jacobs, 2003). Concluding finally that the design for the folk school he had been dreaming about since his last summer in college “can only come from the people in the life situation” (Horton, Kohl & Kohl, 1990, p. 55), Horton returned to the U.S. and founded the Highlander Folk School in the summer of 1932. Over the next 75 years, the school would progressively serve labor organizers, civil rights leaders, poor Southern whites, and Latino immigrants.

Not surprisingly, Freire and Horton's similar influences produced similar conclusions about the goals, principles, and methodology of liberating education, the social relations of the educational setting, and the relationship between liberating education and social and political movements. For Horton (2003), the goal of liberating education was the creation of a new social order characterized by economic and political democracy in which people live together in brother- and sisterhood. The new economic system should be based on "production for use and not for profit" (p. 213). Consonant with Gramsci's idea that previously passive people must be activated to work for change and Freire's concept of conscientization, Horton (2003) wrote that his goal was to help people develop an understanding of the class nature of society and the need for changing society. Like Mariátegui before him and the MST after him, Horton thought that in order to create a new social order, people would have to be induced to give up their individualistic tendencies. In his later years, Horton wrote that while revolution had been a reasonable goal when Highlander was founded, it no longer was. Rather, keeping their goal of a new social order in mind, radical educators needed to start where people were and develop them toward that goal.

The principles of liberating adult education, according to Horton (2003), began with the idea that education is by nature political. It is the responsibility of liberating educators to create a relaxed atmosphere so that people will feel free to share their experience and ideas. Doing so allows educators to start with what people already know. In Horton's words, "In a real sense, [workshop participants] bring not only their subject with them, they also bring their curriculum. That curriculum is their

experience” (p. 13). Drawing out what people know is essential, since Horton believed that the poor had immense untapped capacity. “If a way could be found to turn people on and give them confidence, we felt they would have something to say about their own lives” (p. 10). Once people began to share their experience and to listen to the experience of others, true learning could begin. Unlike Freire, who at least initially assumed the teachers would have to come from the upper classes, Horton felt that the process of liberating education would work best if teachers were close to the life experience of those they teach. “We think the best teachers of poor people are the poor people themselves. The best teachers about black problems are the black people. The best teachers about Appalachian problems are Appalachians, and so on” (p. 13). Inspired by the example of the Danish Folk Schools and reminiscent of the practice of the popular universities in Latin America in the 1920s, Horton emphasized the role of culture, music and drama in the educational process. To a greater degree than Freire, Horton appreciated the fact that we learn with both our hearts and heads, our emotions as well as our intellect. Like Freire, Horton held that education should be followed immediately by action. Like Latin American leftists generally, who emphasize the need to be both “*conciente y consecuente*” (conscious and consistent), Horton stated that “we . . . strive to live out our ideals in so far as it is possible” (p. 211).

For Horton (2003), these principles have clear implications for both methodology and the social relations of the educational setting. In Horton’s words, “Obviously, working with a life situation requires an entirely different method from that used in

teaching an academic subject” (p. 213). At the heart of this method is the idea of problem-posing as opposed to problem-solving. “The purpose of Highlander is not to solve problems, but to use problems and crises as the basis for educating people about a democratic society. To make them want more, and make them understand they can do more” (Horton, 2003, p. 43). As well as motivating people to action, both Horton and Freire agree that problem-posing increases the significance of the act of learning. Horton emphasizes how problem-posing promotes the acquisition and retention of knowledge, writing that “facts acquired because they are essential to the solving of a problem are more or less permanently added to one’s body of usable knowledge” (p. 215). Freire (1978) stresses that problem-posing makes that knowledge more useful, saying, “To know is not to guess; information is useful only when a problem has been posed. Without this basic problem-statement, the furnishing of information is not a significant moment in the act of learning and becomes simply the transfer of something from the educator to the learner” (p. 11).

Horton (2003) believed strongly that the social relations of the educational setting should prefigure the new society he was trying to build. “By the way we lived and the kind of policies we had, we thought of Highlander as a place to give people a glimpse of the kind of society you could have” (p.36). Creating this vision of the new society was facilitated by the residential nature of Highlander workshops. Groups would come together for several weeks at a time and make their own decisions, including decisions about whether attendance at classes would be mandatory. Shared decision-making was crucial, according to Horton (2003), since it built leadership:

Almost immediately [after founding Highlander] we discovered how rapidly ordinary people could demonstrate their ability to play leadership roles and develop a sense of responsibility to their fellows. All depended, it now seems clear, on their being involved from the start in the making of all necessary decisions with respect to their education (p. 237).

Teachers participated as equals in the decision-making process; they did not have more authority simply because they were teachers. One rule, however, was firm. In line with the idea that had come down from Marx that intellectual and manual labor had been incorrectly separated by capitalism and the industrial revolution, no workshop participants were excused from manual labor. Horton's description of the residential workshops at Highlander brings to mind Freire's description of the Training Center at C in Guinea-Bissau (1978) and my own memories of the MST's National Training School outside So Paulo in Brazil, which I had the chance to visit in July of 2007. Residential workshops where people can live, work and study together while developing relationships, experiencing a new social reality and practicing collective skills are a particularly valuable expression of popular education.

Horton (2003) was unequivocal in his belief that popular education is most effective when conducted within social movements. "The best educational work at Highlander had always taken place where there is a social movement," he wrote (p. 54). In fact, more democratic forms of education are only meaningful if they are connected to a political or social movement. This is because, while education is important, education alone cannot change the world. "We have repeatedly found that

education alone cannot counteract the influence of the establishment on individuals,” stated Horton, “so we avoid dealing with those who are not free to act on what they themselves think is right” (p. 238). Even connecting participants to an organization is not enough, since “if you stop there, that’ll retrench the system” (p. 269). Ultimately, Horton felt, to really change the world organizations had to come together as social movements.

By the time of his death in 1990, Horton had seen many changes, but the overall political situation was, if anything, grimmer than when he began his work in the Cumberland Mountains in 1927. How did he maintain hope in the possibility of a better world? Like Latin Americans, Horton took the long view. The following quotation sums up his approach to his educational work for social justice:

What you do is build little cells of decency, little cells of democracy, little experiences of people making decisions for themselves, little philosophical discussions about civil rights and human rights. All those get built into what’s going to happen later on. So you’re really building for the revolution when you do something to develop local leadership. You get some satisfaction out of seeing steps as you go along, even though you don’t get all the way (p. 43).

Throughout a lifetime that spanned most of the 20th century, Myles Horton clung steadfastly to the goal of establishing economic and political democracy by supporting oppressed people to discover their own wisdom and work together for change. He defended educational principles including creating a relaxed atmosphere, drawing out what people already know, and teaching to both heart and mind. His methodology

was based on problem-posing and using the educational setting to give people an experience of the world for which they were striving. Finally, he emphasized the crucial link between liberating education and social movements and encouraged people to take a long-term perspective on social change. In so doing, he both reinforced and contributed to the tradition of popular education in a uniquely North American voice.

Popular Education Theory as Expressed in the Praxis of the MST

Brazil's Landless Rural Workers' Movement (MST) is widely acknowledged to be the largest social movement in Latin America. The emergence of the MST was the result of the convergence of three sets of factors: objective socio-economic pressures caused by the displacement of millions of rural workers because of rapid mechanization of agriculture between 1975 and 1980; socio-cultural and political factors, principally liberating pastoral work in the countryside combined with the intensification of pro-democracy organizing throughout the country; and particular factors which sparked disparate groups to undertake land occupations in five states in the south of Brazil in the late 1970s and early 1980s (Caldart, 2004). Since its formal founding in the state of Paraná in 1984, the MST has grown to include more than 1.5 million members and is active in 23 of 27 Brazilian states. Throughout its history, its goals have remained virtually unchanged: land to the people who work it, agrarian reform, and broader changes in society that facilitate equity and social justice.

In the spring and summer of 2007, I had the opportunity to spend two months observing the political and educational practice of the MST. Along with more than

18,000 Brazilians and internationals, I attended the MST's Fifth National Congress, which took place from June 11 through June 15, 2007 in Brasilia, the national capital. I chose to spend time working with the MST because of its extensive and masterful use of popular education. Popular education is not only the chosen pedagogy of the MST; it influences virtually every aspect of the Movement. Based on my observation and my reading, I hold that the MST embodies the praxis of popular education at the beginning of the 21st century. In this section, I will reflect on what the praxis of the MST can teach us about continuity and change in popular education theory.

Because of the intimate connection between popular education and the MST, the best source of information about popular education theory is the organization itself – its goals, principles, and values. As stated above, the three goals most often referred to in the Movement's literature and speeches are land, agrarian reform, and broader changes in society (Stédile & Fernandes, 1999). The Movement has additional goals, such as the creation of a socialist state. According to João Pedro Stédile (Stédile & Fernandes, 1999), one of the founders and leaders of the Movement, "One model failed, yet we remain convinced that socialism, in relation to capitalism, signifies an advance for humanity" (p. 89). The MST's struggle is conceived in much broader and more theological terms than were the socialist struggles of previous generations. "It is about obtaining a radical and immediate change in the structures of iniquity that are causing the impoverishment and exclusion of the majority of the Brazilian people," writes Dom Tomás Balduino (Stédile & Fernandes, 1999, p.10) in his introduction to a book about the MST. (By locating the cause of suffering in "the structures of

iniquity,” the cleric reaffirms Liberation Theology’s analysis that sin is the cause of human suffering [Smith, 1991].) The principal strategy for bringing about this change is the creation of new social subjects (Caldart, 2004), men and women capable of participating actively in the creation of their own destiny, and who are agents of social transformation (Harnecker, 2002). The creation of new social subjects will result in the creation of a new culture that does not correspond to hegemonic social and cultural patterns.

The MST places great emphasis on the importance of *values* within their struggle. At the Fifth National Congress, four huge banners emblazoned with MST values hung from the towering ceiling of the stadium in which all main events were held. Values of the Movement include love for the cause of the people, honesty, discipline, *compañerismo* (comradeship), responsibility, solidarity, humility, criticism and self-criticism, and dedication to the cause and the organization (Harnecker, 2002, p. 274). Part of the MST’s concern with values is tactical. “The rich fear our virtues more than our organic force,” writes Ademar Bogo, a member of the MST. “For these move consciences and hearts in order to plant utopias in the social scene” (quoted in Caldart, 2004, p. 56). But the concern with values goes deeper. According to Caldart (2004), we are in one of those times in history when the contradictions implicit in the current system can no longer be overlooked. Capitalism maintains almost complete hegemony in the world, yet has caused a social misery which has in turn produced a spiritual or ethical misery. In this situation in which Brazilian society and even the world are looking for alternatives, the MST appears as a sign that history has not

ended and we can take another route. Everything depends on the moral choices we will make and the values we will choose, since in the words of Marxist historian Edward Thompson “all class struggle is at the same time a struggle over values, and the socialist project is not in any way guaranteed and can find its own guarantees only in reason and by way of a broad choice of values” (quoted in Caldart, pp. 48-49). With its emphasis on the role of values, the MST reaffirms its commitment to an interpretation of Marxism where people really can *and must* make choices, though always within the constraints of their historical situation.

Along with a set of values, the MST is also strongly committed to a set of organizational principles. In fact, the commitment to principles is frequently cited by leaders and members of the MST as one of the cornerstones of their success as a social movement (Caldart, 2004; Harnecker, 2002; Stédile & Fernandes, 1999). Many MST principles demonstrate continuity with the principles of earlier generations of popular educators. These include independence from other organizations, class consciousness, the maintenance of a strong connection to the organization’s campesino base combined with a role for organic intellectuals, collective decision-making, a commitment to learn from the history of previous campesino struggles, and the idea that all people (in this case, all members of the campesino family) have something to contribute and should be included in decision-making (Harnecker, 2002; Stédile and Fernandes, 1999). Particularly notable is the organization’s openness and non-dogmatic theoretical formation, which Stédile (Stédile and Fernandes, 1999) attributes to the influence of Liberation Theology, itself a combination of Marxism, Christianity

and Latin Americanism. While I hold that such openness is an essential characteristic of popular education, in my experience it has not always characterized the movements and organizations that use popular education, which have sometimes tended toward dogmatism.

Other principles reflect changing times and lessons learned from past struggles. For example, whereas earlier popular educators were criticized for ignoring the importance of racial/ethnic differences, in its various higher education and technical training programs, the MST takes advantage of the fact that they have people from all over the country and different ethnic groups. “They work on integration without falling into regionalism but at the same time without killing the richness of each place which each person brings with him/her” (Harnecker, 2002, p. 242). They promote the inclusion of women and seek to root out *machista* tendencies. As well as being collective, decision-making is delegated and localized; decisions are frequently delayed until something close to consensus is achieved. Militants are encouraged to discover and use their own unique talents.

Two innovations deserve special note. To a much greater degree than previous organizations influenced by popular education, the MST appears to have resolved the historical tension between mobilization and concientization, by declaring roundly that both are of equal importance. While the MST is deeply committed to equipping its members with the capacity to analyze the logic of its opponents, it is equally committed to mobilizing the largest number of people possible, since “rights assured by law do not represent any conquest by the people” (Stédile & Fernandes, 1999, p.

43) and it is only mass struggle that changes the correlation of political power in society. Thus, we see the MST on the one hand dedicating immense resources to furthering the education of its members, while on the other hand conducting radical actions and mounting massive marches to demonstrate its power to the larger society.

The second innovation is the use of what the MST calls *mística*. In its more limited sense, *mística* refer to the carefully planned and elaborately staged dramatic pieces which opened each day of the National Congress. These pieces serve a pedagogical as well as an emotional and motivational role. For example, in the *mística* on the first day of the Congress, large puppets like those that have been used in demonstrations against the World Trade Organization were dressed as a priest, bride and bridegroom. The bride and bridegroom represented the *fazenderos* (large land owners) and *agronegocio* (agro-business), who were being married by the Brazilian government. On the second day of the conference, a large map of the world had been laid out on the floor in the center of the stadium. As music played, groups of people entered dressed as campesinos from around the world. A peaceful pastoral feeling developed as the campesinos tilled the earth in their respective regions, until suddenly a large bird/plane representing the U.S. swooped down out of the sky and began to menace all the campesinos. Scenes including the attack on the Twin Towers and photographs of George Bush were projected on huge screens behind the assembled actors. The *mística* ended with the assembled campesinos having overcome the threat from the U.S. They formed a large circle, linked arms and swayed to the music of “La Via

Campesina,” one of the many songs of the Movement. The entire audience of more than 18,000 people linked arms and swayed with them, many people singing along.

The importance of dramatic pieces such as this can hardly be overstated. Stédile (Stédile & Fernandes, 1999) refers to them as “a social practice that makes people feel good about participating in the struggle” (p. 129) and compares them to the liturgy of the church. Yet as one young MST militant pointed out to me, the meaning of *mística* does not end with these theatrical pieces but extends to describe the larger ethos or mystical feeling that pervades the Movement and its members.

The praxis of the MST reflects key elements of popular education theory at the outset of the 21st century. According to this theory, the goal of popular education continues to be a radical reordering of the “structures of iniquity,” accomplished through the creation of new social subjects who are able to participate in the construction of history. Values such as compassion, discipline, and love for the cause of the people are at the heart of the prophetic vision of popular education, both because they serve as signs of the Kingdom and because the choice to create a different and better society is essentially a choice over values. Adherence to a set of principles is crucial to bringing about the new society. Principles such as shared decision-making and independence from political parties represent continuity to an older vision of popular education, while appreciation of difference, equal emphasis on concientization and mobilization, and increased use of liturgical devices such as the *mística* represent lessons learned in 30 years of social movement and popular education practice.

Popular Education Principles

From my review of the theoretical literature regarding popular education, I have identified 13 key principles of popular education (Figure 1). These principles served as the defining characteristics of the popular education intervention described in Chapter III.

Figure 1: Principles of Popular Education

1. The current distribution of the world's resources is unjust and change is possible.
2. It is important to create an atmosphere of trust so that people can share their ideas and experiences.
3. We all know a lot. As educators and organizers, we should always start with what people already know and/or do.
4. The knowledge we gain through life experience is as important as the knowledge we gain through formal education.
5. Education should progress from action to reflection to action (the cycle of praxis).
6. Knowledge is constructed in the interaction between people.
7. People should be active participants, rather than passive recipients, in their own learning process.
8. Popular education is an inclusive movement that combines influences from many sources.
9. In each situation in which we try to teach or organize, the conditions should reflect the conditions of the society we are trying to construct. This means equality between "teacher" and "student," and democratic decision-making.
10. It is important that educators and organizers share the life experience of those they want to teach and/or organize.
11. We learn with our heads, our hearts, and our bodies.
12. The arts (music, drama, visual arts, etc.) are important tools for teaching and organizing.
13. The purpose of developing critical consciousness is to be able to take action to change the world. (Critical thinking alone is not enough.)
14. The goal of popular education is organized action to change the world.

Popular Education and Adult Education

North Americans – particularly North American educators – who are introduced to popular education for the first time, frequently ask how popular education is different from adult education, which began to be formalized as a discipline in the U.S. in the 1920's (Knowles, 1988). In fact, there are overwhelming similarities between popular education and adult education, both in their assumptions about learners and the educational practices that grow out of these assumptions.⁶

Malcolm Knowles, whose lifetime, like Horton's, spanned most of the 20th century, had a profound impact on the development of adult education in the U.S. (Bolton, 1985). In his seminal text, *The Modern Practice of Adult Education* (1988), Knowles contrasts *pedagogy*, which is based on experience and assumptions about teaching children, to *andragogy*, a term which was first coined by European educators (Knowles, 1988). While Knowles originally assumed andragogy to mean, "the art and practice of teaching adults," he later realized that andragogy was simply another set of assumptions about learning that could be applicable to both children and adults. These assumptions have been widely accepted by adult educators (Bolton, 1985) and can be seen as representative of the adult education movement. Fundamental to the concept of andragogy is the idea that as human beings grow and develop, they become increasingly self-directed.

⁶ Two reasons for these similarities may be that both systems came into their own during a roughly similar period in history, and that they shared some common influences, including Eduard Lindeman, an early adult educator who influenced Myles Horton (Horton, 2003).

Andragogy as explicated by Knowles (1988) bears many similarities to popular education. Both systems recognize that adults may doubt their own capacity to learn, based on previous experience with formal education. For this reason among others, both popular and adult educators are encouraged to create a learning environment where learners feel accepted, respected, and supported. In both systems, rows of chairs or desks are eschewed in favor of circles of chairs or small tables. (In andragogy this is done to avoid unwanted associations with formal education situations, while in popular education it recalls indigenous decision-making practices.) Andragogy and popular education both view the life experience of learners as a “rich resource for learning” (Knowles, 1988, p. 44) and emphasize starting with the situation in which the learner finds him or herself. The idea that people learn more when they are actively involved is fundamental to both systems, and thus both employ participatory, interactive methods. Both systems assume that the primary motivation of adult learners is the desire to solve problems in their lives, so both systems are problem-focused and emphasize practical applications. Involvement of learners in defining what they want to learn and how they want to learn it is seen as key in both systems. Like popular education, andragogy acknowledges that we learn with our emotions and our bodies, as well as our minds. In both andragogy and popular education, the teacher is viewed as a guide and facilitator. Far from being the ultimate authority, teachers are seen as co-learners with students. Prized teacher behaviors in both systems include careful and sustained listening, openness to feedback, and willingness to change.

The major differences between popular education and adult education probably result from the different orientations and goals of their progenitors. The progenitors of popular education, like Freire and Horton, were, for the most part, political philosophers and theologians, while adult education in the U.S. was primarily developed and influenced by developmental psychologists (Knowles, 1988). Thus, in adult education as practiced in the U.S., there is a strong emphasis on adult development. (Knowles [1988] acknowledges that most of the assumptions about adult development implicit in adult education are based on studies of middle class North Americans.) Consistent with the political and racial/ethnic culture in which it was developed, adult education tends to focus on individual learners and their individual needs and goals, as opposed to the needs and goals of communities. For example, Knowles (1988) states that in andragogy, “learners see education as a process of developing increased competence to achieve their full potential in life” (p. 44). There is no mention here of the goals of the community, only of the individual. Further, there is a tendency in Knowles’ writing to characterize the adult learner as the problem, the person who diverges from some ideal model of “the ‘good’ supervisor, the ‘good’ public speaker, the ‘good’ parent” (p. 47). Life problems among the learners are seen to exist because of gaps in the “personal equipment” of the learners (p. 57). Passages like these come uncomfortably close to Freire’s (2003) descriptions of banking education, which treats oppressed people as “individual cases, as marginal persons who deviate from the general configuration of a ‘good, organized, and just’

society. The oppressed are regarded as the pathology of the healthy society . . .” (p. 74).

One of the most important differences between popular and adult education is that adult education theory in the industrialized world does not tend to analyze the reasons that some adults may arrive at adulthood without the sense of self-directedness that is assumed to exist in most adult learners. There is no mention here of what Marx referred to as “false consciousness” (Stone, 2002), what W.E.B. Dubois referred to as “double consciousness” (Ladson-Billings & Tate, 1995), or what Freire (2003) referred to as “carrying the oppressor within.” All three were alluding to the fact that in oppressed-oppressor relationships, oppressors try to maintain members of the oppressed group in a dependent, child-like position. This can be seen extremely clearly in the practice by whites in the southern U.S. of referring to African American adult males as “boy.” Because adult education theory in the U.S. does not acknowledge this dynamic, it does not create any practices to deconstruct it, but rather contents itself with vague allusions to “obvious inequities in the social structure” and vague prescriptions that “learners need to become critically aware of how these factors have shaped the ways they think . . . so that they may take collective action to ameliorate them” (Mezirow, 2000, p. 28).

There are exceptions to the generalization that adult education in the industrialized world does not have a well-developed political analysis. The International Council for Adult Education (ICAE), founded in 1973 and currently based in Uruguay, has a strong presence in Canada and receives funding from various Western European

governments. Its mission is to “promote the use of adult learning as a tool for informed participation of people and sustainable development” (ICAE, 2008). One of the member organizations of the ICAE is CEAAL, the *Consejo de Educación de Adultos de América Latina* (Adult Education Council of Latin America), a coalition of groups from around Latin America that are strongly influenced by popular education. So, there are adult education groups active in North America that share the political analysis of popular education. However, the ICAE and its members stand outside the mainstream of adult education in the industrialized world.

Traditional Education

In the proposed study which I will outline below, popular education as I have defined it above is contrasted to a construct I will refer to as “traditional education.” Unfortunately, from an academic perspective, there is no clear definition of “traditional education.” It is, simply put, what most of us experienced and continue to experience, whether in Sunday School or third grade or graduate school or a professional conference or a vocational training program. In other words, it is the dominant mode of education in classroom settings in the industrialized (and many parts of the non-industrialized) world. Both because of its ubiquitousness and its divergence from popular education models, it is the logical contrast to popular education.

Clearly, a full exposition of the roots and principles of traditional education is far beyond the scope of this inquiry, which focuses primarily on popular education. However, in order to draw a distinction between the two philosophies and

methodologies, a brief exposition of the principles and practices of traditional education is warranted. Traditional education bears many similarities to what Knowles (1988) describes as the pedagogical model, e.g. it assumes that: 1) the role of the learner is a dependent one, 2) the teacher should determine what is to be learned, 3) the life experience of the learners is of little value, 4) people will become ready to learn whatever they are forced to learn, and 5) the best techniques for imparting knowledge are “transmittal techniques” like lectures, assigned readings, and audio-visual presentations.

Traditional education is what Freire (2003, p. 72) refers to as “banking education.” According to Freire’s (2003) description, this model involves a “narrating Subject (the teacher) and patient, listening objects (the students)” (p. 71). Its outstanding characteristic is “the sonority of words . . . which the student records, memorizes, and repeats” without perceiving their real meaning” (p. 71). It turns students into “‘containers,’ into ‘receptacles’ to be ‘filled’ by the teacher” (p. 72). It presumes an absolute dichotomy between teachers, who are knowledgeable, and students, who know nothing.

In relation to learning theories that are well known in the West, traditional education bears a relationship to the philosophy of John Locke, who believed that infants are blank slates who come into the world knowing nothing (Phillips & Soltis, 2004). However, whereas Locke believed that as soon as children begin to interact with the world, they begin to have experience from which they construct simple and then complex ideas, traditional education as currently practiced extends the blank slate

metaphor to encompass all learners coming to a new subject they have not formally studied before. As regards the acquisition vs. participation metaphor posed by Anna Sfard (2004), traditional education comes down squarely in favor of acquisition.

Based on my own experience of both systems, there are additional differences between popular and traditional education. Whereas in popular education the goal is social change through empowerment of learners, in traditional education the goal is to acquire the information presented in the class so that learners can succeed in the marketplace. While popular education places equal value on academic and experiential knowledge, traditional education places higher value on academic knowledge. Consonant with the “blank slate” philosophy described above, traditional education holds that knowledge is pre-existing and can be “delivered” from the teacher to the student. In traditional education, little emphasis is placed on the feeling tone of the educational setting and the role of emotions and the arts in learning is downplayed. The most important content for learning comes from the curriculum, which is chosen by the teacher who is seen as the expert and has higher authority than the students. This also reflects the hierarchical decision-making typical of traditional education. Traditional education prizes listening as a behavior for students, but not for teachers. According to the principles of traditional education, it is not necessary for teachers to share the life experience of those they teach. Whereas in popular education participants are viewed as members of a community, in traditional education they are viewed and treated as a collection of individuals. A summary of contrasts between popular education and traditional education can be found in Appendix A.

The Empirical Literature

In this section of my paper, rather than taking as my topic *all* the empirical literature regarding popular education, I will focus exclusively on empirical applications of popular education in a health context. My study was set in North America; therefore, my review focuses primarily on studies conducted in North America. Because the studies I reviewed use widely different methods and address different questions, I will follow Baumeister's (2003) advice and present my findings in the form of a narrative review.

In the U.S. public health literature, popular education has been presented almost exclusively within the context of the construct of empowerment. Indeed, in this context, the association between popular education and empowerment is so strong that popular education is most often referred to as *empowerment education*. (L. Wallerstein [2005, personal communication] explains that her decision to use the phrase *empowerment education* was one of expedience, due to the difficulties in understanding posed by the word "popular" for a primarily-English speaking audience. Her English speaking colleagues simply "didn't get it" when she talked about popular education.) In the Spanish and Portuguese public health literature, in contrast, these difficulties do not exist; thus, popular education is called by its name and stands alone as a theoretical construct, although the word empowerment is sometimes used.

Because the construct of empowerment is central to an understanding of the U.S. public health literature about popular education, I will begin my review of the empirical literature with an extended discussion of empowerment theory as applied to

health, before proceeding to review the literature on popular education and health. An additional reason for providing an overview of empowerment theory is that empowerment is the primary outcome variable of interest in my study. DeVellis (2003) emphasizes that when a researcher is trying to measure an abstract construct that can't be directly observed, it is very important to be "well grounded in the substantive theories related to the phenomenon to be measured" (p. 60). Theory serves as a guide so the researcher does not end up measuring something she or he didn't intend to measure.

Empowerment and Health

In this section, I will provide an overview of the emergence of empowerment as a construct in social science and public health, followed by information about efforts to define, conceptualize, and measure empowerment. Next, I will review some facilitators and barriers to empowerment. I will close the section with discussions of the limitations of empowerment interventions and empowerment research. By outlining how empowerment research has evolved over the last 20 years, I intend to justify how I conceptualized and measured empowerment in my own study.

The Emergence of Empowerment in Social Science and Public Health

The concept of empowerment has its origins in the work of community organizers such as Saul Alinsky (1946), who proposed that oppressed people needed to build "power coalitions" to equalize conditions with other, more powerful groups (Wallerstein, 1989). The first social science field to adopt the political philosophy of empowerment was community mental health, where advocates like Rappaport (1981,

1984) and Zimmerman (1988) began to explore its potential and seek ways to define and measure the construct in the 1980s. These advocates proposed empowerment as an alternative to the paternalistic philosophy and practice that had guided social services since the 19th century (Swift, 1984). Subsequently, the concept has been applied to and used within occupational and stress research and public health (Wallerstein, 1992).

The growing importance of empowerment within public health is related to three interconnected and concurrent developments within the field: 1) increasing empirical evidence about the associations between adverse social conditions and ill health; 2) a diagnosis of *powerlessness* as the common explanatory variable in all these associations and a prescription of *empowerment* as the appropriate treatment to address and change that variable; and 3) a growing body of research that supports this connection by demonstrating associations between increased empowerment and improved health.

Public health advocates and researchers have been aware of the impact of adverse social conditions on health for more than 200 years (Eisenberg, 1984). Research over the past 25 years has demonstrated associations between ill health and a wide variety of adverse social conditions, including poverty (Pappas, Queen, Hadden & Fisher, 1993), racism (Kreiger, Rowley, Herman, Avery & Phillips, 1993), low job control/high demands (Karasek & Theorell, 1990), social class (Rose, 1985), and relative income disparity (Kawachi & Kennedy, 1997). Wallerstein (2002) has proposed that *powerlessness* is the unifying (and perhaps the determining) factor among all the adverse social conditions and that, therefore, *empowerment* takes

precedence over other theoretical frameworks (such as social capital) used to address these conditions. Her claims are buttressed by a variety of studies that have found that components and strategies of empowerment are associated with a wide range of measures of improved health (Lugo, 1996; Wallerstein, 2002, 2006) and independently predict better self-reported health and fewer depressive symptoms (Wallerstein, 2006). Thus, empowerment has emerged as a “viable public health strategy” for improving health and reducing health disparities (Wallerstein, 2002, p.14).

Defining Empowerment

In keeping with the variety of settings in which it has been discussed and practiced and with the development of knowledge based on these endeavors, empowerment has been defined in a variety of ways. There are several cross-cutting aspects of these definitions. For example, empowerment is generally seen as both a process and an outcome (Israel, 1994; Wallerstein, 1992). Various authorities have warned against reifying the outcome, both because empowerment will look differently in different communities (Rappaport, 1984) and because empowerment is a continuous, not a dichotomous variable (Bernstein et al., 1984; Keiffer, 1984). Empowerment has also been characterized as an intermediate outcome that leads to improved health status (N. Wallerstein, personal communication, 2006). Empowerment researchers largely agree that empowerment is easier to define in its absence than in its presence, with its opposite being variously described as powerlessness, alienation, and learned helplessness, among other descriptors (Rappaport, 1984; Wallerstein, 1992).

For the purposes of this study, I chose to adopt the definition of empowerment provided by Wallerstein (1994). According to this definition, empowerment is “a social-action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment” (p. 142). Because I approach popular education as both a public health practitioner and an educator, I also want to take note of the definition provided by Keiffer (1984), who characterized empowerment as a “long-term process of adult learning and development” (p. 9) and “an ordered and progressive development of participatory skills and political understandings” (p. 17). Keiffer’s definition reminds people designing empowerment interventions that these interventions must be relatively long-term and that they must seek to increase both participation and political awareness.

Within empowerment theory, power is understood to be an attribute not of a person but rather of a relationship. Similarly, both powerlessness and empowerment are seen as the results of an interaction between the individual and his or her environment (Keiffer, 1984; Zimmerman, 1990). In this field, power means “power with” not “power over.” Empowerment theorists generally ascribe to non-zero-sum conceptions of power in which the fact that one person acquires power does not necessarily mean that someone else has to give it up (although sometimes it does). Power is viewed as having spiritual and moral as well as objective dimensions and as capable of being used for both positive and negative ends (Bernstein et al., 1994).

Conceptualizing and Measuring Empowerment

Empowerment is generally acknowledged to have at least three levels: individual, organizational, and community. Zimmerman (1990) has advanced the concept of psychological empowerment as an individual level variable that takes into account the social context (Wallerstein, 1992). Attempts to conceptualize and measure empowerment can be categorized by the level or levels of empowerment they address.

Most early work on empowerment in community psychology focused on the *individual level*. Based on his qualitative study of 15 multi-ethnic grassroots community leaders from around the U.S., Keiffer (1984) concluded that empowerment can be seen as the attainment of “participatory competence,” which he defined as “the combination of attitudes, understandings, and abilities required to play a conscious and assertive role in the ongoing social construction of one’s political environment” (p. 31). The three intersecting dimensions of participatory competence, according to Keiffer, are: 1) improved self-concept, 2) increased critical understanding of the social and political context, and 3) development of the individual and collective resources needed to take political action. In her study of empowerment among residents of a rural community in Puerto Rico, Serrano-García (1984) found the three-dimension model of empowerment proposed by Keiffer to be applicable. Interpreting the dimensions as developmental stages, she warns that it may be inappropriate to emphasize consciousness-raising until participants have developed the concrete skills and improved self-concept required to integrate and act on a new, more critical understanding of reality. The similarities between the three-dimension model and the

popular education process are more than coincidental; both Keiffer and Serrano-García cite Freire as having contributed significantly to their theoretical understanding of empowerment.

Other work in community psychology focused on *psychological empowerment*. As mentioned previously, psychological empowerment, while an individual-level construct, attempts to take into account the impact of the social context on the individual (Zimmerman, 1990). Building on Keiffer's (1984) work, this level of empowerment was seen to be composed of sense of community (Maton & Rappaport, 1984) and elements of individual experience such as "self-acceptance and self-confidence, social and political understanding, and the ability to play an assertive role in controlling resources and decisions in one's community" (Zimmerman & Rappaport, 1988, p. 726). Later refinement of this early work characterized psychological empowerment as including self-efficacy, perceived control, critical awareness of social context, and participation in change (Zimmerman, 2000).

Zimmerman and colleagues conducted a number of studies aimed at developing *measures of psychological empowerment and its components*. For example, Zimmerman and Rappaport (1988) conducted three studies designed to shed light on the relationship between empowerment and participation. The first study used scenarios to divide college students into four groups of "citizen participants." Respondents then completed 11 indices of empowerment and results were compared. The indices represented personality, cognitive, and motivational aspects of empowerment. A measure designed to assess leadership and a measure of alienation

were included to provide convergent and discriminant validity. The second and third studies ranked college students and members of voluntary organizations, respectively, according to their actual involvement in community activities and organizations, and then their level of empowerment was measured using the same 11 indices. Results showed the indices of empowerment to be correlated but not to the point that they did not measure separate constructs. Results of all three studies showed that people who reported higher levels of participation also scored higher on indices of empowerment. The authors raise but do not attempt to answer the question of whether empowerment leads to participation or participation to empowerment.

Interesting aspects of these studies included the fact that self-efficacy was one of the 11 indices that tended not to differ across levels of participation, perhaps suggesting that it is a more stable individual variable that is less likely to change based on the activities in which one becomes involved. A limitation of the study appears to be its definition of civic duty as “the belief that one ought to participate in the political process as a responsibility to others” (p. 729). This definition does not take into account the experience of people who, for example, immigrated to the U.S. from a variety of South American countries that were ruled by dictators in the 1970s and 1980s. They grew up under conditions in which citizen participation was violently discouraged. A notable recommendation of this study for future research is that studies complement self-report measures of empowerment with other measures, such as asking community leaders about changes in lay leadership.

Narrowing their focus to one component of psychological empowerment -- perceived control -- Zimmerman and Zanhiser (1991) conducted three additional studies that collectively aimed to develop a *sociopolitical control scale* (SPCS). Sociopolitical control is characterized as one of three types of perceived control (along with personal and interpersonal control) and defined as “beliefs about one’s capabilities and efficacy in social and political systems” (p. 189). According to the authors, it may be a “critical component of psychological empowerment” (p.191). The first study identified relevant items from the three domains of control mentioned above (personal, cognitive and motivational) and examined their factor structure. The second study tested the stability of the factor structure from study one. The third study explored the properties of the measures with a different sample of community residents, and controlled for age and level of education. The factor analysis in study one resulted in two factors: leadership competence and political or policy control. Study two confirmed these results. The results of study three generally confirmed the results of study two, with the exception that social isolation was uncorrelated with either factor (leadership competence = $-.02$, $p > .05$; policy control = $-.13$, $p > .05$).

The authors point out that the SPCS measures two significant components of psychological empowerment (leadership competence and policy control) and therefore may be useful, in concert with other measures, in identifying empowerment potential. Taking into account the fact, mentioned above, that empowerment is not a state to be obtained but rather a continual process of human development, the authors caution that the SPCS should not be used to label people as empowered or not. Also, as in the

1988 Zimmerman and Rappaport article reported above, they caution that “explicit behavioral measures” (p. 201) such as attendance records of organizations should be used to validate self-report measures such as the ones they have developed.

The most significant limitation of the SPCS, as the authors partially recognize, is that it was created with communities that were not diverse in terms of race/ethnicity or national origin/immigrant status. Most of the items that seek to measure political control would not be appropriate for many recent immigrants, especially those who have lived under repressive governments. For example, items such as “It hardly makes any difference who I vote for because whoever gets elected does whatever he wants to do anyway” clearly do not apply to non-citizens, who cannot vote even if they perceive it would make a difference. Items such as “I enjoy political participation because I want to have as much say in running government as possible” share the same limitation, as well as the one mentioned above: for people who have lived under dictatorship, their lives have depended on *not* participating in politics. (This is not to ignore the studies which suggest that in some Latin American countries such as Chile, people actually participated in politics more and more meaningfully under dictatorship than they did afterwards, when “civic participation” was promoted but carefully managed [Paley, 2001].) A scale based on the Zimmerman and Zanhiser (1991) measures, which will be reported on below, significantly corrects many of the limitations I have identified.

While community psychologists have generally designed scales to measure psychological or individual components of empowerment, public health researchers

have built on the work in community psychology to conceptualize and measure *empowerment across all three levels – individual, organizational, and community*.

Wallerstein (1992) characterized the organizational level of empowerment as consisting of internal democracy and external ability to influence change, and community-level empowerment as consisting of enhanced participation by community members and transformed physical and social conditions as a result of community action. Israel and colleagues (1994) created a 12-item tool to measure empowerment across the three levels, though the scale does not obtain a collective assessment but rather is based on individuals' perceptions of the group. A 2006 World Health Organization (WHO) report (Wallerstein) which assesses the evidence about the effectiveness of empowerment to improve health reaffirms the importance of measuring empowerment at multiple levels and identifies three key components of empowerment: participation, sense of community, and psychological empowerment.

Drawing carefully and extensively on previous work, Romero and colleagues (2006) developed and piloted a questionnaire designed to measure domains of empowerment including self- and collective-efficacy, sense of community, and perceived control at the organizational and community levels, along with non-empowerment-related factors such as knowledge about HIV and ability to communicate about sex. This research took place in the context of an intervention which used Freirian methodology to increase empowerment and prevent HIV. It will be reported on later in the section on popular education and health. Notably, this research was conducted among a multi-cultural group of 308 at-risk women in urban

and rural areas of New Mexico, thus significantly correcting some of the limitations of previous research. Significantly also, the quantitative measurement in this study was supplemented by qualitative measures including extensive recording of participants' comments on flip-chart paper, participant evaluations, external observer notes, facilitator logs, and follow-up focus groups.

Facilitators and Barriers to Empowerment

Research suggests that, while one person cannot “empower” another, certain strategies can facilitate empowerment. These strategies include praxis, defined above as the process of acting, reflecting on action, and returning to action (Keiffer, 1984). The WHO report (Wallerstein, 2006) found that participation was crucial (though insufficient) for empowerment, and that participation could be facilitated by Community Health Workers (CHWs), culturally competent interventions, and the development of empowering leadership. The same report characterized the CHW model (defined as the practice of employing CHWs to promote community health) as a “key empowerment strategy” even apart from CHWs’ role in promoting participation. Overall, empowering interventions worldwide were reportedly based on “group dialogue, collective action, advocacy and leadership training, organizational development, and transfer of power to participants” (p. 9).

Serrano-García (1984) and Rivera (2003) have provided useful insights about ways in which objective conditions can make true empowerment (as opposed to the illusion of empowerment) difficult or impossible. For Serrano-García, the limiting factor was the colonial nature of the Puerto Rican society in which she did her work. For Rivera,

it was the 1995 Massachusetts Welfare Reform Law, which mandated welfare recipients to find work as soon as possible. By 1999, only one woman out of the 50 originally included in the study was still participating in the GED preparation and empowerment program about which Rivera did her study. Additional barriers to empowerment identified by Rivera included health problems, learning disabilities, lack of transportation, lack of child care, domestic violence, substance abuse, and the practical need to get the GED credential.

Limitations of Empowerment Interventions

Previous empowerment interventions have consistently shown that, while it is possible to change participants' personal sense of control, it is much harder to motivate them to actually become involved in change efforts at the personal or collective level (Clare, 2006; Rivera, 2003; Romero, 2006). Based on an early review of the literature regarding applications of Freirian pedagogy in North American settings, Wallerstein (1986) arrived at the same conclusion: "The principle of promoting action among students or community members can be difficult to implement" (p. 86). One problem appears to be that most programs included in this review did not include an experience of making change together as part of the intervention. The one exception to this rule which I found in the literature was the study by Arenas-Monreal and colleagues (1999) which is quoted at the beginning of this paper. In this study, the rural Mexican women who were trained as *promotores de salud* (health promoters) actually took over responsibility for a child nutrition surveillance program in their locality. In the words of the authors, the promoters

“appropriated the work proposal” (p. 114). This was also the only study I found in which improvements in an actual, physical health status measure were reported (in this case, levels of child malnutrition). This difference may be related to the fact that the training of the promoters in this program showed extreme fidelity to the popular education model. It began with a self-diagnosis of the practices and concepts of the promoters themselves, moved on to analyze structural causes of problems, and concluded with a return to practice, to plan actions to address problems the women had identified.

In order to address deficiencies identified in previous programs, we did attempt to include an experience of making change together as part of our intervention. While both experimental groups were asked to plan and conduct health promotion projects within their parishes, in the popular education group, we emphasized identifying and addressing underlying social causes of illness. Results were mixed, as I will explain further in the limitations section in Chapter 5.

Limitations of Empowerment Research

Romero and colleagues (2006) state that the most significant limitation of the measurement aspect of their research was the lack of a comparison or control group, which the authors say, “preclude[s] a definitive statement of intervention effectiveness” (p. 402). The lack of a control or comparison group is, generally, the biggest limitation of studies of empowerment to date, and it is one we corrected in *La Palabra es Salud*, as I will outline below.

Another limitation of the empowerment research, and one not so easily corrected, is the lack of evidence for a direct connection between increased empowerment and improved health. Wallerstein and Bernstein (1988) have reasoned that because “individual behaviors are inherently difficult to change in the face of health-damaging environments” and these environments are “intractable to immediate solutions and require long-term and broad based public policy and social changes,” (p.388) when assessing the impact of empowerment interventions, it is acceptable to measure mid-range indicators such as self-esteem and participation in community organizing efforts. However, the evidence for a direct link between empowerment and health is growing; some of this research will be reported in the section on Popular Education and Health. To contribute to this growing body of research, we included self-reported health status and health behavior as outcome variables in *La Palabra es Salud* (see Chapter III).

Popular Education and Health

A definition of popular education was provided in Chapter I and a list of popular education principles was included in Chapter II. In this section, I will focus on outcomes associated with applications of popular education in a health context, conditions which appear to facilitate or limit the success of popular education interventions, methods used to measure outcomes, and limitations of the current literature on popular education within a health context. The majority of studies included in this review utilized a case study or comparative case study design. Only two employed an experimental design. While the majority used only qualitative

methods such as in-depth interviews, a few studies combined qualitative methods with a single group pre- and post-assessment. The most important methodological lessons to be drawn from these studies are the importance of combining qualitative and quantitative measures to understand the outcomes of popular education interventions, and the need for experimental and quasi-experimental studies that compare popular education to traditional education.

Outcomes Associated with Using Popular Education in a Health Context

The use of popular education in a health context has been associated with a variety of desirable outcomes. These can be divided into *empowerment-related* and *health-related outcomes*. I will report first on the empowerment-related outcomes. These outcomes include people taking more control over their lives and their health (Arenas-Monreal, Paulo-Maya, & López-González, 1999; Chang, 2004), increased self-esteem and self-confidence (Arenas-Monreal, Paulo-Maya, & López-González, 1999; Chang, 2004; Rivera, 2003; Wallerstein & Bernstein, 1988), undertaking actions to improve the community and help fellow community members (Arenas-Monreal, Paulo-Maya, & López-González, 1999; Chang, 2004; Minker & Cox, 1980; Rivera, 2003), increased participation (Chang, 2004; Minker & Cox, 1980), increased activity to bring about change through advocacy (Rivera, 2003; Weinger & Lyons, 1992), improvement on a wide-ranging battery of empowerment-related factors (Romero et al, 2006; Wiggins et al., 2009), development of critical consciousness (Minker & Cox, 1980), and increased perception of riskiness, consequences, and future orientation (Wallerstein & Bernstein, 1988; Wilson et al., 2006).

At its most basic level, empowerment involves *people gaining greater control over their lives*. Several studies have linked popular education interventions to this outcome. For example, women involved in a popular education intervention in Mexico took over responsibility for conducting an epidemiological surveillance program aimed at tracking changes in child nutrition (Arenas-Monreal, Paulo-Maya, & López-González, 1999). Similarly, in a qualitative study conducted with 15 cancer patients in Taiwan, the patients, who had become disempowered by their interactions with the medical system, began to participate more actively in their care planning after involvement in a dialogical interviewing intervention modeled after Freire's work (Chang, 2004). This study is additionally interesting in that it represents a successful application of popular education in an Asian context.

Attempts to use Freirian or popular education in health settings have also been associated with *increases in self-esteem and self-confidence*. Based on in-depth interviews, Chang (2004) reported that patients involved in the Taiwanese study experienced increased confidence. Similarly, in their study of women involved in the child nutrition program in Mexico, Arenas-Monreal and colleagues (1999) concluded that the women's success in obtaining the resources needed to carry out actions aimed at improving child nutrition "has contributed to improving the self-confidence and self-esteem of the women, a basic principle for empowerment, and it has also awakened interest and respect on the part of the men of the locality" (p. 118). The ethnographic case study by Rivera (2003) mentioned previously in which homeless and formerly homeless women in Boston participated in a GED preparation program

that used problem-posing and consciousness-raising also found increases in self-esteem among participants. Finally, interviews with reservation youth involved in an emergency department-based alcohol and substance abuse prevention program which used popular education revealed that the youth felt more confident in talking about issues with their friends (Wallerstein & Bernstein, 1988).

Undertaking actions of solidarity to improve the community, help fellow community members, and achieve community goals is another outcome that has been associated with popular education interventions. Qualitative interviews revealed that the women involved in the GED program in Boston became motivated to help one another with schoolwork, parenting, and instrumental support (Rivera, 2003), while the Taiwanese cancer patients developed more desire and strength to help others in similar situations (Chang, 2004). In a Honduran village where a *promotora de salud* (health promoter) used popular education, members of the Housewives Club motivated the village men to begin to build a school. When the men stopped work on the school at harvest time, the women completed the school themselves (Minker & Cox, 1980). Likewise, the Mexican women involved in the child nutrition project initiated a series of community actions to improve child nutrition, such as organizing to obtain needed supplies and then administering them (Arenas-Monreal, Paulo-Maya, & López-Gonzalez, 1999).

We have seen that participation is both an important component and outcome of empowerment. Popular education interventions have been associated with *increased participation* in Honduras, where women began to participate more in land reform and

land recuperations (Minkler & Cox, 1980), and in Taiwan, where cancer patients became more involved in their care planning (Chang, 2004). Anecdotally, I can report that the extensive use of popular education by the Landless Rural Workers' Movement in Brazil has been a key factor in increasing participation in the MST's program of land reform and global economic change.

Participation in health-related popular education interventions has also been related to *increased motivation to bring about change through advocacy*. For example, a popular education program among farmworkers which was associated with lower exposure to pesticides was also associated with an increase in farmworker activity to bring about change, including testifying at hearings, filing complaints to enforcement agencies, and using the media to put pesticide problems on the public agenda (Weinger & Lyons, 1992). Similarly, the interviews and participant observation conducted by Rivera (2003) with women involved in The Family Shelter Program in Boston suggested that the women developed a desire to address the root causes of health and advocate for their rights.

Popular education interventions have also been associated with *increases in a wide range of empowerment-related factors*, measured both qualitatively and quantitatively. Paired t-tests used for cognitive and attitude questions in the study by Romero and colleagues (2006), mentioned previously, reflected significant changes on 21 (of 38) empowerment-based cognitive questions, five (of 10) of the perceived control items, three (of 4) self-efficacy items, all six collective efficacy items, and all seven factors identified in the factor analysis ($p < .05$). Perceived control, self- and collective

efficacy are all conceptualized as components of empowerment. In a qualitative study which serves as a precursor to the proposed study, Wiggins and colleagues (2009) conducted in-depth interviews with Community Health Workers (CHWs) involved in the *Poder es Salud*/Power for Health Program in Oregon, to explore their perceptions of changes associated with their use of popular education. According to the CHWs, their own use of popular education as the primary strategy for identifying and addressing health issues contributed to increases in self-esteem, sense of personal potential, level of community involvement and participation, quantity and quality of leadership, and sense of community solidarity.

The *development of critical consciousness* has been among the least studied outcomes of popular education interventions; nonetheless, some studies have measured this outcome. The 1980 study by Minkler and Cox focused directly on the development of critical consciousness. In order to develop critical consciousness, the training curriculum for the Honduran health promoters dedicated the entire first week to *concientización*. As well as discussing the Honduran reality, the role of women in Honduras, and the relationship between poor health, malnutrition, and oppression, the *promotoras* also learned how to facilitate dialogues in a way that would encourage critical thinking, identification of root causes, and development of solutions for radical change. In the course of the intervention, the women began to question their inferior position relative to men. Other concrete outcomes of this intervention – increases in the number of women who boiled water, the building of a school, increased female

participation in land reform and land recuperation – also attest to the development of critical consciousness among participants.

A variety of studies of popular education interventions conducted with youth have identified *changes in the youth's perceptions about riskiness, consequences, and "future orientation"* (Wilson et al., 2006). While these variables are not synonymous with the greater awareness of the social and political context which defines "critical consciousness," they do indicate changes in the youth's ability to think critically about their own individual actions. An early study reported by Wallerstein and Bernstein (1988) used random assignment and a repeated measures design to assess outcomes of the Alcohol Substance Abuse Prevention (ASAP) Program at one middle school in New Mexico. They found a statistically significant increase in the self-reported perception of riskiness of particular behaviors for the intervention group at 8-month follow-up. This result counters developmental patterns and is important because a sense of vulnerability has been identified as a risk factor for unhealthy behavior. Interviews with the reservation students involved in this intervention suggested students became more aware of the consequences of drinking.

Use of popular education has also been associated with positive change on a number of *health-related factors*, including positive health behavior change (Ferreira-Pinto & Ramos, 1995; Minkler & Cox, 1980; Romero et al., 2006), increased health knowledge (Romero et al., 2006), improved health literacy (Wallerstein, 1992), and improvements in physical markers of health risk factors (Weinger & Lyons, 1992). Popular education interventions have been associated with *health promoting behavior*

change. For example, more rural residents in Honduras boiled their water after participating in a consciousness-raising program in which rural women were trained as *promotores de salud* (health promoters). This outcome was particularly notable, since a series of programs had been trying, unsuccessfully, to achieve this outcome for more than 25 years (Minkler & Cox, 1980). While no control group was used, this outcome suggests that popular education may be more effective than other methods of education at achieving behavior change. Results of the one-group pre- and post-questionnaire used by Romero and colleagues (2006) in their study of urban and rural women in New Mexico who were at risk for HIV infection showed that participants became significantly more likely to use a condom or latex barrier when having sex (mean change from 2.97 to 3.17; $p < .000$), and significantly less likely to have unprotected sex (mean change from .67 to .62, a reduction in risk, $p = .041$). In an HIV prevention and education program in Ciudad Juarez, Mexico, which was based on popular/Freirian education principles, quantitative results were non-significant (see below). Nonetheless, in-depth interviews suggested that participants did make substantive changes in the behaviors that put them at risk. The researchers hypothesize that the source of these changes were changes in women's self-esteem, self-efficacy, and awareness of the social, political, and economic context (Ferreira-Pinto & Ramos, 1995).

Study results also suggest that popular education is an effective method for *increasing health knowledge*. Using a McNemar test, Romero and colleagues (2006) found statistically significant changes on the majority of knowledge questions about

HIV transmission and prevention among the multi-ethnic women who participated in the intervention in New Mexico, all of whom were at high risk for HIV infection. For instance, the women better understood how HIV can be contracted and prevented.

Popular education has also been seen to further aspects of a construct that is growing in importance in the public health literature: *health literacy*. The U.S. Public Health Service, in its *Healthy People 2010* document, defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p. 15). The World Health Organization (WHO), influenced by British and Australian public health researchers, has defined health literacy more broadly, as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.” In this guise, according to the WHO, “health literacy is critical to empowerment” (Nutbeam, 1998, p. 264). Based on a review of programs that use popular education methods to integrate English and literacy skills into health and safety education, Wallerstein (1992) concluded that popular education is particularly appropriate for addressing the barriers that low literacy and limited English proficiency pose to workers’ understanding of health and safety education materials.

Other programs that used popular education to increase worker safety have been associated with *improvements in physical markers of health risk factors*. In Nicaragua, a statistically significant correlation was found between having participated in an educational program that used popular education and having reduced

exposure to pesticides (Weinger & Lyons, 1992). Depressed cholinesterase levels are indicative of exposure to pesticides. In this study, the cholinesterase levels of trained workers were .83 I.U. higher than the levels of untrained workers (95% C.I. 0.30, 1.36; 1 is not included in the CI indicating statistical significance). Causation cannot be imputed because the popular education intervention was only one part of a larger campaign. However, the researchers did eliminate a variety of competing explanations for the outcome by controlling for confounders.

Due in part to the extended periods of time required to change the underlying social, economic and political conditions that affect health, very few studies of popular education interventions have been able to demonstrate *actual physical changes in health*. I found only one. As reported above in the section on limitations of the empowerment literature, Arenas-Monreal and colleagues (1999) reported a very slight improvement in child malnutrition associated with the training of *promotores de salud* in the State of Morelos in Mexico. Between September 1994 and February 1995, the percentage of children under 5 with mild to moderate malnutrition went from 64% to 62% (N = 108). However, no statistical tests on this change or attempts to control for other possible explanatory variables are reported. Clinical team members and patients involved in a program which used Freirian principles to improve medication adherence among people living with HIV reported anecdotal improvements in adherence, but the study was too preliminary to report quantitative outcomes (Williams et al., 2005).

Facilitating and Limiting Conditions for the Success of Popular Education

Interventions

The literature reveals a number of conditions that either facilitate or hinder the success of popular education interventions. For example, based on their experience of applying Freire's approach among peasant farmers in Honduras and elderly residents of the Tenderloin District of San Francisco, Minkler and Cox (1980) concluded that stable kinship networks and placement within a broader context of radical social change efforts facilitated the success of the first effort, while isolation and lack of a sense of community contributed to the failure of the second effort. Similarly, Romero and colleagues (2006) stated that in order for empowerment interventions to bring about actual changes in social conditions, "a community organizing model involving groups of women over time would be useful" (p. 402). They cite a 12-year intervention in which sex workers in India have successfully reduced their risk of HIV by creating a sex workers' association. Finally, Arenas-Monreal and colleagues (1999) point out the advantages implicit in the popular education model itself. They conclude that programs aimed at improving child nutrition will have better chances of success when they involve the local population, and that this is possible when they use a methodology that promotes participation "and create spaces which permit them to realize a practice that transforms their reality. Popular education methodology offers the guidelines in this sense" (p. 113). In sum, then, interventions which are embedded within a supportive social context characterized by a strong sense of community and training of new cohorts over time and those which maintain fidelity to popular

education methodology and philosophy are more likely to succeed than those that lack these advantages.

We expected the Community Health Workers in the current study to benefit from a positive context for community organizing, since the Parish Health Promoter Program is on-going and new groups are added each year. In addition, a generally strong sense of community among participants in Latino Catholic congregations (C. Potter, personal communication, 2008) was expected to promote the success of the intervention. We attempted to maintain fidelity to popular education through *a priori* identification of the essential principles and practices of popular education, and careful application of these principles and practices in the refinement of the curriculum.

Measuring the Impacts of Popular Education Interventions

The most important insight arising from the literature regarding measuring the impacts of popular education interventions is the importance of combining qualitative and quantitative measures. To gain credibility in the field of public health, additional studies that measure the quantitative outcomes of popular education are needed. However, the literature suggests that quantitative measures alone can overlook important effects of popular education interventions. For example, in the study of female partners of injection drug users conducted in Ciudad Juarez, Mexico, results on a National Institute for Drug Abuse (NIDA) questionnaire revealed no significant changes in condom use, which could lead to the conclusion that no behavior change was associated with the intervention. However, in in-depth interviews, the researchers learned that several participants had actually left their partners because they would not

use condoms, a much more effective risk-reduction measure (Ferreira-Pinto & Ramos, 1995).

Similarly, in the study by Arenas-Monreal and colleagues in Morelos, Mexico (1999), changes in child malnutrition levels were small and probably not statistically significant. Nonetheless, as the authors point out, the fact that the participants in the program actually took over responsibility for the surveillance program is “central, in the sense that it has continued, despite the fact that the advisors have partially discontinued their activities” (p. 119). Quantitative measures alone would not have revealed this extremely important result.

Limitations of the Literature on Popular Education and Health

The literature regarding popular education and health possesses a number of gaps and limitations. Some of these are related to the general difficulty, mentioned above, of showing a clear relationship between empowerment interventions and improved health. Other limitations are the result of study design and data collection, analysis, and reporting. For example, in the study by Arenas-Monreal and colleagues (1999), while the qualitative changes reported are impressive and mixed methods were used, the quantitative improvement in child malnutrition rates is undercut by the fact that no attempt was made to show whether this result could have occurred by chance. The study by Rivera (2003) provides too little information about the specifics of the program. Additionally, while the author concludes that “popular education can best address the academic, personal, and community goals of very poor women,” she does not say what she is comparing popular education to and provides no evidence to

support her claim. The two studies conducted in clinical settings (Chang, 2004; Williams et al., 2005) completely overlooked the communal aspect of popular education, with the small exception that Chang (2004) did introduce participants in her dialogical interviewing intervention to one another. Even in the study by Romero et al. (2006), which was firmly grounded in empowerment theory, recommendations for changes in the curriculum after the Year 1 evaluation all seem to deal with individual level change (e.g. adding a behavior change contract). As the author acknowledges, there was almost certainly selection bias among women who chose to participate (as compared to those who did not) and there was no long-term follow-up.

Overall, the most significant limitation of the literature on popular education and health is the lack of longitudinal, experimental or quasi-experimental studies that compare the outcomes of popular education interventions to the outcomes of other types of educational interventions and to temporal changes through use of a control group. In the absence of such studies, we cannot infer a causal link between popular education and changes which have taken place in the past, nor can we predict that popular education will produce such changes in the future.

Summary

The general conclusion of the literature I reviewed is that popular education philosophy and methodology is effective in helping oppressed people to develop an awareness of their inherent wisdom and capacity. Popular education effectively creates settings in which members of oppressed communities can learn from one another and develop a critical consciousness about how their own issues and problems

are connected to larger national and global realities. Finally, it provides an opportunity and develops motivation for oppressed people to work together to identify common issues and create a world which is, in the words of Arenas-Monreal and colleagues (1999), “in accord with their interests” (p. 115). Within the context of health promotion, the literature supports the theory that popular education is an effective method for empowerment and that empowerment is associated with improved health. However, the existing literature does not provide empirical evidence that popular education is more effective than traditional education at increasing health knowledge and empowerment and changing health behavior.

CHAPTER III: METHODOLOGY

Chapter II laid out the historical, theoretical, and empirical foundations for research into popular education, and identified some of the gaps in the research to date. In Chapter III, I move into a description of *La Palabra es Salud*, the study I conducted along with my colleagues on the Project Team. I will describe the research paradigm we employed, provide background to the project, and explicate the methods we used to collect and analyze the data. In the process, I will explain how we sought to fill some of the gaps and address some of the limitations presented in the previous studies.

Research Paradigm

Popular education is linked both historically and philosophically to a trio of research paradigms which Guba and Lincoln (2005) collectively refer to as “new paradigm” approaches (p.203). These are the naturalistic/interpretive/constructivist paradigm, the critical theoretical paradigm, and the participatory paradigm. Guba and Lincoln contrast the new paradigm approaches to the positivist paradigm, which is based on the assumption of an objective truth which exists “out there,” and which can only be apprehended through the senses.

Most interpretivist/naturalistic researchers believe that reality is either created or constructed in the minds of individuals and/or communities. In either case, human beings can never know reality fully. The belief in a constructed reality led some researchers to link this paradigm early on to the constructivist paradigm in epistemology (Lincoln & Guba, 1985). A “shift toward action” among constructivist/interpretivist researchers in the 1990s made it possible additionally to

link them to critical theorists and participatory researchers (Guba & Lincoln, 2005, p.201). The naturalistic/interpretive paradigm is strongly influenced by German social theorists of the late 19th century. These theorists believed that the difference between humans and animals was humans' ability to make and share meaning. Thus, they believed that the human sciences should employ hermeneutical or interpretive methods that could "discover and communicate the meaning perspective of the people studied" (Erickson, 1986, p. 123). This position, elucidated by Dilthey, influenced Marx, who (as mentioned above) emphasized that one's perspective on self and the world is strongly determined by the concrete circumstances of daily life (Erickson, 1986, p. 123). This position in turn influenced Freire and many of his contemporaries in the development of popular education.

Critical theory grew out of the work of the Frankfurt School, a group that came together at the Institute of Social Research at the University of Frankfurt in the 1920s and included Habermas, Marcuse, and Adorno (Kincheloe, 2005). Critical theory focuses on questions of power. While acknowledging that our visions of reality are shaped by our positionality, critical theory holds that some visions of reality are more accurate than others, and that our position in the social structure can either obscure or clarify reality. As an approach to research, critical theory requires that researchers consider the possibility that we are operating in ways that reproduce current inequities, take steps to overcome limitations on our perspective imposed by class, race/ethnicity, gender and other factors, and use research results to create a more just world (Young, 1999; Guba and Lincoln, 2005). Like popular education, critical theory was strongly

influenced by Marx. In addition, Freire was directly influenced by Habermas (Gadotti, 1994). Similar influences produced a similar emphasis on power and the need for researchers/teachers/leaders to be reflexive about our own practice.

Based on these shared historical roots, popular education and the naturalistic/interpretive and critical paradigms share a number of assumptions and goals. These include an emphasis on the importance of context, a commitment to amplifying the voices of the marginalized and dispossessed, an iterative way of working, a desire to transform the world, and a belief that theory should grow out of practice.

While historical and philosophical similarities suggest that both naturalistic methods and a critical perspective are quite suited to inquiry into popular education practice, popular education bears perhaps its strongest historical and philosophical links to participatory approaches to research. The participatory paradigm views reality as participative and co-created, supports the combination of experiential, propositional, and practical knowledge, and encourages researchers to use their knowledge for the betterment of humanity (Guba & Lincoln, 2005). It assumes that people who have more access to a situation will produce more valid reports and that both facts and interpretations have to be “vetted” by subjects of the inquiry or people like them (Lincoln & Guba, 1985).

Researchers who identify themselves as participatory can be divided into various schools or traditions. Wallerstein and Duran (2003) characterize participatory approaches to research as lying along a continuum from “problem solving utilitarian”

on one end to “emancipatory” on the other (p. 31). They attribute different emphases on the two sides of the continuum to different geographic and historical origins.

According to Wallerstein and Duran, a so-called “Northern tradition” grew out of the work of psychologist Kurt Lewin, who sought to “bridge the gap between theory and practice and to solve practical problems through an action research cycle involving planning, action, and investigating the results of action” (p. 29). This is the variety of participatory research that is best known in the field of education, where “teachers have been encouraged to become researchers in their classrooms to tackle questions previously left to academics” (Wallerstein & Duran, 2003, p.29).

Wallerstein and Duran (2003) contrast this Northern tradition to a so-called Southern tradition. Growing out of the historical realities of underdevelopment and oppression in the global South and linked closely to its application in actual communities, the Southern tradition produces “openly emancipatory research, which challenges the colonizing practices of positivist research and political domination by the elites” (p. 28). Among the most important progenitors of the so-called Southern tradition is Paulo Freire (Wallerstein & Duran, 2003).

In recent years, progressive researchers within the field of public health have increasingly identified with a strand within participatory research which has come to be called community-based participatory research (CBPR). The W.K. Kellogg Health Scholars Program (2001) defines community based participatory research in health as:

. . . a collaborative approach to research that equitably involves all participants in the research process and recognizes the unique strengths that each brings. CBPR

begins with a research topic of interest to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities (n.p.).

While Wallerstein and Duran (2003) assert that CBPR combines the best of both the Northern and the Southern traditions, they further state that the goal of eliminating inequities “demands a research practice within the emancipatory perspective that fosters the democratic participation of community members to transform their lives” (p. 29). They clearly identify CBPR as more allied to the Southern than to the Northern tradition. CBPR is also strongly influenced by feminism, poststructuralism, and postcolonialism. Community-based participatory researchers are sympathetic to the claim of the “epistemic privilege of the oppressed” (Narayan, 1988, p. 31) made by both feminist epistemologists and popular educators. CBPR researchers draw from “critical theory, interpretive, and postmodern approaches to research” and frequently combine both qualitative and quantitative methods (Wallerstein and Duran, 2003, p. 35).

To convey a sense of what CBPR looks like in practice, I will use the example of *Poder es Salud*/Power for Health, the CDC-funded project mentioned above for which I served as Project Director. Previous to obtaining funding for *Poder es Salud*, the Community Capacitation Center was collaborating with the Latino Network, a community-based organization, on a leadership development project called EL PODER. When I saw a CDC program announcement titled “Community-based participatory prevention research,” it appeared to offer an opportunity to expand EL

PODER and extend it to other communities. I brought together our partners from the Latino community with partners from the African American community. Together, we identified the key concepts and approaches for the research, which included popular education, the Community Health Worker model, and CBPR. We also constructed a list of the qualities and skills we were seeking in researchers, and went about finding appropriate researchers. Ultimately, we identified three colleagues from Portland State University. They contributed their extensive knowledge of CBPR and research methodology and together, we wrote the grant application. Once the project was funded, it was guided by a Steering Committee composed of the researchers, the project staff (including the CHWs), and community representatives. While some division of responsibility was inevitable and necessary, major decisions about research design, instruments, analysis, and dissemination were taken jointly by the Steering Committee. For example, once a draft survey instrument had been developed by the researchers, it was extensively pilot tested and edited by a sub-committee of the Steering Committee. In addition, we conducted other activities such as feedback sessions to involve the broader community in the analysis and dissemination of our results. Members of the Steering Committee, again including the CHWs, authored a number of academic papers together, and made presentations together at major academic conferences such as the annual conference of the American Public Health Association (APHA).

The ties between popular education and CBPR are multiple and deep. As mentioned above, the ideas and methods of Paulo Freire are at the core of both

approaches. Both approaches view the knowledge of any particular group as partial and seek a merging of academic and experiential knowledge. Addressing the underlying causes of problems and working for social justice are overt goals of both approaches. In my experience conducting *Poder es Salud*/Power for Health, the two approaches proved to be symbiotic. Popular education creates the atmosphere of equality in which true CBPR can be practiced. Likewise, CBPR reinforces the principles of popular education within the research process. Indeed, the connections are so strong that I would assert that CBPR *is* the research application of popular education.

CBPR offers another advantage which made it particularly well-suited for *La Palabra es Salud*. As I have mentioned above, while combining elements from the three new paradigm approaches, community-based participatory researchers also frequently combine qualitative methods with the quantitative methods that are most commonly associated with the positivist paradigm. An approach to research that provides guidance on how to judiciously use quantitative methods is particularly valuable for the proposed study, for the following reason. The ultimate objective of my research is to explore the potential of popular education for greater use among a wide range of educators in the U.S. and others parts of the industrialized world. My professional location is public health, a discipline that, while liberatory at its heart, depends heavily on the empirical, positivist methods of medicine. To gain greater credibility for popular education in public health, we need more studies that can speak to mainstream public health practitioners in their own language, the language of

statistics and best practices. In the words of Thomas Kuhn (1996), “if a paradigm is ever to triumph it must gain some first supporters, [people] who will develop it to the point where hardheaded arguments can be produced and multiplied” (p. 158).

Developing such hardheaded arguments was an underlying purpose of the current study. Part of what makes quantitative data “hardheaded” is that they are less open to charges of researcher bias than qualitative data. This was an important consideration given my stated commitment to popular education as a philosophy and methodology. A final, related advantage of using CBPR for this study was that “collaborative and action research methods” have been identified as methods that promote the critical reflexivity which is a requirement for validity for qualitative researchers working within a critical paradigm (Anderson, 1989).

In this section, I have demonstrated that the naturalistic/interpretive, critical, and participatory research paradigms share intellectual roots and epistemological and ontological assumptions with popular education and concluded that all three paradigms lend themselves to investigation into popular education. I have shown how community-based participatory research (CBPR), an approach to research currently used principally in public health, draws from all three traditions. Finally, I have identified CBPR as the most appropriate research approach for this study, principally because it is deeply connected to popular education, both historically and philosophically, and also because it provides guidance about how to combine qualitative and quantitative methods to add depth and credibility to popular education research.

Background to the Study

The current study was conceived within the context of a larger proposed study situated in the Parish Health Promoter Program (PHPP). Since 1999, Catholic Charities' El Programa Hispano (The Hispanic Program), a community-based organization (CBO) serving Latinos/as in the greater Portland area, has partnered with Providence Health and Services (PH&S) to conduct the PHPP. The PHPP attempts to mitigate the factors which predispose immigrant Latinos to poor health, by recruiting and training members of the parishes as Community Health Workers (CHWs) or *promotores de salud* (health promoters). For four months, groups of approximately 30 volunteers meet each Saturday morning to participate in classes on a wide variety of health topics. Popular education is the established philosophy and methodology guiding the training program; however, fidelity to the popular education model has varied depending on the facilitator. The initial training period ends with a Mass and a gala graduation celebration attended by parish leaders and members of the CHWs' families. After completing their training, the CHWs engage in a variety of activities designed to improve the health of people in their parish communities. CHWs are encouraged and supported to use popular education methodology in their community work.

In my role as Manager of the Community Capacitation Center (CCC) of the Multnomah County Health Dept., I have been involved in the PHPP since its inception. In addition to planning and presenting several training sessions to the CHWs, my co-worker Teresa Rios and I also provide training on popular education

philosophy and methodology to other facilitators and provide general technical assistance to the Program. My relationship as a trainer in the PHPP changed with the commencement of the current research project, as I will explain further below.

In the nine years since it began, the PHPP has garnered a high degree of interest and commitment from parish communities. It has demonstrated its sustainability and ability to keep volunteer CHWs engaged over time. However, due to a lack of program resources, previous to this study the PHPP had been unable to carry out systematic research or evaluation of its activities in parish communities. Data that could contribute to evaluating the program was needed if the program hoped to maintain PH&S funding.

With this need in mind, approximately two and a half years ago the Coordinators of the PHPP approached me with the idea of conducting a research study that would contribute to program evaluation. They were also aware of my need for a setting in which to conduct my dissertation research. Shortly thereafter, I saw a Program Announcement from the National Institutes of Health (NIH) titled, “Understanding and Promoting Health Literacy.” It appeared that this funding might enable the PHPP and me to accomplish our goals. Subsequently, the PHPP coordinators and I involved a researcher from CORE, the Providence Health System’s research and evaluation unit. Together, we developed and submitted an application for a grant from NIH, on which the CORE researcher and I proposed to act as Co-Principal Investigators. In October of 2008, we were notified that while the proposal had received a high score, it would not be funded due to lack of resources. However, because we had planned the

study in two phases, the first of which could move forward without NIH funding, I was able to proceed with the study I had described in my dissertation proposal.

In our initial meetings, my colleagues from the PHPP, the Providence researcher, and I all agreed we would approach the study using a CBPR framework. Agreeing to use CBPR meant that all project partners would be involved in all phases of the research, including developing the research design, designing data collection tools, collecting and analyzing data and presenting study results. Thus, in the course of preparing our NIH application, we met with experienced CHWs and parish leaders to get their input on the research questions and the research design. In addition, once the current study was underway, my colleagues from the PHPP and I convened an Advisory Committee composed of researchers, program staff, experienced CHWs and parish leaders to guide the project. This practice helped us stay true to the CBPR model.

Consistent with CBPR, when speaking of both the larger proposed study and the actual study described below, I will use the pronoun “we,” since no decisions in a CBPR project can be made by one person acting alone. While acknowledging the contributions of my colleagues⁷, I want to make it clear that I initiated the project and developed the general outlines of the research design, both for the proposed and the actual study. In the case of the current study, I was responsible for designing the data

⁷ I would especially like to acknowledge the contribution of Bill Wright, PhD, of the Providence Health and Services CORE Program, who helped to conceptualize the initial research design but was not involved in carrying out the project.

collection tools and collecting, analyzing, and reporting the data. To the degree I was able, I involved my colleagues on the Project Team in each step of the process.

Overview of Methodology

This project used mixed methods and a community-based participatory research framework to better understand differences which may exist between popular education and traditional education as methods for enhancing health knowledge and skills, increasing empowerment, and improving health status and behavior among Community Health Workers (CHWs). Specifically, we employed a three-cell, quasi-experimental design to compare quantitative changes in the outcome variables among CHWs who are members of Spanish-speaking Catholic parishes in the greater Portland metropolitan area. One group of new CHWs participated in an intensive, 14-week training course using popular education, while a second group of new CHWs received training of identical duration and content using traditional education. Members of a Latino congregation not involved in the intervention and who did not participate in training served as controls. Outcome variables were assessed before the new CHWs began their training and immediately after the training was complete via a questionnaire (see Appendix B). In addition, we used participant observation and in-depth interviews to better understand what elements of popular education contributed to its differential effects, if these existed, and whether and how CHWs perceived that they had changed as a result of participating in training. The research was guided by a Steering Committee which included the researcher, PHPP staff, experienced CHWs, and parish leaders. A graphic representation of the design can be found in Figure 2.

Intervention

The intervention in *La Palabra es Salud* consisted of recruiting CHWs to participate in training and then providing that training. Below, I will provide details about both these steps in the intervention process. In addition, I will provide information about the Project Team and Advisory Committee which, while not strictly part of the intervention, were integral to the intervention.

Recruitment of CHWs

CHWs in this study were members of the Latino congregations of seven Catholic parishes on the west side of the greater Portland, Oregon, metropolitan area, and one Anglican parish on the east side. CHWs were recruited via announcements in church

bulletins and flyers that were distributed on three consecutive Sundays in June, 2008. On the fourth Sunday, PHPP Westside Coordinator Adele Hughes and Assistant Coordinator Adriana Rodriguez or other experienced CHWs visited the parishes and spoke during the Spanish Mass. They invited parish members to participate in the program and handed out applications after Mass. Completed applications were turned in the same day, left in the church office for pick-up, or mailed to the Coordinator. The Project Coordinator and Assistant Coordinator screened applications and attempted to contact all prospective participants by phone. They explained the program expectations and benefits. In addition, they explained that CHW trainees would be participating in a research study and that they would receive more information at the first training session and be able to sign an informed consent form. (Consent to participate in the study was needed from *all* participants in the training since, in the absence of the research study, CHWs would not have been assigned to one of two groups in which different methodologies were used.) (See Appendix C: Guide for Informing Prospective CHWs. Due to a misunderstanding about the difference between “anonymous” surveys and “confidential” surveys, participants were told by phone that they would be completing an anonymous survey, but this misconception was clarified during the first session.)

The inclusion criteria for the program were that parish members be able and willing to complete the training and undertake health promotion activities in their parish. Generally, prospective CHWs needed to participate in one of the seven parishes, in order to assure they would have adequate support for their work as CHWs. However,

in three cases a person who was not a member of one of the parishes was accepted, because there was space in a training group and the interested person was a member of another group that could provide support. CHWs from four parishes (n=38) were assigned to attend training at Parish A and CHWs from three parishes (n=59) were assigned to attend training at Parish B, for a total of 97 participants in the two experimental groups. At the first training session, all participants were required to read and sign an informed consent for the training and the CHW Questionnaire (see below). The informed consent for the training and CHW Questionnaire can be found in Appendix D.

Thirty-one members of the Spanish-speaking congregation at an Anglican parish were recruited to act as participants in the control group. Their demographic profile strongly resembled that of the CHW trainees. Members at this Anglican parish did not participate in training during 2008, but will participate in training in 2009. (In fact, the Anglican parish will host the 2009 training.) They were recruited to act as controls through bulletin announcements and announcements at Mass. The Anglican parish was chosen for several reasons: 1) no suitable Roman Catholic parishes were available; 2) the researcher was a member of the Anglican parish, facilitating entry into that parish; and 3) there was a desire on the part of the PHPP to extend their reach beyond Roman Catholic parishes and this study provided an opportunity to do that. Although the researcher was a member of the Anglican parish, she had not done any health teaching in the parish before the study; thus the parish was not contaminated and was appropriate to serve as the control parish.

Training

Training sessions took place on 14 Saturdays beginning on September 6, 2008, and ending on December 13, 2008. Classes at Parish “A” began at 10 a.m. and ended at 2 p.m. Classes at Parish “B” originally began at 2 p.m. and ended at 6 p.m. However, due to participant preferences and conflicts with the Saturday evening Mass, we changed the schedule for the afternoon group to 1 p.m. to 5 p.m. Approximately one hour of each session was dedicated to announcements, breaks, and a biblical reflection, leaving three hours for instruction and learning activities. Classes took place in Spanish and on-site childcare was provided. In addition to the trainer, the Project Coordinator or Assistant Coordinator was present – often, both were present -- at each session to prepare the room, set out the snacks, open and close the session, and deal with any logistical issues that arose.

Each parish was assigned one type of educational method. CHWs at Parish “A” participated in training using popular education methodology. CHWs at Parish “B” received training of the same length and approximately the same content, but using traditional education methodology. Differences in the two methods are summarized in Appendix A. Many popular education (PE) sessions included *dinámicas*, social learning games which are designed to create an environment in which participants feel comfortable and willing to share their ideas. Other methods used in the PE sessions included sociodramas, cooperative learning, brainstorming, and games. Traditional education (TE) sessions included presentation of key content of the session, using strategies such as lecture, Power Point, and/or handouts. Participants in both groups

had the opportunity to ask questions. Both the PE and the TE sessions began with a Bible reading and a prayer. However, consistent with Liberation Theology, in the PE sessions the group reflected together on the reading, relating it to their daily lives, whereas in the TE sessions, the Project Coordinator or the facilitator offered a short reflection on the reading.

With one exception (the CPR session), different trainers conducted the PE and TE sessions. In general, trainers were assigned an approach based on their particular skills and underlying philosophical orientation. In one case a skilled popular educator who is also a student of traditional education was requested to facilitate a traditional education class, and in another case a trainer who is somewhat comfortable with both methodologies led one popular education and one traditional education session. It was our intention to involve as many different facilitators as possible. Not only would this provide variety for the participants; it would actually add to our confidence in the research findings because differences in outcomes could be attributed to the methodology rather than to the influence of one good or bad trainer (Gall, Gall & Borg, 2007). However, because of the lack of trained popular educators who are also content experts, this was difficult to do in the case of the popular education group. To ensure fidelity to the two educational philosophies/methodologies and to the curriculum content, we oriented all trainers to the research study and to the primary differences between popular education and traditional education, using Appendix A, “Comparison of Popular Education and Traditional Education” and Appendix E, “PHPP Expectations for Facilitators.”

Topics covered in the curriculum included: 1) Orientation to the Training Series and the Research Project; 2) Leadership Skills and Role of the Community Health Worker; 3) Teaching Skills; 4) Social Determinants of Health; 5) Exercise Anatomy and Physiology; 6) Nutrition and Food Safety; 7) Diabetes Prevention and Management; 8) Heart Health/Hypertension; 9) Mental and Emotional Health Promotion; 10) First Aid and CPR; 11) Navigating the Health Care System/When to go to the doctor/Vaccines and Fever; 12) CHW Skills: Making referrals, confidentiality, advocacy; 13) Hospital visit/Mission focus/Financial assistance; and 14) *Ceremonia de Compromiso* (Commitment Ceremony)/Project Report-Out.

The curriculum that was used for *La Palabra es Salud* was based on the existing curriculum of the PHPP and the Basic Curriculum of the Community Capacitation Center (CCC) of the Multnomah County Health Department. The PHPP curriculum has been developed iteratively by the Coordinators based on feedback from CHWs about what they want and need to learn. The curriculum of the CCC is based on the findings presented in the Core Roles and Competencies Chapter of the National Community Health Advisor Study (Wiggins & Borbón, 1998). It has been approved for academic credit by the Oregon State Board of Education. During the summer of 2008, the Project Team (see below for more information about membership) identified the objectives and crucial content for each training session (see Appendix F). In our Project Team meetings, we brainstormed possible objectives for each session. When I typed up the notes from the meetings, I refined the objectives and submitted them to the other members of the Project Team for approval. The approved objectives were

then provided to the facilitators and they developed their lesson plans to ensure that all objectives were covered.

Project Team and Advisory Committee

The intervention in *La Palabra es Salud* was planned and conducted by a Project Team which included the Eastside and Westside Coordinators of the PHPP (Catherine Potter and Adele Hughes, respectively), an Assistant Westside Coordinator hired by Providence Health and Services to make it possible to conduct two parallel training sessions (Adriana Rodriguez), the Capacitation Coordinator for the Community Capacitation Center-CCC (Teresa Rios-Campos) and the researcher, who is also the Manager of the CCC (Noelle Wiggins).

The Project Team met twice monthly from March through August of 2008 to plan the curriculum, consult on various aspects of the research design and data collection tools, and develop a timeline and a plan for recruitment of the CHWs, among other agenda items. During the time the training was taking place (from September to early December), the group met weekly for at least 2.5 hours to support one another, identify and resolve any problems that were occurring, and prepare for each weekly session. Since the courses ended, the Project Team has met at least once a month, principally to review and analyze the qualitative and quantitative findings from the research, but also to plan follow up events such as an “Unnatural Causes Marathon” where multiple episodes of a DVD that explores health inequities were screened and discussion was facilitated.

Most Project Team meetings took place in the homes of Project Team members. We usually shared a pot-luck breakfast; the Project Team member who was hosting the meeting would coordinate dishes with an e-mail in advance of the meeting. Agendas for our meetings usually included a spiritual or Biblical reflection, a check-in to see how all members were doing and to provide mutual support, a discussion of pertinent issues and a meeting evaluation. A regular attendee at our meetings was Adele's daughter Amalia, who was six months old when we began to meet and is now 22 months old. In our meeting evaluations, we commented frequently on how much we enjoyed Amalia's presence in our meetings.

In addition, consistent with the principles of community-based participatory research (CBPR), an Advisory Committee for the project was organized and began to meet in September of 2008. The Advisory Committee has met five times to date. The Advisory Committee includes all members of the Project Team as well as four experienced CHWs and two leaders (one deacon and one parish priest) from other parishes not participating in the research study. Including CHWs and leaders from other parishes that participate in the PHPP but who did not participate in the research study provided the benefit of community input while avoiding any potential contamination of the two study groups. (See below, *Minimizing Threats to Validity*.) Advisory Team meetings took place at Providence St. Vincent's Hospital and usually lasted two hours. We met over the lunch hour and lunch was provided by the PHPP in order to facilitate members' attendance. Our meetings usually included an opening prayer, a spiritual or Biblical reflection, discussion of key topics, and a meeting

evaluation. Members of the Advisory Committee provided input on a wide range of issues, from interpretation of participants' statements in the in-depth interviews to the best way to display data in tables. Below, in the section on Data Analysis, I provide more detailed information about how I worked with the Advisory Group and the type of input they provided.

Data Collection

Introduction

Our study employed both qualitative and quantitative methods to assess change in study variables. Employing mixed methods allows researchers to capture both the process and outcome aspects of empowerment (Israel et al., 1994), develop a better understanding of the construct of empowerment (Zimmerman, 1990), and capture changes which might otherwise be overlooked (Ferreira-Pinto & Ramos, 1995; Arenas-Monreal et al., 1999). In addition, triangulation of methods is another classic measure for ensuring validity in a qualitative study (Lincoln & Guba, 1985). Also, pursuant to recommendations from Israel et al. (1994) and Zimmerman and Rappaport (1988) about measuring changes in empowerment variables, we substantiated self-report measures and measured change in objective conditions with observational and other non-self-report measures. Figure 3 presents a graphic overview of research questions and the data collection mechanisms that were used to answer each question.

Figure 3: Source of Data for Research Questions

Research Questions	Sources of Data Used to Answer Questions
Question 1: Is type of instruction (PE vs. TE) associated with any changes . . .	CHW Questionnaire
Question 2: Do any changes from baseline to follow-up differ systematically from temporal changes . . .	CHW Questionnaire
Question 3: From the perspective of the participants and the researcher, how does PE work . . .	In-depth Interviews Participant Observation/Field Notes Participant Evaluation Forms
Question 4: What changes, if any, do CHWs perceive in themselves, their families, and their communities . . .	In-depth Interviews Participant Observation/Field Notes
Question 5: From the perspective of the researcher and the project team, what costs and benefits accrue to a CHW training program . . .	Participant Observation/Field Notes Notes from Project Team Meetings
Question 6: From the perspective of the CHWs and the researcher, what elements contribute to the success of a CHW training program . . .	Participant Evaluation Forms In-depth Interviews Participant Observation/Field Notes

Quantitative Methods

CHW Questionnaire

The principal quantitative data collection tool was a written self-assessment which CHWs completed in the language of their choice before and after the intervention (see Appendix B). It was the primary data source used to determine whether the independent variables were associated with differential changes in the dependent variables (Research Questions 1 and 2). The independent variable was type of instruction. This variable had three values: popular training, traditional training, or no training. A second independent variable was time (pre and post). The five dependent variables and measures used to assess them are outlined below:

1. Health knowledge: We used 17 newly-created items designed to measure knowledge about health issues targeted by the curriculum.
2. Ability to share health information: We assessed ability to share health information and promote health with two items created for this project.
3. Empowerment: We used items from a questionnaire developed by Romero et al., 2006, which were in turn based on items from Chavis and Wandersman (1990), Zimmerman and Zanhiser (1991), and Israel et al. (1994). These items are designed to measure key components of empowerment (sense of community and perceived control at the personal and community levels) that have been repeatedly identified in the literature. For the purposes of the study, we defined community as the Latino parish community. We chose not to include the items designed to measure perceived control at the organizational level, since the CHW trainees in this study were not affiliated with a particular organization. DeVellis (2003) notes that it is often best to delete some items in a scale when using the scale with a population where these items might tap a phenomenon different from the one the researcher wants to study. In the case of items designed to measure sense of community, we adapted the items so that they referred to the Latino parish community as opposed to a geographic community. We believed this adaptation would make these items more relevant to a largely immigrant population who are less likely to identify with the broader community, especially given recent anti-immigrant sentiment in the U.S. In addition, as recommended by Zimmerman (1990), we added three new items designed to measure critical awareness of the

social context (or *concientization*). Finally, we added three new items designed to measure motivation and action for change and actual change at the personal and community level. The number of items used to measure each construct is based on a combination of past personal experience in similar studies (such as *Poder es Salud*), precedents set by past studies reported in the literature (particularly Romero et al., 2006), and a general desire for parsimony in order to minimize the burden on participants. In addition, pursuant to Gall, Gall, and Borg's (2007) statement that "content-related validity . . . is particularly important in . . . experiments involving the effect of instructional methods on achievement" (p.196), we did make an effort to ensure that health knowledge items included a representative sample of all the content taught in the course, though our efforts were not systematic.

Historically, items used to assess empowerment have been constructed on a 4-point Likert-type scale, and this was true of the items in our questionnaire. I was wary of using Likert-type scales in this study, since both the literature and my personal experience suggested that Likert-type scales are confusing for various groups of people, including recent immigrants and people with low levels of formal education (McQuiston, Larson, Parrado & Flaskerud, 2002). However, in this case the benefits of using questions to measure empowerment that had a proven track record seemed to outweigh the risks presented by the format of the questions.

4. Self-reported health status: We used the SF-36 “general health status” question to assess health-related quality of life, which asks respondents to rate their overall health on a five-point Likert-type scale. The SF-36 is a generic, multi-purpose, short form health survey which has been translated and used in more than 50 countries (Ware, 1988). The self reported general health status question has a very high rate of predictability of mortality (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006).
5. Health behavior: We used two questions from the CDC’s BRFSS Survey and six health behavior questions that were developed and used successfully in a previous study sponsored by the American Heart Association, Oregon Chapter. Specific items assessed regular check-ups, tobacco use, physical activity, nutrition, and weight and stress management.

In addition to collecting information on the above-mentioned domains, we collected information on a number of demographic variables, including age, gender, level of formal education, birthplace, average annual household income, household size, marital status, primary language, and number of years the respondent had been in the U.S. The CHW Questionnaire made a unique contribution to this study in that: a) it allowed us to compare our data to data from previous studies that had also used quantitative questionnaires; 2) it accommodated the Likert scales that have most often been used to assess changes in empowerment; and 3) it increased the credibility of the study within a public health context.

We took a number of steps to reduce threats to the reliability and validity of the questionnaire. Items were scored in the same direction to facilitate calculation of reliability. Pursuant to recommendations by DeVellis (2003), new items were worded strongly, since “very mild statements may elicit too much agreement when used in Likert scales” (p. 79).

A draft version of the questionnaire was reviewed and revised by the Project Team, which included experienced Latino CHWs. It was translated into Spanish by the Assistant Coordinator, a native Spanish speaker who is also fluent in English, and then back-translated into English by a native English speaker who is fluent in Spanish. The researcher, who is also bilingual, reconciled inconsistencies in the Spanish and English versions. The questionnaire was piloted tested with six family members of experienced CHWs by the Eastside Coordinator during a summer pot-luck, and with 17 participants in two different community groups by the Capacitation Coordinator for the CCC. The pilot testing reaffirmed the importance of several steps that we already intended to take during questionnaire administration, e.g. explaining the nature of Likert scales, providing complete instructions, and reminding participants to answer all questions. We also made various changes to the questionnaire as a result of the pilot testing, including deleting some knowledge items that were too easy, changing the formatting of the knowledge questions, bolding and italicizing key phrases in similar items in the empowerment scale, making minor wording changes for clarity and consistency on a few items, and collapsing the separate race and ethnicity questions into one question. In addition, we added two items designed to assess where

participants typically go to receive medical care, and their knowledge about appropriate use of the emergency room. Such outcomes have commonly been measured in CHW programs and are of interest to health care systems, since appropriate utilization is both more medically effective and more cost-effective.

Members of the two experimental groups completed the CHW Questionnaire during the first and last training sessions. Three PE participants and 19 TE participants who were unable to attend the first training session completed the CHW Questionnaire at the second training session. Two additional TE participants completed the questionnaire in the third session. In the case of CHWs who were unable to complete the assessment due to limited literacy (one in the PE group and 2 in the TE group), other trained project staff administered the assessment orally in the CHW's language of choice. In the PE group, 24 participants completed the baseline survey, while in the TE group, 37 participants did so.

I will describe the experience of administering the survey to the morning (PE) group at some length, since the experience was instructive for me and also may have been related to some of the attrition from the PE group. The survey was scheduled as the last activity during the first session. The morning had started off well; with one exception, all members of the Project Team, plus one additional experienced CHW whom Adele had recruited to help out, arrived 1.5 hours before the designated start time for the class. At Adele's suggestion, we gathered in a circle and Adele offered a prayer for the team and the participants. I wrote in my log notes from this session that by 10:35, after a *dinámica de presentación* led by Teresa, a nice feeling was

developing in the group. (In the *dinámica*, which is called “The Reporters,” participants pair off and interview one another, using a set of two or three questions, and then introduce one another to the group.) But various factors did not go as planned, casting somewhat of a pall over the first half of the session. Only 21 participants attended on the first day, far fewer than we were expecting based on registrations. The training sessions at Parish A were held in a room in the school across the street from the church. Music from a *balet folklórico* (folk dancing) class that took place simultaneously right down the hall proved to be a distraction that first morning and during the entire training course. A nun from the parish used a long reading as part of her opening prayer, confusing some members of the Project Team and leading us to believe the reflection had already happened. Later, when the reflection did take place, participants were not asked to relate the Biblical reading to their own experience, a hallmark of Liberation Theology. One participant in particular tended to dominate the discussion and relatively few other people participated. This same participant made a disparaging remark towards his wife who was also participating. The writing on some of the educational materials was too small to be read across the room. Perhaps most crucially, activities during the first half of the morning were too sedentary and fidelity to the popular education model was low. As a result, the participants’ energy lowered during the first half of the class.

We began the survey administration about 12:30 p.m. after returning from lunch, which took place in the parish hall. After I introduced myself and told participants a little about my experience working with CHWs, Catherine and I enacted part of a

sociodrama that we had created for a previous meeting to share the origins of the study. Next, I explained the reasons for doing an informed consent. My intent was to explain how the informed consent process had developed as way to protect the rights of research participants and prevent unethical research such as the Tuskegee experiment. For at least one participant, this explanation was interesting and eye-opening; he approached me after class and wanted to know how to spell “Tuskegee” so he could Google it and learn more. However, for others, my emphasis on the informed consent, combined with my effort in the consent form to imagine every possible type of harm that could come to participants as a result of participating in the survey, backfired and raised concerns rather than quelling them. We read the informed consent, with one person reading each paragraph. When I asked participants if they had questions, initially no one did, but when I pressed them, one participant asked why I needed people’s names. I tried to explain why I needed to be able to link the responses of a particular participant before the training to the responses of the same participant after the training without mentioning statistics; I am not sure how well I succeeded. At this point, the same participant who had dominated the first half of the session and made the disparaging remark about his wife launched into an extended discourse about how one can never really be sure how one’s information is going to be used. During most of this discourse, I stayed calm, and acknowledged the many good reasons participants from the Latino community would have such questions. But eventually, I became somewhat defensive, and explained that I had shared information about my background so that people would understand I was not a

newcomer to the community who was going to take their information and never return. A few participants, including a Guatemalan doctor who had conducted research, came to my aid, reaffirming the potential benefits for participants of being involved in research. Ultimately, because time was running very short, I explained that if participants had questions, I would talk with them later individually to respond to their questions and concerns, because we needed to get started on the survey.

Everyone eventually signed the consent form and took the survey. The young woman who had asked the first question only did so after I talked to her privately. During that exchange, I learned that she had had a bad experience at Portland Community College, where someone had told her that her information would be kept confidential, and did not keep it confidential. To ensure data quality, I checked the surveys as participants turned them in for missing responses.

I learned several important lessons from this experience, some of which I was able to put to use later that same day with the afternoon (TE) group. Overall, it appeared to me that the informed consent form was much more daunting to participants than the survey itself. One reason for this was that the informed consent required a signature. Too late for this study, I learned that passive consents are becoming much more common, especially for research in communities like the Latino immigrant community where participants have a well-founded fear of giving their names. For future research in this community, I will strive to utilize passive consent. Second, I learned that including every possible harm that might come to participants in the informed consent raised their fears in a counter-productive way. (When we debriefed the survey in the

second PE session, most participants commented that the questions on the survey were “normal,” the same ones they are asked when they go to a doctor.) When I administered the survey to the TE group in the afternoon, I made a joke about this, telling them the consent form was a little dramatic, and I experienced none of the resistance I had confronted in the morning session.

Neither of the two PE participants who had raised questions about the survey returned to the second session, nor did the wife of the male participant. Although it was our intention to contact these participants, a cultural difference in communication between two members of the project team resulted in their not being contacted, and they never returned. While I cannot know with certainty that the survey process was responsible for their attrition from the group, it certainly seems likely that the two phenomena were related.

In the case of the control group, participants were able to complete the survey after Mass on two dates in early September and three dates around the end of the year. Assistance in completing the questionnaire was also available to members of the control group. At the suggestion of a CHW on the Project Team, we offered a food basket as an incentive to members of the control group who completed both the baseline and follow-up survey. A total of 31 control group members completed the baseline survey.

Participant Evaluation Forms

Generally, a Participant Evaluation Form was distributed and completed by each CHW at the end of every class. There was one exception. Because the coordinators

had forgotten to bring evaluation forms to the Social Determinants of Health session with the PE group, participants in that group completed the evaluation for that session the following week. Most often, the Assistant Coordinator collected the evaluations and gave them to me; I in turn gave them to our Office Assistant at the Community Capacitation Center for data entry.

The Participant Evaluation Form, which was previously developed by staff at the CCC, includes questions on a five-point Likert-type scale such as, “As a result of this session, I am more able to promote health in my community,” and “The facilitator for this session included information from a variety of cultures and perspectives.” The systematic, individual-level data provided by these forms helped to identify strengths and weaknesses of the training content and format and were used to help answer Research Questions 3 and 6.

Qualitative Methods

In-depth Interviews

I conducted semi-structured in-depth interviews with a purposive sample of 12 CHWs, six from the popular education group and six from the traditional education group (see Appendix G: In-depth Interview Guide). Along with data from field notes based on participant observation (see below), I used data from the in-depth interviews to determine, *from the perspective of the CHWs*, how popular education works, if it does; what changes, if any, occur in CHWs, their families and their communities as a result of the training; and what elements contribute to the success of a CHW training program, regardless of the methodology (Research Questions 3, 4, and 6).

In addition to the questions included in the draft Interview Guide submitted with my proposal, which concerned CHWs' experience of the training and effects they perceived the training might have had, I also added two questions to deepen my understanding of participants' responses to two statements on the CHW Questionnaire. The first statement assessed the degree to which participants agreed that other people in their community shared the same values, and the second asked how much participants agreed that their community had control over their decisions. As I entered the data from the CHW Questionnaires, I was struck by the strength of the negative responses to these items, and wanted to understand how participants understood the items and why they reacted as they did. I will discuss these items and participants' reactions to them in Chapter IV. When I reached saturation in the in-depth interviews regarding these two additional questions, I stopped asking them.

In order to develop a diverse purposive sample of CHWs and thus guard against biasing my findings in any direction, I constructed a grid that included potential participants' names along one axis. Along the other axis were demographic characteristics including age, gender, country of origin, years in the U.S., marital status, employment status, years of formal education, primary language, and parish community. Along this same axis, I also included information from the potential participants' baseline and follow-up surveys, such as number of incorrect health knowledge items at follow-up, changes from baseline to follow-up in level of empowerment and health behavior, whether the respondent had a regular source of health care, and a subjective assessment of the likelihood each participant would be a

good subject. I filled in the grid and then sought to construct a diverse pool of interviewees. My initial list of interviewees was also influenced by input I solicited from the Project Team. Once I began the interviews, I replaced one male participant who seemed unwilling to participate with another male participant from the same experimental group. Doing so resulted in overrepresentation of one Central American country.

Another anomaly which may have affected the results was the fact that the TE sample included four mothers, one father, and one son whose mother had also participated in the course. The PE sample, by contrast, included three mothers, one father, one unmarried woman who lived at home, and one man who lived alone. This meant that the TE sample included more parents, and thus more people who had control over their family's eating and exercise habits. This may have resulted in greater reporting of changes in diet and exercise among the TE sample (see below, Chapter IV, Research Question 4.)

Initially, I did not intend to conduct any interviews with couples, but because several couples had participated in the training together and it was difficult to invite one member of a couple to participate without inviting the other member, ultimately I interviewed two couples, one from the PE group and one from the TE group. Although I made this decision based on my desire to maintain good relationships, I came to feel it benefited the research, since couples would often build on what each other were saying, thus providing me with a different kind of data that is more typical of focus groups.

In order to protect participants' confidentiality, I assigned aliases to all of the CHWs who participated in the in-depth interviews. I use those aliases when I report the results of the interviews in Chapter 4. To help the reader keep track of the interviewees and their experimental group, Figure 4 provides a list of the interviewees (by alias) and their respective experimental groups.

Figure 4: Interview Participants by Experimental Group

Popular Education Group	Traditional Education Group
Blanca	Sonia
Yesenia	Ana María
Emiliana	Juanita
Lupe	Delmi
Angel	Hilario
Alejandro	Israel

The qualitative interviews used open-ended questions to elicit a wide range of responses and to allow the researcher to probe for better understanding. In addition, I practiced the sort of mutualistic interviewing described by Fontana and Frey (2005). In this style of interviewing, the researcher seeks to build trust and counteract status differences between him or herself and the participant by sharing personal information, answering questions and expressing feelings, while consistently redirecting attention to the participant as the expert. For example, in my interview with Hilario and Delmi, two members of the TE group, Hilario used a Spanish word that I did not know, but was able to deduce from context meant “old.” Because I have spent time in Hilario and Delmi’s home country, I confirmed that the word meant old and then said, “They didn’t teach me that word when I was in [country of origin].” Hilario went on to explain that the word is used to avoid making people feel bad by

calling them “old” and I thanked him for teaching me a new word. Similarly, a bit later in the same interview, when Hilario made a reference to a song about the value of friendship, I recognized the song and told him it was one of my favorites. A more substantive example of mutualistic interviewing took place in the interview with Israel. In the context of a discussion about the session on Social Determinants of Health, the following interchange took place:

Israel: I remember watching the video about Native Americans reserves, where they would only give them bad foods and I guess cancer and they got sick from it, and they got diabetes, because it was really bad food. That is what caught my attention.

Noelle: Yes, because I think what’s important about that session is that far too often we blame people for their health status and we can make them think it is their fault.

Israel: But, it’s not their fault because it’s like the only option they have.

While I obviously had to guard against making comments that would lead the interviewees to certain conclusions, I feel that brief interchanges such as these served to build trust and mutual understanding with the participants and elicit more complete and nuanced data.

Interviews with CHWs occurred in January and February 2009 after completion of the initial training but before the session on February 7, 2009, in which we debriefed the participants from both experimental groups about the research. All the interviews took place in participants’ homes and lasted between 30 minutes and one hour. I recorded the interviews and they were transcribed by a professional transcriptionist in

Spanish; in addition, I made an effort to note and record the nonverbal aspects of the interviews. For example, in my interview with Juanita, I mentioned to Juanita that her body language suggested that she was not satisfied with what she had learned and wanted to learn more. She confirmed this was what she was feeling. I had to re-interview one respondent, because we conducted the original interview in a library and the tape was inaudible to the transcriptionist. This interview occurred after the debrief with the two experimental groups. Because I wanted to know whether the respondent's answers differed materially from her responses in the first interview, I went back and listened to the first tape recording and was able to transcribe most of the interview. While I found that the responses in the second interview were not markedly different, the initial interview had a certain freshness that I preferred. When reporting responses from this participant in Chapter IV, I will indicate which transcript I am working from.

In addition to allowing the CHWs, even those with quieter voices, to be heard, qualitative in-depth interviews permitted me to develop a relationship of solidarity with the respondents. In the words of Kong, Mahoney, and Plummer (2002), the interview became "a methodology of friendship" (p. 254, cited in Fontana & Frey, 2005, p. 696). CHWs already knew me because I attended 12 of the 14 training sessions. The in-depth interviews presented an opportunity to deepen those pre-existing relationships and establish a partnership, as we worked together to "create a narrative" (Fontana & Frey, 2005). I attended carefully to the development of this relationship, both because of the highly relational nature of Latino culture and also

because of my outsider status as an Anglo-European and a non-CHW. Individual interviews provided the best chance to accomplish this goal, and indeed were highly successful in this regard.

Field Notes

I attended 12 of 14 CHW training sessions (both morning and afternoon) as a participant observer, although I did not always stay until the end of the afternoon session. Initially, I intended to attend only selected sessions. However, after attending the first two sessions, I quickly realized that actually being present in the sessions and watching how they unfolded and the participants' reactions to them provided data that I could gain in no other way. I also attended and took field notes in *all* meetings of the Project Team and the Project Advisory Committee.

In the training sessions and meetings I observed, I took detailed notes on a laptop computer, documenting the content of verbal discussions and nonverbal exchanges or communication. After the classes and meetings, I produced a set of field notes. I also collected and filed any documents or materials distributed at the meeting or capacitation session. Field notes from the training sessions helped to assess how popular education works, if it does (Research Question 3), how the two modes of training affect trainees (Research Question 4), and what elements contribute to the success of a CHW training program, regardless of the methodology used (Research Question 6) in that I was able to observe and record techniques, facilitator behaviors, and other aspects of the training and their effect on participants.

Field notes from meetings of the Project Team and the Advisory Committee provided additional data about elements that contribute to success (Research Question 6) and were the primary data source for assessing what benefits accrue to a CHW training program as a result of being involved in research (Research Question 5). Field notes that I began to produce during Project Team meetings before the formal research began convinced me that the meetings were a rich source of information about Research Question 5. In fact, I added this research question when it became clear to me that I was collecting valuable data on this question, which would be of use to the PHPP as well as other similar programs.

Minimizing Threats to Validity

A number of factors can threaten the internal validity of experimental and quasi-experimental studies. A list of those threats and an explanation of how we sought to minimize them is provided below.

Selection Bias

Selection bias refers to systematic differences between members of the groups in an experimental or quasi-experimental study (Newsom, 2006). In our study, some selection bias was introduced by the fact that “Parish A” was chosen to receive the popular education training because of its perceived weakness in terms of leadership capacity. In addition to the desire to enhance leadership at “Parish A” through the use of popular education, the PHPP Westside Coordinator felt that if the members “Parish A” were assigned traditional education, attrition from the group might be so great that

the group would cease to exist. (The effect of this decision was somewhat attenuated by the fact that members of two additional parishes participated in training at “Parish A.”) In a sense, by assigning popular education to the weaker parish, we biased our study against finding significant differences “in favor” of popular education.

Collecting demographic data in the CHW Questionnaire provided a way to identify systematic differences among the members of the three groups. In addition, using mixed factorial ANOVA, in which each participant acts as her or his own control, in the analysis (see below) helped to correct for any systematic differences.

Endogenous Change and History Effects

The term “endogenous change” refers to changes that occur within and among the participants during a study. It includes a trio of threats: 1) testing effects (the tendency of people to do better the second time they take a test); 2) maturation, (the natural process of growth or decline as participants grow older); and 3) regression to the mean (a statistical process in which extreme scores tend to move toward the middle – and middle scores toward the extreme) (Newsom, 2006). Having a control group that did not receive any treatment helped to guard against these threats, since the members of the control group were equally subject to them. The same was true of “history effects” -- events occurring in the external environment that could also be responsible for observed effects -- that might have affected Latino immigrants as a group. In addition, the PHPP Westside Coordinator had regular contact with leaders

in all the participating parishes and did not become aware of any history effects that were unique to one or more of the parishes.

Contamination

Contamination occurs when members of different experimental groups come into contact with and change one another. We attempted to guard against contamination by assigning people from the same parish to the same experimental group; this effort was not entirely successful because people often attend more than one parish. We also attempted to keep the two groups separate. For example, when two members of the afternoon (TE) group arrived early for the financial assistance session and entered the room where the morning session was still going on, the Assistant Coordinator quickly moved them to another room. Some evidence of minor contamination was found. A PE participant in the in-depth interviews revealed that he had heard something about the methodology that was being used in with the afternoon group, but his knowledge was within the bounds of what we had agreed to share with the participants. There was no evidence of contamination of the control group, whose members generally lived on the other side of the Willamette River and did not naturally interact with members of the two experimental groups.

Threats to Validity of the Qualitative Data

Because qualitative research rests, to a large degree, on different axioms than quantitative research, different methods are required to assure the validity of qualitative data (Lincoln & Guba, 1985). This is especially true of qualitative data

collected within a critical paradigm. We took a number of steps to assure the validity of the qualitative data collected in this study. Following “standard practices associated with what Lincoln and Guba (1985) call the ‘trustworthiness’ of ethnographic research” (Anderson, 1989, p. 253), we practiced triangulation of both data collection methods and sources of data. This meant that we collected various types of data (qualitative and quantitative) and compared results from the two types against one another. It also meant we sought variation within qualitative data; we conducted both in-depth interviews and participant observation. We also practiced “member checking” by preparing preliminary data analysis reports and sharing these with the Advisory Committee so that they could inspect, correct, and expand on my interpretations.

In addition to these standard methods for assuring trustworthiness in traditional qualitative studies, we also applied methods that have been shown to be useful for dealing with what Anderson (1989) has called the “conceptual ‘front-endedness’” (p. 253) of research conducted within a critical theoretical paradigm. Specifically, I attempted to practice critical reflexivity by: 1) including memos in my field notes about my own reactions to what I was observing; 2) using CBPR as my primary research paradigm; and 3) negotiating outcomes of the study along with my colleagues on the Project Team and the Advisory Committee.

Data Entry

Quantitative Data

An Access database was constructed and data were entered into the Access database and then transferred to SPSS. Data were cleaned to avoid missing values when possible, e.g. substituting missing values for demographic variables in Wave 1 with the corresponding values from Wave 2 when those were present, and vice versa. Missing records from Wave 2, which were erroneously entered as “0” when the date was transferred from Access to SPSS, were re-coded as missing. Five surveys were chosen at random and data were checked for accuracy. In the case of the Participant Evaluation Forms, the data were entered into a previously constructed Access database by the Office Assistant at the Community Capacitation Center.

Qualitative Data

The interview transcripts were transcribed and my field notes were created in Microsoft Word. I began conducting the analysis manually in Microsoft Word. After doing open coding on five interview transcripts, I entered the data into Atlas ti and conducted the remainder of the analysis in this qualitative data analysis (QDA) program. I made the switch primarily because of the quantity of data I needed to analyze. Using the QDA program allowed me to retrieve quotations more quickly.

Data Analysis and Interpretation

Quantitative Data

Cook and Campbell (1979) recommend starting the analytic process for any quasi-experimental study by “sifting through the data descriptively to see what they suggest. This data is then combined with the researcher’s knowledge of (1) the subject matter, (2) the causal forces underlying the measured variables, (3) the selection process, and (4) the specific research setting, to suggest which analyses are plausible and to build appropriate models” (p. 200). This was the process I undertook with both the CHW Questionnaire and the Participant Evaluation Forms, before proceeding to more systematic analysis, as I will describe below.

CHW Questionnaire

Entering the data from the CHW questionnaires manually into the Access database provided an excellent opportunity to begin to familiarize myself with the data before I began the formal analysis process, and to begin to note trends and questions that I wanted to explore later in the analysis. I began the formal data analysis process for the questionnaire by developing a revised analysis plan based on the plan I had developed for my research proposal. For my quantitative analysis, I sought to use methods which were suited to my data, i.e. I did not try to use overly powerful methods (like multi-level analysis) that are ill-suited to small data sets with only two time points.

To develop demographic profiles of the participants at baseline and follow-up, I calculated descriptive statistics such as means (with 95% confidence intervals), standard deviations, skewness and kurtosis. To better understand distributions of

variables, I made liberal use of graphs, including stem and leaf displays, box plots, and frequency histograms with normal curve overlays. The graphs allowed me to examine the data for outliers and to assess whether the variables were normally distributed. To determine whether the groups differed significantly on the continuous demographic variables at baseline, I used one-way ANOVA. To obtain the same information for the categorical demographic variables, I calculated chi-square statistics.

To assess changes within and between the three groups from baseline to follow-up, I used mixed factorial ANOVA. Experimental condition was the between-subjects factor and pre/post (time) was the within-subjects factor. To test for simple effects for the within subjects factor in the case of a significant interaction, I conducted paired t tests. I also used paired t tests to test for significant changes among members of the two experimental groups in the absence of a significant interaction. Paired t tests are more powerful than independent samples t tests because each subject acts as his or her own control, and differences between subjects at baseline are taken into account. Because of the small sample size in this study and because assumptions of normality and homogeneity of variance could not be assured, I reanalyzed the data using Wilcoxon signed rank tests, which are more robust and less sensitive to violations of the normality assumption.

I also conducted a number of tests to explore the reliability of the instrument itself (the CHW Questionnaire.) Cronbach's alphas were computed to investigate the internal reliability of the scales and sub-scales included in the questionnaire for which there were no right and wrong answers. Acceptable reliability levels are between .7

and .8 for Cronbach's alpha. A reliability level of .7 means that 70% of the variation in scores is assumed to be true variation.

Table 1: Reliability of Scales and Sub-Scales, provides a summary of the scales and their respective reliability levels. The table reveals that all reliability scores were within the .7-.8 acceptable level, with the exception of Perceived Control at the Community Level, for which the standardized alpha level was .656. Results revealed that this alpha level could not be improved by deleting any item from the scale. The lower reliability level of this scale may be due to many factors, including: inconsistencies in how respondents defined "community" (despite specific instructions in the questionnaire); a strong resistance to the idea of the community having control over the individual (see Chapter Four); the relative powerlessness of the Latino immigrant community vis à vis the larger society; and dissatisfaction with actual levels of community control based on the previous circumstance.

An alpha level of .743 for the three questions making up the concientization scale revealed good reliability for this newly-created scale. Likewise, the three questions making up the new "Action for Change" scale achieved an acceptable reliability of .719. While the questions in the health behavior scale had been used before, internal reliability had not previously been calculated; this scale achieved an acceptable reliability level of .746.

To investigate the correlation of scales in the questionnaire, I used correlation analysis. Unlike the descriptive statistics presented above, which describe a single variable, correlation analysis describes the relationship between two variables. In

correlation analysis, a set of scores for one variable is plotted on a graph in relation to the scores of the same set of individuals on another variable. Then, a line is fitted to the resulting points. The dispersion of scores around the line indicates the strength of the relationship (or lack of relationship) between the two variables. The direction of the line indicates the direction and magnitude of the relationship between the two variables. In some cases, a curve may fit the data points better than a line; this can indicate a curvilinear relationship. Correlation is computed from the mean, indicating it is sensitive to outliers. Therefore, it is necessary to calculate and examine scatterplots to determine the effect of outliers on the data. Whether a correlation statistic is considered small, moderate or large depends on the field of study (Newsom, personal communication, spring 2006). There are many influences on the attitudes and behaviors that educators study, so any one factor is not likely to exert a strong influence. Thus, correlations in the range of .2 to .4 are considered good. (Gall, Gall, and Borg, 2007). Correlations are tested for statistical significance using a t test; the t test statistic is produced when the correlation is obtained in SPSS.

In order to investigate the correlation of scales in the questionnaire, new variables were created as summary measures for health knowledge, self-reported ability to promote health, empowerment, and health behavior. In addition, sub-scales were created within the empowerment scale for sense of community, perceived control at the community level, perceived control at the personal level (self-efficacy), conscientization, and motivation and ability to act for change. Then, in order to determine whether there was a significant linear relationship between the scales, a

correlation matrix was created, first using the sub-scales for empowerment rather than the global scale of empowerment (see Table 2: Correlation Matrix for Empowerment Sub-scales). Results revealed there were significant positive linear relationships between several of the scales. Health knowledge was moderately correlated with concientization and health behavior ($r = .291, p = .006$; $r = .255, p = .014$). Self-reported ability to promote health was moderately correlated with sense of community, control at the personal level, and self-reported health status ($r = .330, p = .001$; $r = .384, p = .000$; $r = .214, p = .041$). Additional significant correlations existed between control at the community level and control at the personal level, concientization, ability to act for change and health status; between control at the personal level and concientization, ability to act for change, health status and health behavior; between concientization and ability to act for change, health status, and health behavior; between ability to act for change and health behavior; and between health status and health behavior.

In order to assess the influence of outliers on the correlation statistics, bivariate scatterplots with a best fit line overlay were obtained for health knowledge and all the other scales and self-reported ability to promote health and all the other scales. Inspection revealed no marked outliers. It also revealed that the small number and range of data points made it difficult to identify outliers, so no further scatterplots were obtained.

Next, a correlation matrix was calculated using the global scale for empowerment and excluding the empowerment sub-scales (Table 3: Correlation Matrix for Global

Empowerment Scale). This analysis revealed that empowerment was moderately correlated with self-reported ability to promote health ($r = .327$, $p < .01$), self-reported health status ($r = .365$, $p < .01$), and health behavior ($r = .343$, $p < .01$). Bivariate scatterplots with a best fit line overlay were obtained and revealed no notable outliers.

Participant Evaluations

For the Likert scale items on the Participant Evaluation Forms, means were computed for each question for each session, and then an overall mean score for that session was computed. Again following the advice of Cook and Campbell (1979), I began my analysis by examining the mean scores for each session and each question, looking especially for notably high scores, since high scores on this tool indicated less favorable ratings. This non-systematic analysis allowed me to begin to detect patterns in the data. For example, I noted that the Heart Health session with the TE group had six ratings of 2 or above, whereas most questions for most sessions had scores between 1 and 2. Next, I ranked the sessions for both groups separately from most favorable to least favorable.

Qualitative Data

In the case of the write-ups of my field notes from participant observation of the two training groups, as much as possible I began to code the notes soon after I had created them, and before the next participant observation session. The same was true of my notes from Project Team meetings and Advisory Committee meetings. This was not possible for the in-depth interview transcripts because of the time frame within which I had to conduct the interviews. I needed to wait to begin the interviews

until after the courses had ended (in early December 2008) and I had to complete the interviews before the first joint meeting and debrief with the two experimental groups on February 7, 2009. The “arctic blast” that prevented travel during the latter part of December 2008 compressed the timeline still further. The distances I had to travel to conduct the interviews made it preferable to conduct several interviews on the same morning or afternoon. Often, I had to go straight from one interview to the next, without much time in between to reflect on what I was learning. However, this did not prevent me from making some changes during the interview process. After observing that respondents had trouble remembering the names and facilitators of particular sessions, I began to take along a list of sessions and facilitators. While this aided participant recall, it also seemed to focus their responses to the “What did you like?” question on particular sessions rather than other aspects of the training, so eventually I only brought the list out when participants requested it. In another example of how I adapted the interview process as I went along, when I felt I had reached saturation on the two questions asking for interpretation of statements on the CHW Questionnaire, I stopped asking these questions.

I used an approach to coding which fell somewhere between the classic “grounded” approach introduced to me by Strauss and Corbin (1990) and the pre-structured approach described by Miles and Huberman (1994). Based upon past experience, I first approached my data with the intention of doing a grounded analysis, but quickly discovered two things: first, that I had my research questions firmly planted in my mind, and thus brought those categories to the data, and second, that the data were

conforming nicely to those categories. This was not surprising, given that I had developed the in-depth interview guide based on the research questions, and the format for the interviews was relatively structured. Thus, I quickly developed a coding scheme based on a list of higher-level codes (Miles and Huberman [1994] refer to them as “pattern” codes) drawn from my research questions: *Elements* (for elements that contribute to the success of a training program – q6); *Effects* (for changes that occurred in the CHWs, their families and their communities – q4); *How does PE work?* (q3); etc. Having these etic codes in my mind did not prevent me from seeing and noting other emic codes and themes, such as the prominence of stress in the lives of the participants.

In the case of the three open-ended questions on the Participant Evaluation Forms, a report was prepared which included all the comments, organized by session and respondent (although responses were anonymous). After reviewing all the data to identify patterns and trends, I created a matrix in which I listed the most frequent responses by session for each experimental group. I created additional matrices for each experimental group that were not divided by session but rather identified the most common responses. Creating both matrices helped me to distinguish between comments which were specific to particular sessions, and comments which were common across sessions, and thus representative of reactions to the two methodologies.

Member Checking

Member checking, defined as the practice of testing “data, analytic categories, interpretations, and conclusions . . . with members of those stakeholding groups from which the data were originally collected” (Lincoln & Guba, 1985, p. 314), is one of the standard practices used to guard against bias and establish the validity of qualitative research (Anderson, 1989). I prepared and presented iterative reports on the analysis at meetings of the Project Team and the Advisory Committee, so that the members (including experienced CHWs) could check my understandings and interpretations against their own. (For an example of one of these reports, see Appendix H: Answers to Research Questions.) This provided a variation of what McLaren and Giarelli (1995) refer to as “checkmating oppression,” since I am neither a person of color nor a CHW. In other words, from their position as members of at least two oppressed groups (CHWs, who sit on or near the lowest rung of the hierarchical medical system, and people of color), CHWs on the Project Team and the Advisory Committee were likely to see things I did not see as a result of my position of relative privilege. Providing an opportunity for CHWs to review and comment on iterative analysis reports assured that these perspectives were not lost. In addition, negotiating meaning with participants in the Advisory Committee, who were members of stakeholder groups, provided particular protection against bias in this study which was shaped by my own ideological commitments. Ultimately, qualitative results were triangulated with quantitative results to provide a more nuanced understanding of the

outcomes associated with the two types of training and to explain how the two types of training produced their effects.

An example of how I worked with the Project Team comes from our meeting on May 27 and June 19, 2009. In preparation for these meetings, I printed quotations from the in-depth interviews with the PE participants on strips of paper. I labeled separate flip chart pages with research questions 3, 4 and 6, and I labeled two additional flip chart pages as “other.” In the meeting, Project Team members read the quotations and then taped them to the flip chart pages labeled with the research question to which they believed the quotation related. They also wrote comments off to the side of the paper strips. For example, if they believed a quotation was related to more than one research question, they noted it on the flip chart paper near the quotation. When we had assigned all the quotations, we discussed our impressions and talked about what thoughts occurred to us during the activity. In our meeting evaluation, Project Team members commented that they had enjoyed reading the quotations and, repeating one of the quotation she had read, one member commented, “I liked the methodology; it made the time pass quickly!”

An example of how I worked with the Advisory Council took place at our meeting on June 19, 2009. For this meeting, I prepared a 12-page summary of the answers to Research Questions 1-4 (Appendix H: Answers to Research Questions). In this document, I used dot points and quotations from the participants to summarize my findings to date on each research question. In the meeting, I divided members into two groups, first assuring that the groups were balanced in terms of number of CHWs,

number of clergy, and number of Project Team members. I assigned questions 1-3 (the results of which were more succinct) to one group and question 4 to the other group. I asked them to review the results in whatever way they preferred (reading the document aloud to one another or reading it silently) and then to identify and discuss the points that seemed most important or salient to them. When each group had completed this task, we came back together as a large group and discussed the findings.

During the discussion, members commented that they were struck by how popular education participants spoke in terms of “empowering” others while TE participants spoke about “helping” them. They asked each other questions, such as whether it is possible to use popular education to share large amounts of new information. In the meeting evaluation, members reported that they enjoyed reading the quotations from participants and that they could picture people saying the words. They also stated that the summary was great and helpful and that they had enjoyed working in small groups.

Participant Characteristics

Participant Characteristics at Baseline

Descriptive statistics for the three groups (PE, TE, and control) for continuous demographic variables (age, years in the U.S., years of formal schooling, and number of children) at baseline were obtained along with stem and leaf displays, box plots, and frequency histograms with a normal curve overlay (see Table 4: Descriptive Statistics and Significant Differences for Continuous Demographic Variables at Baseline). The total sample size (n) at baseline was 24 for the popular education (PE)

group, 37 for the traditional education (TE) group, and 31 for the control group (CG), although the “n” for each question varied because of missing data.

The TE group had the oldest mean age, at 41. The mean age for the PE group was 37 and for the control group, 39. Variability of age was similar for all groups, indicated by a shared standard deviation of 12. Box plots further revealed that the mean age for the PE group was affected by two outliers, one at 16 and one at 67, while the mean age of the control group was pulled up by two outliers at 71 and 65. The frequency histograms revealed that the PE and CG groups were somewhat skewed to the upper values (PE=.473, CG=.712), while the TE group was somewhat skewed to the lower values (TE= -.409). However, recognizing the limitations of the skewness statistic, skewness was within acceptable levels for all groups. Having confirmed that the normality assumption was at least approximated by all groups, it was possible to conduct a one way ANOVA to determine whether age differences between the three groups were statistically significant at baseline. The ANOVA revealed no significant differences between the three groups ($F=.824$, $df=2$, $p=.442$).

An identical process was conducted for the other three continuous demographic variables; results are found in Table 4. The only significant difference on these variables for the three groups was found for number of children ($F=5.810$, $df=2$, $p=.004$). A Tukey post-hoc test to control for familywise error (FWE) was obtained for the ANOVA for number of children. It revealed significant differences between the PE group and the control group ($MD=-1.208$, $SE=.392$, $p=.008$) and between the TE group and the control group ($MD=-.973$, $SE=.351$, $p=.018$).

To explore the categorical demographic variables at baseline and any significant differences between them, crosstabs and chi-squares were obtained. (See Table 5: Three Categorical Demographic Variables at Baseline.) The crosstabs revealed that while the PE and TE groups were predominantly female, the control group had almost equal numbers of men and women. The chi-square revealed this difference was significant ($\chi^2(3) = 12.82, p < .001$). To further confirm that the differences in gender breakdown between the PE and TE groups was not statistically significant, a chi-square including only these two groups was obtained; the result was not statistically significant.

The crosstabs for country of origin revealed that the TE group was the most diverse; while 62.2% of this group was from Mexico, 34.2% was from other countries in Latin America. The control group was the most homogenous, with 77.4% of its members from Mexico. The PE group had the largest percentage of members born in the U.S., at 16.7%. Cell counts were small and differences did not achieve statistical significance.

A large majority of all members of all three groups preferred to communicate in Spanish (PE=79.2%, TE=83.8%, CG=67.7%). Despite having a greater percentage of members born in the U.S., no members of the PE group preferred to communicate in English, while 16.1% of the control group members did. The PE group had the largest percentage of members who felt equally comfortable in English and Spanish (20.8%).

In terms of ethnicity, all members of the PE and TE groups were Hispanic/Latino. Only 1 member of the control group identified as Anglo; all the rest were Hispanic/Latino.

In terms of marital status (see Table 6), the PE group had the largest percentage of single people, at 20.8%. The control group had the largest percentage of unmarried people living together (19.4%) and the largest percentage of married people (64.5%). Almost 20% of the TE group were divorced and separated (18.9%); this was substantially larger than the next highest group (PE group = 4.2%). Again, however, cell counts were small and differences did not achieve statistical significance.

A survey of the crosstabs for employment status (see Table 7) revealed a similar employment profile for all three groups. Between 58% and 68% of all three groups were working. Between 6.5% and 8.3% of all group members were taking classes. The PE group had the largest percentage of homemakers (20.8%, compared to 13.5% for the TE group and 16.1% for the control group.) Only the TE group had members on sick or maternity leave (2.7%) or not working because of disability (5.4%). Differences were not statistically significant. Because participants were allowed to check more than one employment category, a second table was created including all responses. (See Table 8: Employment Status at Baseline with all Responses.) The group profiles did not change substantially, since most second and third choices in all groups were “student taking classes” and “homemaker.”

While income was actually a categorical variable, it was most meaningful to analyze it as a continuous variable, by obtaining box plots and frequency histograms

and then conducting a one-way ANOVA to explore differences between the three groups. (See Table 9: Income Levels at Baseline.) The mean of the three groups was quite similar (PE=5.30, TE=5.25, CG=5.55). However, histograms revealed very different distributions. The distribution for the PE group extended from 1-8 and was skewed toward the lower values. The distribution for the TE group extended from 1-10, was flat topped, and had substantial numbers at both ends. Of this group, 16.2% had incomes at or above \$40,000 per year, whereas no members of the PE group reached this level. The distribution for the control group was somewhat more normal, but had peaks at the low and mid values and almost 20% of the members of this group reported incomes below \$2,000 per year. At the same time, 19.4% of members of this group reported incomes at or above \$40,000/year. The differences between the three groups were not statistically significant. All the information about income may be of little value, however, since it appeared to the researcher that some respondents had overlooked the direction to combine income for all family members living in the home, and had rather included only their personal income.

By design, the three groups were significantly different in terms of the parishes that the members represented ($\chi^2(18) = 147.532$, $p < .001$). (See Table 10.) All control group members were from one single parish and no one from this parish was included in either experimental group. However, there was more overlap than intended between the two experimental groups. Four parishes had members in both the PE and TE groups. This indicates the possibility of some contamination among group members. Because participants were allowed to check more than one employment

category, a second table was created including all responses (see Table 11). Again, including all responses does not substantially change the distributions; it only further blurs the lines between the two experimental groups and makes it clear that parish affiliation is not a fixed variable.

While the quantitative data revealed few significant differences between the two experimental groups at baseline, the three people who had the most contact with the two experimental groups – Project Coordinator Adele, Assistant Coordinator Adriana, and myself – all felt, from the outset, that the two groups were substantially different. Some of these differences are revealed by the quantitative data. For example, a large proportion of participants in the TE group were from one parish, the parish at which the training was held (58% reported attending this parish, although two people listed multiple affiliations). Several of them sang together in the choir at the Spanish Mass. Our interpretation was that this provided a kind of pre-existing sense of community in the TE group that did not exist, but rather had to be developed, in the PE Group.

Other differences were more ineffable. The PE group was both smaller and quieter -- Adele used the word “shyer” -- and these characteristics seemed to reinforce one another, at least in the initial sessions. (For example, in my field notes from the fourth session, I observed that the TE group just seemed happier than the morning group.) While the quantitative analyses revealed no significant differences in age or time in the US between the two experimental groups, the afternoon group seemed older and more established; this may have been simply because there were *more* middle-aged participants who had been in the US for a number of years, and these participants were

vocal in the afternoon group, thus making their presence felt. The statistical profile for income in the morning (PE) group showed a more normal distribution with a smaller range, while the profile for income in the afternoon (TE) group revealed a broader distribution with substantial numbers at both extremes. In the afternoon group, the presence of several professional people with high incomes was marked, and contributed to our sense that the afternoon group was generally economically better off than the morning group. The higher percentage of participants from South America (who tend to be more formally educated than immigrants from Mexico and Central America) and a greater number of people with more than 17 years of formal education probably also contributed to our general impression that the afternoon group was of a higher social class than the morning group.

Other sources of qualitative data reinforced the impression that there were greater differences between the two groups than those revealed by the quantitative data. For example, on the participant evaluations conducted after each class, it was common for four to five participants from the TE group to write their answers in English rather than Spanish, whereas this never happened with the participants in the PE group, indicating to me that more participants in the TE group were truly comfortable communicating in English.

Participant Characteristics at Follow-Up

To begin to explore changes in the three groups from baseline to follow-up, I calculated descriptive statistics for the continuous demographic variables at follow-up. These calculations revealed attrition from baseline to follow up of 37.5% for the

popular education group, 21.6% for the traditional education group, and 22.6% for the control group. The total sample size at follow-up was 15 for the PE group, 29 for the TE group, and 24 for the CG group. (There were actually 16 participants who graduated in the PE group; one person who joined the PE group in week 3 did not complete the baseline survey so could not be included in the analysis.)

Various hypotheses are possible to explain the higher level of attrition from the PE group. As noted in the research design, we intentionally assigned popular education to the group at Parish A because of its perceived weakness in terms of leadership capacity. Parish A is ethnically divided and the Latino community is resource-poor. We feared that if Parish A was assigned the traditional education condition, attrition might be so great that the group would cease to exist. In addition, when two cohorts went through the Parish Health Promoter training in 2007, there was more attrition from the group on the west side of the county, and Parish A was on the west side of the county, whereas Parish B was on the east side of the county. Thus, we anticipated higher attrition from the group at Parish A.

Another possible explanation for the higher attrition at Parish A has to do with the opposition to completing the baseline survey that developed during the first session at Parish A. As noted above, one participant in particular, and another participant to a lesser degree, raised objections to completing the survey, which may have discouraged other participants. These two participants did not return after the first class. Different communication styles which are partially related to culture between members of the Project Team resulted in the fact that PE participants who did not return for week two

did not receive a phone call to check in, as was intended. Finally, differences in attrition may be related to the differences in the two groups noted above. Participants in the TE group may have had a higher level of self-efficacy at baseline, and thus may have been more likely to complete the course. (They did have a slightly higher mean for perceived control at the personal level at baseline; including all participants who took the survey at baseline, the mean was 2.78 for the PE group and 2.98 for the TE group, though a one-way ANOVA revealed that the differences were not statistically significant.)

A one-way ANOVA for the continuous demographic variables revealed that the only statistically significant difference between the three groups was in terms of number of children ($F=4.837$, $df=2$, $p=.011$), as at baseline. A second ANOVA comparing only Groups 1 and 2 revealed no statistically significant differences between the two experimental groups at follow-up. Crosstabs and chi-squares were obtained for the categorical demographic variables (gender, country of origin, marital status, preferred language) at follow-up and revealed no statistically significant differences. The small size of the sample and inability to assure that all assumptions of parametric tests were met means that any conclusions drawn on the basis of these results are suggestive at best. Nevertheless, the results provide at least some confidence that: 1) differences in the two groups at follow-up can be attributed to the intervention rather than to other systematic differences in the two groups; 2) attrition from the two groups did not create systematic differences that did not exist at baseline;

and 3) participants who were lost to follow-up were not so similar that their withdrawal created substantively different groups.

CHAPTER IV: RESULTS

The purpose of *La Palabra es Salud* was to explore the potential of popular education for greater use in the U.S. and the industrialized world by rigorously comparing the relative effectiveness of popular education and traditional education for increasing skills and knowledge and empowering participants. Additionally, this study sought to determine what elements of popular education may contribute to its effectiveness and what benefits and costs may accrue to a CHW training program as a result of being involved in research. In this chapter, I will report the results of the study, organizing my findings by research question. Having responded to the research questions, I will report results in four additional domains, two of which arose from the qualitative data and two of which concern methodological lessons learned from the study.

Changes Associated with Type of Instruction

Q1. Is type of instruction (popular education vs. traditional education) associated with any changes in health knowledge and skills, psychological empowerment, self-reported health status, and health behavior among participants in a parish-based Community Health Worker training program? If so, what is the nature and strength of the association?

Research Question 1 is primarily a quantitative question phrased in the language of positivism. Thus it was appropriate to use quantitative methods to answer this question. The data source I used to answer the question was the CHW Questionnaire.

Following the practice of Romero and colleagues (2006), I treated the Likert scale items on the questionnaire as continuous. A 3 x 2 (treatment condition x time) mixed factorial analysis of variance tested the effects of popular education vs. traditional education vs. no education at two time points (pre- and post-training) on the outcome variables. Experimental condition was the between-subjects factor and pre/post (time) was the within-subjects factor. I began by testing the effects of the experimental conditions and time on health knowledge, characterized as number of correct responses. Results indicated a significant main effect for time ($F(1,65) = 42.24, p = .000$). Participants completing the survey at follow-up were likely to score higher on the health knowledge questions ($M = 11.69$) than participants completing the survey at baseline ($M = 10.35$). There was also a significant main effect for treatment condition ($F(2,65) = 11.244, p = .000$). However, as hypothesized, the two main effects were qualified by a significant interaction between the two factors, $F(2,65) = 8.814, p = .000$, indicating that the effects of time were not the same across all three treatment conditions. For the two treatment conditions, the effects of time were pronounced, with the mean score correct increasing from 10.8 to 13 in the popular education group and from 10.7 to 12.6 in the traditional education group.

To further test for the simple effect for the within-subjects factor, I conducted a paired t-test, selecting first the participants in the PE condition, then the subjects in the TE condition, and lastly the participants in the control condition. The t-tests were significant for the popular education group ($t=-5.87, df=14, p=.000$) and for the traditional education group ($t=-5.33, df=28, p=.000$), but not for the control group,

indicating that the participants in both experimental conditions made significant gains in health knowledge from baseline to follow-up. These gains were statistically significant even with the small samples.

Self-reported ability to promote health improved from baseline to follow-up in all three groups, and there was a significant main effect for time ($F(1,65) = 8.497$, $p = .005$). However, there was no main effect for treatment condition, and the interaction between time and group was non-significant. Paired t-tests indicated a statistically significant improvement among members of the popular education group ($t = -2.514$, $df = 14$, $p = .025$) but not among the traditional education or control groups.

For sense of community, there was a significant main effect for time ($F(1,62) = 6.401$, $p = .014$), but no main effect for group, and the interaction between time and group was also non-significant. Paired t tests showed no significant differences from baseline to follow-up for the two experimental groups. However, a paired t test did show a significant improvement in sense of community for the control group ($t = -3.269$, $df = 22$, $p = .004$). We can hypothesize that this was the result of temporal changes within control group as well as Hawthorne effect and/or testing effect.

For perceived control at the community level, neither time nor group nor the interaction were significant, and none of the paired t tests produces significant results, though the means for the PE group did improve from 2.35 to 2.65. For perceived control at the personal level, while there was a main effect for time ($F(1,63) = 14.906$, $p = .000$), there was no main effect for group and the interaction was not significant. The paired t test for the TE group was, however, significant ($t = -2.25$, $df = 27$, $p = .033$).

though *t* tests for the PE and control groups were not. The results for the PE group did, however, approach statistical significance ($t = -1.83$, $df = 14$, $p = .089$).

For conscientization, one of the new scales, there was a significant main effect for time ($F(1,60) = 7.958$, $p = .006$) but no main effect for group and no significant interaction. However, a mean change from 2.74 to 3.27 in the popular education group constituted a significant change ($t = -2.22$, $df = 13$, $p = .045$) as did a change from 2.83 to 3.09 in the traditional education group ($t = -2.17$, $df = 26$, $p = .04$).

There was no significant interaction for ability to act for change and differences from baseline to follow-up were small, though in the hypothesized direction for all three groups.

For the global empowerment variable (which summed together the five sub-scales), there was a significant main effect for time ($F(1,56) = 13.464$, $p = .001$). There was no significant main effect for group and the interaction was non-significant; however, a paired *t* test revealed a significant improvement in empowerment among the PE participants ($t = -2.44$, $df = 13$, $p = .03$). Changes in the other two groups were non-significant.

The main effect for time for self-reported health status was significant ($F(1,65) = 10.289$, $p = .002$) but the main effect for group was not. The interaction between time and group for self-reported health status approached statistical significance ($F(2,65) = 2.33$, $p = .105$). Almost identical improvements from baseline to follow-up produced a statistically significant change in the traditional education group ($t = -3.52$, $df = 28$, p

= .001) but not in the popular education group, solely because of the smaller numbers in the popular education group.

For health behavior, there was a significant main effect for time ($F(1,65) = 15.561$, $p = .000$) but the main effect for group and the interaction were non-significant. Improvements from baseline to follow-up were significant among the TE group ($t = -4.12$, $df = 28$, $p = .000$) but not among the PE or the control group.

Because paired t tests are parametric tests and thus depend on assumptions such as normality and homogeneity of variance which could not be assured in this study, and also because parametric tests are often inappropriate for studies with a small “ n ”, (Newsom, personal communication, June 6, 2006), it was decided to reanalyze the data using Wilcoxon matched pairs signed rank tests. These tests compare the distributions of scores for two correlated samples to determine whether they are significantly different (Gall, Gall, and Borg, 2007). Even these tests cannot provide a conclusive answer to the question of whether changes from baseline to follow-up in the outcome variables are statistically significant, since the test is based on the assumption that the distribution of difference scores is not highly skewed (Myers & Well, 2003).

Basically, the Wilcoxon tests reaffirmed the results of the paired t tests. Significant improvements among participants in the PE group included health knowledge ($Z = -3.34$, $p = .001$), self-reported ability to promote health ($Z = -2.23$, $p = .02$), concientization ($Z = -1.96$, $p = .05$), and overall empowerment ($Z = -2.14$, $p = .03$). Improvements that achieved statistical significance among the TE participants

included health knowledge ($Z = -4.02$, $p = .00$), control at the personal level ($Z = -1.99$, $p = .047$), conscientization ($Z = -2.10$, $p = .04$), self-reported health status ($Z = -2.98$, $p = .00$), and health behavior ($Z = -3.41$, $p = .001$).

Because it uses a comparison between the number of scores that went up and the number of scores that went down, the Wilcoxon test also revealed the interesting fact that *all* participants in the PE group improved their health knowledge scores from baseline to follow-up. (One person got all answers correct both times.) This was not true for the TE group, where three people got lower scores on the follow-up survey than they had gotten on the baseline survey. Nor was this across the board improvement true for any other measure. Results of the paired t tests and Wilcoxon signed ranks tests are provided in Table 12.

In order to determine whether gender had a significant effect on any of the outcome variables either at baseline or at follow-up, I first conducted independent samples t tests comparing men and women in all three groups at baseline on all the outcome variables. Results revealed a statistically significant difference in self-reported ability to act for change ($t = -1.98$, $df = 90$, $p = .05$, equal variances assumed), with women having a higher mean score (2.90) than men (2.58). There was also a statistically significant difference in self-reported health status by gender ($t = 2.31$, $df = 90$, $p = .02$, equal variances assumed), with men reporting higher mean health status (3.25 as opposed to 2.82 for women.) Results further revealed a difference that approached statistical significance for health knowledge ($t = -1.77$, $df = 90$, $p = .08$, equal variances assumed), with women once again having a higher mean score (10.43) than

men (9.50), though there was much higher variability in the data. No other differences at baseline approached statistical significance.

The extremely small numbers of men in the two experimental groups made it impossible to compare the effects of the course by gender in a statistically meaningful way. (There were three men in the PE group at follow-up and 5 men in the TE group at follow-up.) I conducted independent samples t tests for both experimental groups at follow-up and, not surprisingly, no statistically significant differences were found. A review of the mean scores on each outcome variable showed that, in the PE group, the men in the group had a higher mean score than the women on seven of 10 variables, while in the TE group, the men's mean score was higher than the women's mean score on five of 10 variables. The only notable difference in means by gender was for health knowledge in the PE group, where the mean for men was 14 and the mean for women was 12.75. However, when one considers that one of the men in the PE group was a physician in his home country, and another had worked at a health clinic, these differences seem much more related to the particular individuals who were taking the course, than to their gender.

In summary, paired t tests revealed that participants in the PE group made statistically significant gains in four domains: health knowledge, self-reported ability to promote health, conscientization, and on a global measure of empowerment. Participants in the TE group improved significantly in five domains: health knowledge, control at the personal level (self-efficacy), conscientization, self-reported health status, and self-reported health behavior. The mixed factorial ANOVA results

revealed no significant interactions with implications for the experimental groups, meaning that the effects of time (e.g. pre and post) were not significantly different for the two groups. This means that, statistically speaking, type of instruction was not significantly associated with any changes in the outcome variables.

However, when considering these results, it is important to keep in mind that the TE group was almost twice as large as the PE group; for some domains, there were exactly twice as many valid responses for the TE group as for the PE group. This meant that almost identical gains among participants in the PE and TE groups on some scales (such as self-reported health status) reached statistical significance in the TE group but not in the PE group. Likewise, it is important to note that *all* participants in the PE group improved their health knowledge scores from baseline to follow-up, while this was not the case for the TE group.

Differences Between the Experimental Groups and the Control Group

Q2. Do any changes from baseline to follow-up among parish-based CHWs who participate in training differ systematically from temporal changes that may occur among members of a comparable parish community who do not participate in any type of training?

Results from the mixed factorial ANOVA (reported above) indicate that changes in health knowledge from baseline to follow-up differed systematically and significantly between parish-based CHWs who participated in training and members of a comparable parish community who did not. In addition, whereas members of the two experimental groups made significant gains on a number of scales from baseline to

follow-up, the only significant improvement for the control group was in sense of community, and this result could well have been related to other factors present in the environment of the control group, to testing effects, and/or to Hawthorne effect. These results add further weight to the conclusion that the changes in the two experimental groups were not the result of chance or some other variable not measured by the study.

Elements that Contribute to the Effectiveness of Popular Education

Q3. From the perspectives of the participants and the researcher, how does popular education work, if it does? What elements of popular education contribute to its differential effects, if indeed these exist?

The findings from our study as well as other studies suggest that popular education does work, in a variety of ways. In this study, participation in a popular education intervention was associated with statistically significant increases in participants' health knowledge, self-reported ability to promote health, and critical awareness of the social context, despite a small sample size. Perhaps most importantly, PE participants in this study made statistically significant gains on a global measure of empowerment. Much more will be revealed about the effects of popular education on empowerment in the context of Research Question 4.

How does popular education work? What are the operative mechanisms that bring about change? In order to answer this question, it was necessary to differentiate the characteristics that contribute to the success of popular education specifically, and the characteristics that contribute to the success of a CHW training course regardless of

the methodology (Research Question 6). The criteria I used to identify the characteristics that contribute to the success of popular education were that 1) the characteristic only existed in the PE course, or 2) the characteristic is a defining characteristic of PE according to the comparison chart (Appendix A) or the principles chart (Figure 1). Thus, while some of the elements identified below may be present in some conceptualizations of “traditional education” or in educational systems that are not specifically “popular,” they were not present in traditional education as we characterized it for the purposes of this study. (In Chapter V, I will reflect on the question of whether certain elements of popular education, such as consciousness-raising, can occur as well or as easily in a traditional setting.)

Using these criteria, analysis of the in-depth interviews with the PE participants, their Participant Evaluation Forms, and my participant observation field notes from the PE sessions revealed a variety of ways in which popular education brings about change. Below, I have organized those practices chronologically as far as that was possible. That is to say, I started with actions popular educators take even before a class begins, progressed to what they do when participants first arrive, and so on, recognizing that later in the class they are taking many actions simultaneously. All the practices are interrelated, but each makes its own distinct contribution to the experience of popular education.

As explained in Chapter III, I interviewed a purposive sample of 12 participants, six from the PE group and six from the TE group. A chart that uses aliases to identify the interviewees by their experimental group is also included in Chapter III. Readers

will note below that, while in the course of answering Research Questions 3 and 4 I reference all the participants in the in-depth interviews, in some sections I rely more heavily on some participants' responses than others. This is because some participants were better placed than other participants to answer particular questions and have insight into particular issues. For example, Yesenia had recent experience of traditional education in the U.S. and she was part of the PE group. Thus, she spoke particularly eloquently on the topic of the contrasts between traditional and popular education. Overall, however, I sought to capture the themes that appeared most frequently in the data.

It sets the stage.

Popular educators in this study took various steps to set the stage for learning and empowerment. For example, they wrote objectives on flip chart paper, posted them on the wall, and reviewed them at the beginning of the class. They also arranged participants in a semi-circle so that all participants could see one another. This practice elicited positive comments from several participants. Yesenia linked the practice to the development of trust within the group:

. . . the way the chairs were arranged, it was like we were all united. It wasn't like in a line, instead it was like in a circle, and we could all see each other. On the other hand, if you are in a line, it's like okay, I am seeing the back of the person but I am not seeing her/his face, I am not seeing the gestures they are doing when they are talking. But when we are [in a circle], we all see each other, we all focused and

we could make eye contact. This maybe I think was also something that helped us to have trust [in the group]. (Y2)⁸

In this passage, Yesenia identifies the fact that participants could make eye contact as one of the most important benefits of sitting in a circle and credits it with helping to develop trust. Lupe echoed Yesenia, saying she liked sitting in a circle because no one had their back to anyone else and all participants were face to face. In addition to seating participants in a semi-circle, during the first class the facilitator requested that participants take out empty chairs and bring their chairs into a tighter semi-circle. From my observation, this made it easier for participants to see and hear one another and reinforced the sense of unity to which Yesenia alluded. In contrast, in the TE session where participants sat in rows, participants could sit towards the back or away from the rest of the group, and several did, for the majority of sessions. Posting and reviewing the objectives and seating participants in a circle helped set the stage for learning and empowerment in the PE group.

It builds trust (confianza).

The Spanish language possesses a word – *confianza* – which is usually translated into English as “trust.” This is an imperfect translation at best, since unlike trust, which one person may independently feel for another person, *confianza* connotes a feeling of mutual trust between two people or a group of people. The development of *confianza* also holds relatively greater importance in Latino culture than the

⁸ As mentioned above, Yesenia was interviewed twice. When I use quotations from her interviews, I will identify them as either Y1 (first interview) or Y2 (second interview).

development of trust in Anglo-European culture. In many Latino communities, developing *confianza* is a prerequisite to building a deeper relationship or achieving mutual goals together.

Along with seating people in a semi-circle, popular educators in this study used a variety of other methods to establish *confianza* in the group. Yesenia was one of the younger and shyer participants, and the process of developing trust was clearly important to her, as she commented on it various times in her interview and related it to a variety of processes. Because it summarizes much of what she said, I will use a lengthy quotation to explain her point of view:

We were a small group and it was like from the first day you all made us start to have *confianza* between all of us . . . [we always started] with a prayer and each reflection made us reflect on why we were there. Next the *dinámicas* made us relax and made us have *confianza* with the people who were there. Therefore I think this course was better, because we were all relaxed and we had *confianza* because we knew that everything we said was confidential and wasn't going to get out. I knew that the person who was sitting beside me was not going to laugh at what I was saying and because we made rules, something that in other courses we are never going to have rules, that you are going to listen to what the other person says and respect it. I think this was one of the positive things about this course. (Y1)

Yesenia relates the development of *confianza* in the PE group to the practices of starting with a prayer and a spiritual reflection, using *dinámicas* (social learning games

that often involve movement and laughter), and establishing confidentiality by developing group norms.

As is true of many aspects of popular education, the process used to develop the group norms was as important as the outcome, as I noted in my field notes from the first PE session. The facilitator for that session used a brainstorm to develop the group norms. After scribing the norms that were important to participants, the facilitator naturally elicited certain additional norms which she knew were important but which group members were not mentioning. The process also included a thoughtful discussion about the need for more vocal participants to make space for quieter participants. Both having the group norms and the way the facilitator created the group norms with the participants contributed to developing *confianza*.

Creating a relaxed atmosphere is related to creating an atmosphere of trust and, as respondents in a previous study (Wiggins et al., 2006) noted, is particularly important for participants who may have had negative experiences in school and thus come to the educational setting feeling nervous. Yesenia alluded to the connection between feeling relaxed and feeling *confianza* in the quotation above. She returned to this theme and contrasted her experience in other educational settings to her experience in the course, stating, “This course was very different, I liked it a lot, because of the way you taught us. The whole atmosphere was more relaxed than in any other course I have taken.” (Y1) A respondent to the Participant Evaluation Form echoed this sentiment, saying, “I liked the exercises where we stood up and we could move and

relax.” By starting with a prayer and a reflection, using *dinámicas*, and creating group norms, PE facilitators helped participants develop trust and feel at ease.

It starts with what people know.

The practice of basing the educational process on people’s lived experience, what they know and do, is at the heart of popular education and is related to the epistemological principle that experiential knowledge is at least as important as academic knowledge. The vast majority of PE classes in this series began with some form of a brainstorm in which facilitators sought to draw out what participants already knew. Participants in the PE group commented on this practice and how it affected them. Alejandro, who revealed he had heard something about how the other group was being conducted, stated that in contrast to the other group, “with us it was more like digging up what we knew.” According to Yesenia, the PE practice of finding out what people already know “makes people have self-confidence and say, ‘This is what I know, this is what I can contribute,’ by saying from the start, ‘No one here is all-knowing, we all have an idea and we can all succeed.’” (Y2) Here, Yesenia highlights some of the consequences of starting with what participants know: it increases self-confidence and sends the message that all participants have something valuable to contribute.

The popular educators I observed reinforced this message in various ways. Within ten minutes of beginning the class, the facilitator for the session on Navigating the Health System had said at least three times, “You know more than me, “ or “You can learn from each other,” or something else to that effect, thus taking the spotlight away

from herself and shining it back on the participants. In the session on Nutrition, one of the facilitators, herself a CHW, reinforced participant contributions during a brainstorm by commenting briefly and supportively on several of the answers people gave. Later in the same session, her co-facilitator, also a CHW, turned a question about why we need a variety of foods back around to the group rather than answering it herself. All these practices served to emphasize how much participants already knew.

Yesenia identified an additional benefit of starting with what participants already know: facilitators are able to find the appropriate level at which to gauge the class. “So if one gives the opportunity for people to talk first, [then] that is the level at which we are going to have to talk,” she stated. (Y2) By listening to participants first, Yesenia implies, teachers will be more able to speak in a way participants will understand. Popular education facilitators used brainstorms, positive feedback, and reflexive questioning to draw out and affirm what participants already knew. In so doing, they increased participants’ self-confidence and could potentially make learning easier.

It encourages open communication.

After creating a trusting atmosphere and drawing out what participants already know, popular educators use a number of practices and strategies to encourage open communication. One of these is validating and refusing to pass judgment on what participants say. Contrasting his experience in the course with his experience in

school, Angel stated, “Well, here we all participated and all the questions we asked were valid. No one said that that was good, that that was bad. It was very different.”

Participants also commented that facilitators made a particular effort to make sure all questions were answered, an especially important practice in the Latino immigrant community where people often lack access to information and are often left wondering what was said or meant by an interaction. (See below, Research Question 6, “New and Complete Information.”) “No one left without asking her/his question or with a doubt,” said Angel. “In school,” commented Yesenia, “you arrive and you sit down and you are going to listen to everything that comes out of the teacher, and if you understood, good, and if you didn’t understand, not so good. And here no, if you didn’t understand, you asked the person who was giving the information and s/he explained it in another way.” Yesenia’s experience in the course, where facilitators were willing to answer questions, contrasted with her experience in school, where she had been left to sink or swim. Similarly, in the context of a question about whether her experience in the course had been different from her experience in school, Lupe commented, “when you don’t understand something [here], you ask, and [the teachers] are willing to answer.” One practice that several popular educators in this study used to make sure all questions were answered was an “*Almacen de Preguntas*,” a “Question Warehouse” where questions that could not be answered in the moment were “stored” until a response was possible. (While this practice is occasionally used in some forms of traditional education, it was not used by any of the traditional educators in this study.)

In addition to validating all questions, the popular educators in this study created an atmosphere where participants felt comfortable sharing their opinions. In Yesenia's words, "We had some discussions and they allowed us to talk and say, 'I like this, I don't like that . . . This is what we know about the topic, this is what we don't know about the topic.'" (Y2) Yesenia's comment here about the openness of the facilitators to different opinions recalls Angel's comment above about how facilitators did not judge participants' questions. In answer to the question, "What else would you like to tell us about this session?", a participant in the Teaching Skills session commented, "That a very friendly group has been formed in which I feel comfortable sharing my opinion and participating." On the fairly rare occasions when participants would share an idea that required correction, facilitators would not correct them directly but rather encourage them to think more deeply. This happened in the session on Navigating the Health Care System. A participant shared an idea, and rather than contradict her, the facilitator asked her, "Or is it the other way around?" The participant was able to correct herself and remain unfazed. Facilitators for the popular education sessions encouraged open communication by refusing to pass judgment on participants' statements, assuring all questions were answered, and accepting a variety of opinions.

It creates an environment of equality.

A principle of popular education (see Figure 1) holds that the conditions of the educational setting should prefigure the conditions of the society we are trying to build. This principle means there should be equality between teacher and student, to the degree that these classifications even exist. Lupe, a participant who had only a

primary school education, was particularly struck by the relations of equality that existed between teachers and students in this course. In order to draw Lupe out on the specific practices or conditions that had helped her find her voice and become more empowered (see below, Research Question 4), I proposed a contrast between what she had experienced in the course and an educational experience in which an Anglo professor arrived in a suit and tie and gave a lecture about diabetes with no *dinámicas* and no spiritual reflection. Lupe related this description back to a course she had taken 35 years previously in which she learned to give injections and administer oral rehydration solution. “It was exactly like that,” she said. When I probed further about how the CHW training course was different from the course 35 years ago, Lupe answered:

[Here] the teachers are like us, and before, that person that you described, I had him on an altar . . . so now, [in] this course it was like all of us were equal, not *like*, because we all *are* equal. All of us were on the same level, with the exception that you all know a lot more.

While I appreciated Lupe’s assertion that facilitators achieved the reality and not just the appearance of equality, I contested her exception that we (the facilitators) knew more, referring to the equal value of experiential and academic knowledge. Lupe gently swept my comments aside and reaffirmed her main point, saying, “I can’t really explain that word, but those teachers that I had when I had that class [35 years ago] were like above and I was below, and here we were all equal, because [here] I felt *confianza* and with the other teachers I did not feel it. That was the difference.”

Clearly, for Lupe, the important message she wanted to convey was that in the CHW training course, she felt equal with the facilitators, and in the previous course, she did not. She also alludes to the relationship between equality and *confianza*. Likewise, in answer to the first open-ended question on the Participant Evaluation Form for the “Roles of the CHW” session, one participant said s/he liked, “the *confianza* and the treatment which all students are given.” Lupe also alluded to another facet of the environment of equality that existed in the PE course: the openness of the facilitators to criticism. “You all very frequently said, ‘If there’s something you don’t like, [tell us].’ This was said very frequently.” The attitudes and actions of the PE facilitators, including their willingness to accept criticism, created an environment of equality that participants were able to feel.

It uses a variety of interactive techniques.

Participants in the popular education course identified a number of methods or techniques that were used by popular education facilitators. In many cases, they also identified the goals these techniques helped to achieve. First among those techniques were *dinámicas*. Echoing a fondness for *dinámicas* that was expressed by all the PE participants I interviewed, Lupe stated, “The *dinámicas* made us happy, content . . . they woke us up when we had been sitting for a long time. And the *dinámicas* make one *open up* more to what we are doing” (emphasis added). We will revisit this theme of opening up in the context of Research Question 4; for now, it is interesting to note that Lupe attributes opening up to the *dinámicas*. *Dinámicas* were the first thing Angel mentioned when I asked him what he liked about the course, and Yesenia

referred to how the *dinámicas* helped to allay the boredom she had often felt in her previous educational experience.

As well as making participants happy and waking them up, *dinámicas* were also used to move participants into a topic. An example comes from the PE nutrition session. In this session, as participants entered the classroom, they were given pictures of different vegetables which they pinned to their clothing. Then, the CHW facilitators for the session led a *dinámica* in which the leader stood in the center of the circle and said, “My name is x and I made a salad with . . .” and went on to name one or more vegetables. The people whose vegetables were named had to stand up, move around the circle and find another seat, while the leader also looked for a seat. Whoever was left standing led the next round. During the session on diabetes, one of the facilitators (also a CHW) gave each participant a balloon to blow up, which we then threw behind us. We linked hands and the facilitator threw the balloons into the center of the circle and we had to work together to keep the balloons off the ground. The facilitator then used the *dinámica* to start a reflection about how we all have to work together to support people with diabetes in the community.

Whereas *dinámicas* were used to open up discussion about certain topics, *sociodramas* (social skits) laid bare the complicated and interrelated issues that can act as barriers to health, and motivated participants to grapple with these issues. In the Nutrition session, the two facilitators and one of the facilitator’s sons enacted a sociodrama to explore barriers to healthy eating. In the first act, one *comadre* (literally, “co-mother”, the godmother of my son) comes to visit another *comadre* and

her *ahijado* (godson). The second comadre offers the first comadre an unhealthy drink (like Energy Star) and the first comadre says she prefers water. The second comadre says she doesn't have much time to cook and they eat out a lot. The first comadre warns her about the possible consequences of her behavior. In the second act, the mother and son have been to the doctor and the son has been diagnosed as overweight. The first comadre encourages the second comadre to return to the foods they ate in their country of origin, reminding her of the example of her brother, who developed diabetes and died at 24.

In less than eight minutes, the actors covered issues of cultural change, media propaganda, time pressure, and the desire to give children things to which parents did not have access. The effectiveness of the sociodrama was demonstrated when participants jumped in immediately with answers to the facilitators' questions for reflection. Also during the reflection after the sociodrama, one participant asked a difficult question: "How can I give this example [of eating vegetables] to my son, if I did not have it?" Other participants joined in to help her grapple with the question. This stands in marked contrast to the TE session on Nutrition (see below, "Differential Effects by Methodology"), in which the facilitator simply told the participants what they should be eating in a tone that brooked no disagreement or discussion.

Facilitators' use of representations of real objects, such as fruits in the Nutrition session, also evoked positive comments from participants. Linking words to related pictures was a practice that caught my attention, such as when one of the facilitators for the Heart Health session did a brainstorm around a picture of a body.

Several PE participants commented on how the dynamic of the classes held their attention. Blanca emphasized how quickly the time passed and how much she was able to focus:

You know what? Each day I thought about it at the end of the day and the only thing I didn't like was that the time passed so quickly. (Laughter.) That I wanted it to go on. It wasn't enough. But when I realized how much information we were given, or that my brain is becoming so . . . it's absorbing everything. This is not a negative thing. Because it's so interesting, time passes and you don't realize it and you want more.

Lupe concurred, saying that in her opinion, no one got distracted, that they were always paying attention to the class. "We knew that something interesting was coming," explained Blanca, "but we absorbed it in a very focused way and we had enough time to make the most of it." Returning to the theme of contrasts with her experience in school, Yesenia stated, "If you go to school, it's like everything is the same and you get bored. But this no, this was really different, it was dynamic." By using activities such as *dinámicas* and *sociodramas*, PE facilitators were able to create dynamic classes that held participants' attention.

It encourages and balances participation.

Popular education participants applauded the fact that facilitators encouraged all members of the group to participate. Along with *dinámicas*, Angel said he liked the fact that everyone participated, and went on to add, "As the classes went on, I am seeing all the information and how all of us participated; no one was left behind. As

you all said, ‘all questions are valid,’ so that no one would fail to participate [so that] we would leave feeling more encouraged.” Relating participation to the open communication discussed above, a respondent to the Participant Evaluation Form (PEF) for the CHW Role session said s/he liked, “that you try to get everybody to participate and give the opportunity to express our ideas.” In the following session on Teaching Skills, a respondent to the PEF reported liking “the involvement of all who are present.” And in the subsequent Nutrition session, a PEF respondent said s/he liked, “the way *we ourselves* put the foods on the pyramid” (emphasis added). Participants in the PE course commented appreciatively on participation, both their own and that of their classmates.

According to my field notes, PE facilitators encouraged and balanced participation in a variety of ways. At least twice during the Nutrition session, one of the facilitators intentionally made space for people who had not yet shared an opinion. During the same session, when it was time for a cooperative learning activity, the facilitators intentionally divided up cliques that had been developing in the group. I commented in my notes that by doing so, they appeared to have raised the energy in the group.

Facilitators were not content to simply involve the participants; rather, they sought to involve them as leaders. In the Nutrition session, the facilitators asked for a volunteer to lead a *dinámica*. One of the youngest members of the group immediately volunteered and led, “El Cartero.” The facilitator for the “Navigating the Health Care System” session asked for a volunteer to scribe the brainstorm, and one of the quieter participants volunteered and did an excellent job. While these examples of involving

participants as leaders may seem insignificant taken singly, my impression was that overall, they contributed to developing participants' skills and self-esteem.

By the fifth PE session, as a result of the consistent efforts of the facilitators, I noted that everyone was participating, commenting on what one another said and using the word, "*compañero/a*." The use of this word in Spanish, which has no direct translation into English, indicates the development of a feeling of solidarity between people. Yesenia summarizes how participatory activities forced her to interact, and alludes to some of the changes in participants we will explore in the next section, in the following quotation from her interview:

For example, in the beginning if I had been there, I wouldn't have talked to anybody, just the people I knew. But in the activities it was like you had to do it. So by the second class, it was okay. I did it more easily. Each time as the course went on it became easier for me. And now I think that more or less I have again the confidence to be able to speak in front of a group and say, 'Well, these are my ideas, and this is what we have to do.'" (Y2)

In this quotation, Yesenia emphasizes how the use of certain activities by the PE facilitators all but forced her to participate, how participating became easier over time, and how by participating she regained the confidence to express her ideas in front of a group.

While many people did participate by offering opinions and asking questions in the TE group, I noted in my field notes for the third session that proportionately fewer people participated because there were fewer opportunities and facilitators did not

invite participation rigorously or intentionally attempt to balance participation. PE facilitators, by contrast, not only made room for participation, but chose activities that required participation and involved participants as leaders. As a result, participation, solidarity, and self-confidence increased.

It creates a sense of community.

“Sense of community” is one of the domains of empowerment that has been identified in previous research (Matton & Rappaport, 1984; Wallerstein, 2006). While my own observation as well as participant comments during the in-depth interviews led me to believe that a sense of community existed in both the PE and TE groups, popular education facilitators took intentional steps to encourage a sense of community whereas traditional facilitators did not. These additional steps were necessary in the PE group for several reasons. As mentioned in Chapter III, the PE group was smaller and more timid than the boisterous, self-assured TE group. Yesenia commented (see previous section) that because of her shyness, she would not have talked to other participants had facilitators not encouraged her to do so, and my participant observation notes suggested this was true for other participants as well. Had participants not interacted, a sense of community could not have developed. Second, many of the participants in the TE group were from the same parish and already knew one another when the course began. In other words, there was a pre-existing sense of community in the TE group that did not exist in the PE group.

By using many of the practices I have outlined above, facilitators for the PE sessions were able to overcome these barriers and create a sense of community. By

the second session, participants in the PE group were starting to jump up to help post flip chart pages on the wall. By the fifth session, participants spontaneously clapped for one another when small group reporters presented their group's work. Once again contrasting her experience in the course to her experience of more individually-focused education in public school, Yesenia commented, "In this [course] it was more of a group thing." (Y2) This statement emphasizes the collective nature of popular education and the sense of community that popular education intentionally creates.

Insights from the traditional education group.

Interestingly, some insights into Research Question 3 came from the Traditional Education group, even though they did not experience the PE methodology. For example, two TE participants commented in their interviews on the consciousness-raising component of the course, a popular education characteristic that made its way into certain aspects of the TE course. Israel said he liked the session on Social Determinants of Health, "because it kind of showed me the whole perspective of the whole world, like how in some countries it's better health, but it's not as rich as the United States. I liked that one." Sonia concurred, stating:

Look, the Social Determinants of Health [session], for me that one really hit the mark. Because sometimes you hear information . . . but . . . what are the reasons that things are this way? So I think that [session] had a big impact on us. I think on everyone, not only because of what we talked about in the class, but also because of what we as a community continued to talk about and continued to work on.

For Sonia, the Social Determinants of Health session was important because it dealt with root causes that are not often discussed and motivated participants to continue talking and taking action.

Sonia also appreciated the fact that “you gauged [the topics] at the level of our needs, as a community, as the Hispanics that we are.” Basing education on participants’ life experiences is another characteristic of popular education that bled through to the traditional education group.

Although many TE participants complained (both in their individual interviews and on the Participant Evaluation Forms) about the small room in which the TE sessions were initially held, Israel was particularly bothered by the small room and the seating arrangement. “I don’t know if there were any activities that I didn’t like, but just being in a small room . . . I didn’t really like that, or sometimes how the seats were arranged, I didn’t like that.” (Since the seats were *always* arranged in rows in the TE group, one can assume the “sometimes” in Israel’s quote refers to the fact that sometimes this characteristic bothered him more than at other times.) Israel also expressed a desire for more hands-on activities and said he liked the CPR session, “because of how they taught it, and because there was a lot of hands-on things.” The seating arrangement and the reliance on lecture-style activities that Israel disliked were both marks of fidelity to traditional education as we had defined it for this study.

Similarly, when facilitators of the TE sessions departed from the assigned methodology and used participatory and interactive techniques, participants were quick to comment approvingly. A good example comes from the traditional education

session on Nutrition. During a break from this session, the facilitator commented to me that she (the facilitator) didn't think she was adhering to the assigned methodology, that she found it impossible *not* to use interactive techniques. The comments on the participant evaluations from this session bear her out. In answer to the question, "What did you like or find useful about this session," one participant said s/he liked "the teaching techniques that [the facilitator] used so that we would learn," while another noted that "the class was very illustrative, very visual with a good speaker" and a third said s/he liked, "the dynamics [of the class] and the examples that [the facilitator] brought."

Seeming to appreciate the popular education principle that we are all teachers and we are all learners, a participant in the Traditional Education session on Teaching Skills commented that she liked, "the opportunity to work in a [small] group in order to learn one from the other and thus understand better." Reinforcing another popular education principle almost verbatim, a participant in the Traditional Education session on Mental Health reported appreciating, "how [the facilitator] valued the comments and experiences of the participants." As was discussed in a previous section, validating participant comments and experiences is one of the elements that contributes to the effectiveness of popular education.

Popular education also stresses the importance of using language which is accessible to participants. Reinforcing this principle, participants in the Traditional Education group identified complicated language as something that needed to be changed in two sessions. Conversely, one participant appreciated that in the TE

Mental Health session, “the explanation was made with language that was simple and easy to follow and understand.”

Comparing complex and unfamiliar concepts to more familiar concepts is a common practice in popular education. A participant in the TE session on heart health said that she liked, “the way the facilitator compared the functioning of the heart to things in daily life.” However, participants in this otherwise very traditional session reported that they would have appreciated activities in small groups, *dinámicas*, and use of realia, such as “a plastic heart that we could manipulate.” Such activities and materials would have been more characteristic of popular education.

Finally, I observed a contrast between the effects of the two methodologies on participants’ behavior. Whereas participants in the PE group were generally quite attentive to the facilitators and other participants, side conversations occurred frequently in the TE group. Several TE participants commented on this problem in their interviews. “Sometimes, you see, the people . . . blablabla . . . once I had to stand up and quiet everybody down,” said Hilario. Juanita was also bothered by TE participants’ tendency to talk over one another:

“because always one person spoke and then immediately another person spoke and sometimes the person who was at the front wanted to hear the opinion of one of them and then give time for the opinion of the other person and . . . I feel that it is like in a certain moment you have such a desire to speak and to say, ‘Well, this happened to me,’ ‘Well, I saw this,’ and we don’t respect the person who is still speaking and we don’t give that person the opportunity to finish.”

In this quotation, Juanita expresses that though she understands why participants may have felt compelled to speak, the frequency with which this happened in the TE group disturbed her. On a related topic, during the debriefing session in February, one TE participant commented that some of the TE facilitators were not very charismatic. A PE participant asked, “Oh, then they were not the same [facilitators]?” When I explained they were different, various PE participants commented that, on the contrary, the PE facilitators kept them engaged all the time.

Summary

Results of in-depth interviews with the participants, Participant Evaluation Forms conducted after every class, and my own participant observation suggested that popular education brings about change by setting the stage (through mechanisms such as posting an agenda and seating participants in a semi-circle), building trust (using methods like *dinámicas* and developing group norms), drawing out and affirming what participants already know, encouraging open communication (by validating contributions and assuring all questions are answered), creating an environment of equality, using a variety of interactive techniques, encouraging and balancing participation, and creating a sense of community. Even though they were not exposed to popular education as such, participants in the TE group requested some of these same practices and commented appreciatively when they were present.

Changes from the Perspective of the CHWs

Q4. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of the CHWs' participation in training? Do these self-reported outcomes differ as a result of the type of training that is used?

Results of the quantitative analysis of the CHW Questionnaire showed that, while members of both the PE and the TE groups experienced significant increases in their health knowledge and critical awareness of the social context, members of the PE group experienced significant improvements in empowerment and self-reported ability to promote health, while members of the TE group experienced significant gains in perceived control at the personal level (self-efficacy), self-reported health status, and health behavior. These results are borne out and substantially deepened by the results of the analysis of the in-depth interviews with the CHWs, Participant Evaluation Forms completed by the CHWs, and field notes from my participant observation. Indeed, the concordance of the quantitative and qualitative results provides substantial confidence in the findings and the instruments on which they are based.

Below, I will report on the CHWs' perceptions of the changes associated with their participation in the course, beginning with changes at the individual level, moving next to the family level, and then to the community level. I will address the question about differential effects of the two methodologies both within each section and also in a separate section following the section on community-level changes. I will close with a summary section.

Individual Level

Findings from the in-depth interviews suggest that members of both the PE and TE groups experienced improvements in a number of individual-level variables as a result of their participation in the course. These variables included multiple domains of empowerment, knowledge (including but not limited to health knowledge), and health behavior.

Empowerment

In Chapter II, I defined empowerment for the purposes of this study as “a social-action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment” (Wallerstein, 1994, p. 142). I also noted that Keiffer (1984) had defined empowerment as a “long-term process of adult learning and development” (p. 9) and “an ordered and progressive development of participatory skills and political understandings” (p. 17). Based on a review of the literature concerning empowerment theory, I identified the following domains or components of empowerment: perceived control at the personal level (also referred to as self-efficacy), perceived control at the organizational level, perceived control at the community level, sense of community, critical awareness of the social context, and participation in change. With the exception of perceived control at the organizational level, I operationalized these domains and measured them in the quantitative component of this study.

These were the domains of empowerment that I brought with me to my analysis of the CHWs’ comments about ways that they had changed as a result of participating in

the PHPP. In some cases, I found evidence of change in these specific domains. In other cases, I found evidence of changes which seemed to fit the general definitions of empowerment, but did not fit within a previously-identified domain. These newly-identified aspects of empowerment may represent domains researchers will want to operationalize and measure in future studies (see below, Suggestions for Future Research.) Based on the participants' comments, I identified gains in six domains of empowerment: general empowerment, personal growth, perceived control at the community level, critical awareness of the social context, sense of community, and participation. The first two domains arose organically from the data, while the last four are examples of pre-existing domains for which I found evidence in the data.

Members of both groups experienced empowerment as a result of participating in the course. However, substantial differences existed in the level and quality of empowerment between the two groups, as I will show below.

General empowerment.

The first domain of empowerment suggested by participants' comments was an increased sense of general capacity. I termed this domain, "general empowerment." One participant in the TE group, Ana María, expressed such an increase. Attributing her ability to deal with a problem that arose during the course to her participation in the course, she stated:

. . . in the process of taking all the classes, personal things happened to us, that because of the training that I had had, I focused on how to get through this. To not focus on the fear, not on feeling sad or feeling already vanquished because of what

had happened to me during the course. So I felt, well, able to keep going and not be stopped by things that sometime happen in life.

Because of what she had learned in the course, when Ana María was faced by a personal challenge, she was not overcome by fear but was able to “keep going.” Ana María also expressed that she had found in the course something that she had been seeking, and it changed her basic sense of capacity:

Before, I was just here in my house . . . I always said to my children, “I feel like there’s something I want and something I need,” but I always said that first, I am a mother and a housewife and that’s that. But now I don’t think so. I think I can help a lot of people and I have the capacity to do it.

After taking the course, Ana María no longer feels limited to her status as a wife and mother, but knows she is capable of helping “a lot of people.”

Four interviewees from the PE group and one PE respondent to the Participant Evaluation Form reported a general sense of increased capacity. For example, Emiliana expressed a sentiment very close to that of Ana Maria, about how the course had changed her view of her capacity as a mother:

I find that I have more energy to do different things and I see that although I have my two children, I still have the same capacity to do things . . . not at the same speed, not so much that someone could say to me, “I want you here at five in the morning.” Get up at five? Well, no. I know that I have to organize myself with a lot more time to do things. But that yes, it is possible (*sí, se puede*) . . . taking into account that I have my two children.

The course helped Emiliana to recognize that, while it may take her longer to accomplish things, she still has capacity. In answer to the third open-ended question on a Participant Evaluation Form (What else would you like to tell us?), a PE participant responded, “[the course] makes me feel a lot of confidence in myself.” In his in-depth interview, Angel stated, “I feel like I really outdid myself, from where I was before.” These three PE respondents referred to an increased sense of capacity in general and direct terms.

Not only did members of the PE group speak more frequently than TE respondents about their general feeling of becoming empowered, but also described the changes in more depth, and used more evocative language. Yesenia, Lupe, and Emiliana used metaphors of opening up, of bringing out something that was already within them, and of seeing a path clearly ahead of them. “For me,” commented Yesenia, “[the course] was like a door that they opened for me so that my life could be better, so that I could say, ‘Okay, I can do it, and if I decide I am going to do it, I am going to get through it.’” (Y1) Here, Yesenia emphasizes her own power to make changes in her life.

Lupe, one of the older participants and a person with little formal education, spoke at length about how the course had increased her ability to help other people and participate in her community. “This [course] opened up wider for me a path that I was already walking,” she stated. “It opened up that [thing] that was inside me. Because it was already inside me. That’s what I see, that this was already inside me but I didn’t take it outside. And now it’s out.” According to Lupe, the course has helped her to

access her pre-existing capacity. Returning to the metaphor of bringing out what she had inside, Lupe told her parish priest about the course and its effects on her:

I had a talk with the priest that was like two hours long and I opened up everything that I had inside me and I told him about [the course I was taking] and I told him it gave me the courage to speak of everything I had inside. So I told him everything I had had inside me since my childhood and I told him why I didn't participate and he told me I was mistaken. Well, that mistakenness has lasted for many years. But this talk that I had with the priest, along with the course that I had, that is what has opened up my path. The person that I want to be now. Because I was really shut-down (*una persona apagada*). I have lived with a lot of sadness for many years, but now what is happening is another thing in life. But now that I have this motivation, I want to let it out. I want to bring out what I had inside.

Here we see that in the context of the course, Lupe stepped forward to her priest, demonstrating her sense of empowerment. In that conversation, she revealed difficulties she had held inside for decades, an act of vulnerability that also displays her sense of empowerment. Further, for Lupe, the course and this conversation opened up a path that allowed her to bring out skills and abilities that she had inside, and as a result she felt more motivated to participate in her community. Emiliana expressed a similar sentiment in similar terms: "Truly, I thank you so much for this [experience], because I was put in the right place and it changed, something changed, I'm not sure what it was . . . but it was like something that was stuck in the channel." Emiliana, Lupe, and Yesenia all use metaphors that have to do with releasing and

opening to describe how the course helped them to access existing capacity. While one TE participant did attribute an increase in her general sense of capacity to her participation in the training, PE participants spoke about such an increase more frequently and used more evocative language in their descriptions.

Personal growth.

A second dimension of empowerment that arose from the qualitative data was personal growth. This dimension recalls Keiffer's (1984) definition of empowerment as a process of adult development. Both popular education and traditional education participants expressed that they had grown personally as a result of their participation in the course, but again, such comments were more common among the PE participants. Sonia, from the TE group, referred to the course as "an opportunity for one to grow as a human being, as a professional." Blanca, from the PE group, commented that "these courses, they make you mature, mature in daily life." Angel, also from the PE group, echoed her, saying that as a result of the course, he had become more responsible in his home life. "Before, well, one went here and there, and now it makes one more responsible because of everything one has seen, and before I wasted money going here and there and now, well, I have a little more . . . responsibility." Over lunch during the fifth popular education session, a participant shared with me that he had found what he had been looking for in this course, in the sense of a direction and mission in his life. Three PE participants and one TE participant attributed to the course a variety of dimensions of personal growth,

including greater maturity, increased responsibility, and the discovery of a sense of direction and mission in life.

Perceived control at the personal level (self-efficacy).

Perceived control at the personal level – also referred to as self-efficacy – is a dimension of empowerment that is well-documented in the literature (Israel et al., 1994; Zimmerman, 2000). It refers to an individual's belief that he or she is able to perform a given action and is operationalized through statements such as “I find it very easy to talk in front of a group,” and “I can usually organize people to get things done” (Romero et al., 2006). While it is related to the general sense of increased capacity I discussed in a previous section, I have chosen to differentiate it here by focusing on comments the CHWs made about increases in their ability to do *particular* things.

Members of both the TE and PE groups reported an increase in their ability to perform particular actions. For TE participants, the actions mostly related to *helping fellow community members*. For some, their motivation to help the community grew out of increased awareness of need in the community. “[The course] taught us a lot about how there's a lot of people out there who are not informed, and how they need to be informed, so they know how to take care of themselves,” stated Israel. (Israel's assumption that increased information will lead immediately to behavior change may be related both to the methodology he experienced and his youth.) As a result of his new awareness, Israel expressed that he now has a desire to “actually go out in the community and help people and put out what I learned about their health.” Along

with expressing his motivation, Israel clearly expresses that he has new knowledge to share.

In addition to increased knowledge, TE participants reported having increased skills. “I think I have the capacity to know what to do or in what moment to give some advice, to guide a person who perhaps needs help,” said Ana María. Juanita reported that her primary motivation for attending the course was not so much to learn as to be able to help people. “And now, fine, if someone approaches me or if I see something, I know that in some way I can give [the person] guidance, [since] I don’t feel so lost.” In these statements, both Ana Maria and Juanita allude to an increased ability to guide others. Sonia spoke for several other participants when she described the course as an opportunity to be able to help others, “and to become more connected and unified (*integrarnos más*) as a community, as human beings, and do service, which is what the Lord calls us to by way of the Church.” TE participants spoke very specifically of their increased abilities to help members of their community by sharing health information, providing guidance, and doing what God had called them to do.

Whereas increases in self-efficacy mentioned by members of the TE group mostly concerned helping the community, increases in self-efficacy reported by the PE participants were multi-faceted. Recalling Lupe’s words about how the course enabled her to bring out skills and abilities she had kept inside, several other popular education participants related that the course had given them *access to skills they already possessed*. Alejandro, a doctor in his home country, shared that before the course, almost no one in his current circle knew he was a physician, and he seldom

used any of his skills, but now he feels “license” to use them. “So now, well, I am approaching more people, related to health, but because now I feel like I have more backing (*representatividad*) to be able to do it here. I take advantage of some knowledge that I have, to be able to apply it, but only now; before I didn’t approach anyone.” Alejandro stated, further, that he is giving more advice to people, and keeping records of all his encounters so he can put them in the monthly activity report that is required by the PHPP. “But I was waiting for this,” Alejandro added. “Before it was really hard. In spite of the fact I could do it, it was . . . it was like having a rock in my shoe.” For Alejandro, as for other PE participants, the course has removed an impediment that kept him from using his skills. In a similar vein, Emiliana related that for some time, she had been going to her local library to lead cultural activities for the children there. “Now,” she concluded, “I feel more confident in knowing emotionally that I am transmitting something to these children.” According to Emiliana, her sense of self-efficacy around leading cultural activities has increased.

Popular education participants also reported increased self-efficacy around *speaking up and speaking out* in their communities. As mentioned above, Alejandro noted that as a result of the course, he is more likely to talk to people about health. Lupe stated that after participating in the course, she feels more free to talk and more able to stay on topic and use exact words. “Look at this . . . I’ll give you an example,” she stated. “The other day I talked in front of the church and I felt like I was floating in the air, like nervous, but it’s like I feel more courage to speak.” Though Lupe is still nervous, she is now more willing to speak up. Yesenia stated that when she

emigrated from her home country, her self-esteem suffered and she lost her ability to speak confidently to people she did not know. She said the course helped her regain that ability and attributed her renewed ability to speak up to meeting CHWs who have worked in the community for many years and to the encouragement she received from her fellow trainees. In her words:

[When I first went to the class], I said, “I am new in this class and I am not going to talk to anyone” . . . but it was like other people told me, “No, you have to talk to other people.” It made me relax; it was the first time that I could relax in a course. So I said to myself, “This course is going to help me in some way.” And yes, truly it is helping me, because I have noticed I can be in a place where I don’t know anyone and I can say something. (Y1)

As well as becoming more willing to speak up in the PHPP classes, Yesenia has become more willing to speak up in other spheres of her life.

I also observed changes in the participants’ willingness to speak over time. For example, in my participant observation notes from the fifth session, I noted that, “Yesenia, who was so shy in the beginning, comes up front with her group with a big smile and hops (!) into place. She also bows when they are done.” During the same class, I noted that, “Esther, who was so quiet in the first classes, is talking much more today.”

Along with perceived increases in a variety of other skills, popular education participants also expressed positive changes in their *ability and motivation to help the*

community. Blanca explained that before the course, she felt fearful of trying to help someone because she was unsure of her own abilities.

Now I feel confident to give information . . . if they need to go to a hospital or they need a referral to human resources places, I also have the awareness and all the information that we were given. Before we didn't even know this [information] ourselves, and now with pleasure, I think that if I see someone even before they ask me, I will be referring them somewhere. And I feel more confident.

Because she has new information she did not have before, Blanca feels confident to share it with other community members. Yesenia, who works at a local agency and "helps people" for a living, had obviously thought deeply about changes in her ability and her motivations for helping others. On the one hand, she stated that the course had enabled her to help people in a way she could not before, even though she desired to. She spoke about how, in the course, participants had been given the seeds, "and now we have to allow the plant to grow." On the other hand, Yesenia revealed that though she might have helped people before, she did it out of a sense of obligation, whereas now, the motivation comes from her heart. As a result, she feels better about herself.

Linking her increased ability to help others to a willingness to speak up in her community, Yesenia stated:

Before, I saw that my community needed something, like in the church . . . but I didn't know how to do it. I didn't know, well, I knew about resources, but I was never going to be one of those people who was going to take the initiative and start

to do something in the parish or in the community. And now I feel capable of going and talking to the priest and saying, “Well, this is what I am seeing. I think we have to do something.”

Yesenia’s previous feeling of impotence in the face of community needs has been replaced by a feeling of capacity and determination.

Members of the TE group reported an increase in their sense of self-efficacy around helping their community. Members of the PE group reported a similar increase in ability to help the community and, in addition, they reported increases in their ability to use existing skills and speak up. These results agree with the results of the quantitative analysis, which demonstrated a statistically significant improvement in self-efficacy among members of the TE group, and an improvement that approached statistical significance ($p=.09$) among members of the PE group.

Perceived control at the community level.

As discussed above in Chapter II, one component of empowerment that straddles the line between individual and community empowerment is the individual’s perception of his or her community’s ability to act in concert to achieve common goals. This construct is referred to as perceived control at the community level. Although I did not ask about this construct in the in-depth interviews, several participants in the PE group referred to how their sense of perceived control at the community level had increased as a result of participating in the popular education training.

For example, in the context of the class on Social Determinants of Health, Project Coordinator Adele told a story about a previous generation of promotores who had petitioned to have a crosswalk installed at a dangerous intersection in Hillsboro. This story obviously caught the attention of Emiliana, who commented that before hearing the story, she had wondered why the State decided to build a crosswalk, if the State didn't have any funds:

But it wasn't the State that built the road. It was the promotores, the work of the promotores. So that taught me to value that more, because there are other people who have the same information as I do and with a little bit of willingness . . . we can do great things also.

Hearing about the example of other CHWs working together, combined with a new awareness that others besides herself also have information, convinced Emiliana that her community can do "great things," if they are willing.

For Yesenia, the key to increasing her sense of collective efficacy was finding out there were also others working for change. After reflecting on her newfound ability to go and talk to the priest in the passage I quoted above, she went on to say, "Now I know that there are more people in my parish who are trying to do the same thing, that we are trying to support our community to have a better life, better health." (Y1)

With the knowledge that there were others working to improve the community, Yesenia was able to imagine the possibilities inherent in people working together:

It is like a chain, and if I start, maybe the other person can continue. I wouldn't like for the chain to be broken in order to keep helping, and we can all be promoters

even though we don't go to a course, but we can help a little, and maybe thus change many of the inhuman things that exist in the world.”

Running through the words of both Yesenia and Emiliana is the belief, central to popular education, that if each person does her or his part, it really is possible to create a better world. Similar qualitative evidence of increases in perceived control at the community level was not found among participants in the TE group. The results for this variable in the quantitative analysis were non-significant for both groups.

Critical awareness of the social context.

Critical awareness of the social context – *concientización* in Spanish – was one of the variables on which both experimental groups showed significant increases based on the quantitative data. Participants from both groups made a few comments in their interviews that could be construed as evidence of change on this variable, although the comments were somewhat equivocal. Almost all participants made a comment about their way of thinking having changed. “[The course] helped my way of thinking,” stated Angel, while Juanita commented that “it changed my way of seeing things a lot,” and Sonia related that “[it helped me] in particular to be able to see things from a different perspective.” For Emiliana, her changed way of thinking meant she was more able to see the needs around her, and for Yesenia it related to the change in motivation from helping people because it was her job, to helping people because she was motivated in her heart. While the promotores did not specifically identify an increase in their ability to connect their own personal experience to global and national realities (as we defined this variable for the purposes of the questionnaire), they

definitely spoke about a change in their way of thinking and in some cases related it to greater awareness of the need around them. These comments are probably best interpreted as indications of steps on the road to concientization, rather than concientization itself.

Increased sense of community.

A natural prerequisite to feeling that one's community can accomplish things together is the feeling that one is part of a community. In this way, sense of community is the component of empowerment that links efficacy at the personal level to efficacy at the collective level. Members of both experimental groups spoke about feeling more connected to people in their community, though there were subtle and revealing differences in emphasis between the two groups.

Hilario and Delmi, husband and wife from the TE group, spoke appreciatively of the new friends they had made as a result of the course. "I feel different because I have met new people and these people, well . . . they have taken me under their wing (*me acogen*), right? And that's why I feel different" (Delmi). Delmi also spoke of developing "tight friendships" (*amistades muy estrechas*) with people who they previously only saw at Mass. Hilario told a story about another promoter who had taken him to a government office. Hilario and Delmi emphasized the new friends they had made and the personal benefits these friendships produced.

Better integration into the community resulted in increased ability to help the community and improved health behavior according to Sonia, also from the TE group. In a moving turn of phrase, Sonia related that taking the course had helped her to

“come in from the margins.” At the time Sonia took the course, she had become disconnected from her Latino parish community for a variety of reasons. The course helped her to become connected again and to become known by the community so that people could approach her. Joining a walking group organized by other promotores supported her to act on her desire to get more exercise by making it harder for her to make excuses. Sonia summarized the effects of an increased sense of community, saying, “So, by way of these courses it has helped me to become more connected as a community, and that thing that I could not do alone, well now I can.” For Sonia, the benefit of becoming more connected to the community is that she now feels more capable as an individual.

Unlike members of the TE group, who focused on new friendships and the individual benefits of an increased sense of community, members of the PE group highlighted the collective ties that developed between group members, their pride in being part of a group, and the collective benefits such membership produced. “I think that the people who attended [the course], none of us knew each other,” commented Lupe. “. . . as time went on we got to know each other and at the end, from what I could see, we all missed each other.” Alejandro spoke about his pride in being part of a group of promotores that had a long history. Making reference to the title of a film by a popular figure in Mexican cinema, Yesenia said, “Before I felt . . . as the India María says, ‘Neither from here, nor from there.’ Now I feel like I am part of a group that is trying to improve something in this world, for our community -- and also truly for the world. I know that they say that little by little, one can build a city.” (Y1)

Yesenia has come to feel, not only that she is part of a community, but that that community can create a better world. Based on statements by members of both experimental groups, it appears that an emphasis on the individual in the TE group and the collective in the PE group led participants to emphasize different aspects of sense of community.

Increased participation.

The 2006 WHO report on the effects of empowerment on health (Wallerstein), as well as previous studies (Zimmerman, 2006; Zimmerman & Rappaport, 1988), point to the tight relationship between empowerment and participation. Participation is generally characterized as a component of empowerment, though the two constructs have a symbiotic relationship, with greater participation leading to greater empowerment and vice versa (Wallerstein, 2006).

Many of the changes that have been discussed above have implications for increased participation and some clearly indicate increased participation, as do other changes I will report below. However, two PE participants made reference to very specific increases in their participation in their church communities that deserve note. Returning to the topic of her conversation with the parish priest, Lupe stated:

But now I have talked to the priest. I told the priest that I want to participate in whatever I can and now I am going to be in the food bank, but he said, “Not because you are a promotora but because you are just one more parishioner.” So I told him, “But [before] I never dared and now I am getting more involved; I am

going to participate three times a week.” There I am going to start taking baby steps and I want to, then, as I am telling you, do as much as I can to serve others.

This quotation reveals that Lupe is so convinced of the relationship between her participation in the course and her desire to be more involved in the parish that she insists on it, even when challenged by a highly respected authority figure such as a priest.

Emiliana also shared an experience with her parish priest, and at same time alluded to the unfamiliarity of the concept of “volunteerism” for immigrant Latinos. In a meeting at her church, the priest expressed a need for more volunteers. “So for me the idea of becoming a volunteer,” Emiliana said, “before that made me think, ‘Okay, so what does that mean?’ But not anymore.” Emiliana related that because of her experience in the course, she now intended to become a volunteer. According to Lupe and Emiliana, participation in the CHW training course led directly to greater participation in their parish communities.

Increased Knowledge

Above, in the section on self-efficacy, we saw that while improvements in self-efficacy among the PE participants extended to several domains, improvements in self-efficacy among TE participants were more focused on ability to help the community. A similar phenomenon obtained concerning increases in knowledge. Participants in the TE group reported impressive gains in knowledge of services and health knowledge. While participants in the PE group did report improvements in their health knowledge, they were far more eager to talk about new understandings of

the world and new abilities to effectively share information with others. I will begin by discussing changes in knowledge among the TE participants, and then move on to discuss changes in knowledge among the PE participants.

Sonia talked about her excitement in learning about all the services that are available to her community:

Another thing [about the course] that I thought was fabulous, was the quantity of services that are being offered to the community which I did not know. The community-based services that are offered by Providence and the Iris Clinic. And well, different services that I didn't know, and that interested me because I am working with a Hispanic community also in my job and many times they require this type of service.

Sonia was excited to learn about community services because she knows she will be able to use this information not just as a CHW, but also in her paid work.

Juanita spoke at length and in great detail about all the things she had learned about health in the course. She related that she had learned things she never knew before, for example, about nutrition (eating whole grains, eating a variety of foods, eating less sugar, eating fewer processed foods), exercise, food safety, reading labels, and new recipes. In some cases, the things she learned conflicted with things she had been taught since childhood. "One grows up with other ideas. I remember that . . . my mother told me, 'when you heat up the food, let it cool down before you put it in the refrigerator.'" In other cases, what she learned in the course augmented things she already knew. "We know that we can eat vegetables, but we don't know, but I didn't

know, for example, that I could eat up to five or more vegetables a day, right?”

Juanita appreciated all the new things she had learned about health, including those that supplemented or supplanted things she already knew.

Israel also valued the health information he learned in the course, saying, “it taught me more like health wise so I can go out and educate other people and tell them what the right thing to do would be.” The attention of some participants was caught by specific details of the information they learned. For example, Juanita learned when to use ice and when to use heat on an injury, and Delmi learned the importance of drying between her toes to prevent fungus in the session on diabetes.

Members of the TE group also reported learning a particular aspect of health knowledge that is uniquely important in the Latino community. In Latin America, where “prescription” drugs are available over the counter without a prescription, it is common for lay people to “prescribe” drugs for one another. Juanita and Hilario both shared that they had learned not to do this. In Juanita’s words:

Well, yes, really before I didn’t know and sometimes someone said to me, ‘I have a headache.’ ‘Oh no,’ [I said], ‘well go take some pills over there,’ or that is to say, I prescribed or recommended pills, right? When really one shouldn’t say, ‘No, well, go take these pills,’ or if someone has a cough, ‘Oh no, well, go buy that syrup,’ right, or something like that. Now, I try to recommend that they go a little to the doctor . . .

Hilario shared that he used to have a big bottle of aspirin that he would give to his co-workers, but he no longer does this because he knows “we can’t be giving pills out,

because in trying to cure someone we might poison them!” Having learned the dangers of recommending particular pills, Juanita and Hilario no longer do this, and Juanita encourages people to go to the doctor.

Participants in the PE course also reported increases in health knowledge. The Nutrition session was the first session Lupe mentioned when I asked her which session she remembered best. “They were all important, but that was the most important for me,” she stated. During the session on Heart Health, Lupe commented to me that until that day, she had never known what her blood pressure was supposed to be. In a similar vein, Yesenia commented that she learned things she perhaps should have known but had never really understood:

I worked at the [name of clinic]. I knew there were three types of diabetes. I never knew the differences between the three types. Now, after the program, I understand the three types of diabetes! I went to school but I don’t remember that they taught me. And here they explained it to us.

In this passage, Yesenia expresses that she had been able to learn something in this course that she had not learned in school and that this information was important to her. Her comment recalls her statement in the previous section about how the popular education facilitators made every effort to make sure participants understood, in contrast to her teachers in school.

A few popular education participants reported that they were more able than they had been before the course to identify warning signs of illness and advise friends and family members where to go for help. According to Emiliana, she used to ask her

sister for advice about children's health care because her sister has more children than she does. Now, her sister asks her. Recently, one of her sister's children, a 10-month old baby, was ill. Emiliana recognized that the baby might have an infection that would not go away without medication and advised her sister to take her baby to an urgent care clinic where she would not be turned away because she does not have health insurance. Her sister did so, and discovered that the baby's ear drum was about to burst because of a powerful infection. While Emiliana reported this as an increase in her own health knowledge, her new knowledge also had powerful beneficial implications for her family.

Popular education participants also reported learning things beyond the realm of health. For example, Yesenia made a number of statements that suggested that she had learned some of the basic principles and practices of popular education, although she did not identify them as such. Recounting what she had learned in the course, Yesenia mentioned the following basic principles of popular education: that knowledge or wisdom is not determined by formal education or social class; that it is important to start with what people already know; and that if we do everything for other people, they will never learn to do it for themselves. Another statement Yesenia made suggested she had developed an advanced understanding of the role of feelings and emotions in behavior change and a willingness to approach other community members:

With this course now I feel like I learned a little bit and maybe I'll be motivated to say to people, "Okay, what you are doing, you didn't do something bad, but you are

damaging your health.” Before I didn’t know how to say something to that person without offending them, and now in this course they taught us how to say to them, not that what you are doing is bad, but to tell them, “You can try to do this,” and give them like pathways so that they will arrive at better health.

Yesenia’s understanding of the importance of not offending people and giving them options stands in marked contrast to Israel’s rather simplistic view, mentioned above, that if you give people information, their behavior will change. In a similar vein, Yesenia reported she had learned the importance of teaching people to do things – in effect, empowering them – rather than doing things for them. “We can be like promoters,” she stated, “but at the same time, like teachers, to teach them what they can do for themselves and that maybe they can help their neighbor or someone else who needs it who is going through a similar situation.” Using a turn of phrase which is even more lyrical in Spanish than in English, Yesenia concluded that we should, “give them the steps but not take the steps for them” (“*darles los pasos, pero no dar los pasos por ellos.*”) These statements by Yesenia highlight not only the importance of empowerment, but also the responsibility of popular educators to pass along what they have learned.

In the course of her interview, Emiliana demonstrated that she had learned how to get new information and that she had an increased awareness of her rights and the rights of others and how to advocate for them. In her words, “about halfway through the course, I thought, ‘Well, I know that I can increase the tools they are giving me, the ones I am learning,’ and I started to . . . practice more with the information.”

Emiliana related a long story about how she and her husband had gone to the Adult and Family Services (welfare) Office to ask about benefits, since her husband had been laid off. A worker there was rude to them, and Emiliana observed s/he was also being rude to others. She felt empathy, knowing that “when one has an emergency or something, the last thing one wants is to have a bad experience.” A woman approached her and asked if she was filling out the same form. Emiliana explained she was not, but encouraged the woman to sit down and calmly provide the information the form was asking for. At that point, another person approached and asked her another question. Soon, she had become a source of information for many Latinos sitting in the waiting area. “So I thought, this is being, this is truly the role of a promotora,” stated Emiliana. “I don’t know everything, but I can tell the other person to go and ask.” For a middle class Anglo European, the awareness that one can “go and ask” or encourage someone else to “go and ask” may not seem like evidence that someone has developed an awareness of her/his rights. Yet for an immigrant Latino, who possibly does not speak English and who possibly is undocumented, the realization that it is acceptable to “go and ask” actually represents a huge step forward in Emiliana’s sense of her rights and the rights of her fellow community members.

A similar awareness of rights and the ability to advocate for rights infuses another story Emiliana told, about encouraging a woman she knows to go to the hospital to get a problem checked out.

So I think [the course] has helped me a lot to tell her, “Well, you have to ask, and if there is no one who speaks Spanish, you have to tell them, “No, please, can

someone come who speaks Spanish?” so that you will feel sure of what you are asking and you can go away with information.

According to Emiliana, as a result of the course she is now able to encourage others to advocate for their right to an interpreter. A member of the Project Team who is also an immigrant Latina commented on the significance of this statement. “Every time you go to the doctor, you forget your questions. But when you get to the point of saying, ‘I am not leaving until I have the answer to my question,’ that is empowerment.” As a result of the course, Emiliana has become empowered to find new information and encourage others to advocate for their rights. While participants from both experimental groups reported increases in their health knowledge, through the stories they told and the statements they made, members of the popular education group demonstrated they had also learned new things about how to educate, empower, and advocate for others.

Improved Health Behavior

Consistent with the results of the quantitative methods, participants in the TE group reported substantially more changes in their health behavior than participants in the PE group. The majority of these changes will be reported in the next section (“Family Level”), since this is the context in which the respondents discussed them.

At the individual level, participants in the in-depth interviews reported improvements in their mental health and their ability to manage stress as a result of participating in the course. Emiliana, from the PE group, said she felt more able to manage her stress, and that because she could control her stress, she had more energy

for her children. Sonia, from the TE group, stated that when she started the course, she was passing through a period of depression because of things that were happening in her life. She stated the course had helped her to overcome her depression “because I stay active, I enjoy what I do.” TE group member Delmi also related increased physical activity to improved mental health, saying, “When we feel overcome with worry, we get up and we go for a walk. And this course taught us to do that.”

Other participants talked about how the course had helped them to implement changes in their health behavior that they had been thinking about for months or years. In the language of the Transtheoretical Model of health behavior change, it helped them move from the contemplation stage to the action stage (Prochaska & DiClemente, 1983). Sonia explained this process particularly well, stating:

For years I had been saying, “I am going to do exercise, I need to eat healthy, I am going to eat meat,” because I had the knowledge and it was my goal and there are always things a person wants to do but doesn’t do. But after this course, I said, “I want to and I am going to do it.”

Sonia went on to report that she had joined a walking group organized by other CHWs in her parish and was walking regularly. Hilario reported that he had been walking for exercise before the course, but not with the “vehemence” that he does it now. Perhaps one factor that motivated him was another promoter saying to him, “Look Don Hilario . . . the climate doesn’t have to adapt to you; you have to adapt to the climate!” (This was reported by his wife Delmi.) The fact that the previously mentioned walking group was based at his parish provided social support for behavior change, as well.

For Juanita, the changes in exercise had proved more challenging than the changes in nutrition. She reported she had been doing a little exercise, “although sometimes I get home tired, or I have to leave really early to get to work and sometimes in the evening I help my husband also. So in a way there is no time in this organization [of the day] to do exercise.” Changes in nutrition may have been easier for Juanita because in some cases they were changes in degree rather than substance:

Well, now I am eating things that I thought I was eating, but not very frequently, right? Like vegetables, fruits, for example grains (*cereales*) which yes, I ate every once in a while but they were not part of my daily nutrition.

In addition to eating greater quantities of healthy food, Juanita also reported she was taking more precautions with food preparation and maintenance.

In sum, participants in both experimental groups reported that they had changed in a variety of individual ways as a result of participating in the course. These included feeling more empowered on a number of levels, increasing their knowledge, and taking measures to protect and improve their health. Generally, changes among the PE group ranged across a wider spectrum, whereas changes in the TE group were more specifically health-related. In addition, increases in empowerment and in their ability to empower others were more marked in members of the popular education group.

Family Level

From the perspectives of the participants, families were changed in a variety of ways as a result of the participation of one or more family members in the CHW

training course. In some cases, effects on CHWs' families began immediately when the CHWs returned home after class. Many CHWs related how their families would ask them about what they had learned, and they would share highlights. As Juanita stated: "I talked to [my family], for example, sometimes when I arrived home from the course, they would ask me, 'How did it go?' 'Well, good.' 'What did you talk about?' So I would tell them, right? I tried to tell them the most important parts of the course." For the TE participants, the bulk of changes reported concerned diet and exercise. For the PE participants, the changes reported were more varied and included changes in family relationships and levels of independence. As noted above in Chapter III, some of the differences in emphasis between respondents from the TE and PE groups may be related to differences in their stage of life and position in their families.

All the members of the TE group who participated in in-depth interviews spoke about changes their families had made in diet and/or exercise. According to Ana Maria:

. . . we already knew all the damage that food can do, including oil, but when I took [the Nutrition class], among ourselves here at home, we completely changed our way of being, of eating. Everything now is very different. We hardly use oil; we try to eat a lot of vegetables and fruits. We always try to make sure we have some in the house. And we do more exercise and . . . more than anything we try not to have soda in the house, just gallons of water.

Similarly, Juanita identified numerous changes in eating habits that her family had made since she took the course. Like Ana Maria, she stated that her family had previously known what they should be doing, but “until someone had to come and knock on our door,” they did not act on it.

The gap between knowing and doing which so many participants alluded to can be explained to some degree by a substantial number of barriers to healthy eating and exercise which participants also identified. Juanita, whose family owns its own business, reflected on how the need to work can influence eating habits:

Before, for example, we dedicated ourselves to working and we said, ‘Well, let’s make a quick stop, we bought some hamburgers, or we bought pizza and then we went back, it is our food and it’s fast food and then it’s back to work. And on the other hand not anymore, because now we try to take time and to arrive and eat in a healthier way, right?

Juanita’s poignant phrase, “it is our food and it’s fast food and then it’s back to work,” sums up in very few words the relationship between work and food for many immigrants and members of the working class in the 21st century U.S.

Sonia agreed that her busy life causes her to eat too quickly, and also pointed to the influence of technology such as television and computers, which influences people to lead a more sedentary lifestyle. Making reference to the seductiveness of the idea of progress, especially for people who come from non-industrialized countries, Sonia stated, “the problem is that, in quotation marks, we are ‘better’; we are more advanced but towards illness.” The social isolation that is intensified by Oregon’s climate also

plays a role in people not “liberating their energies” through activities like walking, according to Sonia.

Reflecting on a recent trip back to her home country, Sonia identified some of the deeply ingrained cultural values, products of historical experience, which can make it difficult to change eating and exercise habits in the Latino community.

An interesting thing is that I had always been thin and I went, during spring break, to (country of origin) and I was . . . heavier, I had gained weight. So the comment I heard was, “How good you look!” and I said, “Well, I don’t feel good.” The comment came from my sister, from my uncle, and then, erroneously, it’s like when a baby is born, he has to be fat in order to be beautiful. And when he’s fat it means he’s okay. It’s hard sometimes to change this mentality.

In countries where the dominant experience has been of poverty and privation, it is easy to see why signs of wellbeing (such as chubby children) would be valued. Yet conditions are changing in Latin America, as in other post-colonial regions, as Sonia went on to reflect. “When I . . . came from my country, this problem of obesity was not so great, and each time I go back it’s worse and worse.” The ever-greater insertion of multi-national fast food companies into the post-colonial countries, part of the globalization discussed in Chapter I, has produced these very real effects, which health care workers worldwide must now address.

Given all these barriers, it is no wonder that, for the CHWs, trying to change family members’ eating habits can often feel like a battle. “My husband,” stated Juanita, “. . . we have to influence him and help him in this way because he is a little . . . he doesn’t

like certain foods. So it's necessary to struggle with him . . ." "Where changing diet is concerned," concluded Sonia, "it's a day to day task, because with young people, they want to eat other things." Some CHWs had actually met with incredulity and ridicule when they tried to get friends and family members to eat healthier foods. Lupe, from the PE group, reported that when she tried to give her family more vegetables, they responded, "'Where did you get *that* from?" Ana María's adolescent children told her she had been traumatized by seeing how much fat is in the things we eat. And when Juanita tried to influence a friend to change her diet, the friend told her she thought she was special because she had taken the course.

Despite the barriers they face, CHWs reported that eating habits of family members, even those who were initially resistant, have changed. According to Juanita, although her husband doesn't really like vegetables, he is now trying to eat them. In addition, whereas he used to buy food in the street when he was working, he now takes something from home, like a sandwich, fruit, and water. Sonia reported that her son, with whom she struggled at first, recently told her, "'You know what? I ate at school and they said I could eat as many fruits as I wanted and I ate like a thousand!'" Now, the same children who formerly told Ana María that she had been traumatized get home from school and look for an apple and a glass of water.

Perhaps one reason that the changes in nutrition and exercise are taking effect among CHWs' families, despite the barriers, is that many, many families had already been affected by the health problems that were discussed in the course. Of the participants chosen for in-depth interviews, at least four had family members with

diabetes, the husband of another suffered paralysis while the course was taking place, and one participant had had a heart attack himself. These experiences may have been part of what motivated the participants to sign up for the course, as well as factors that peaked their interest in the nutrition and exercise sessions. Israel reported that his family's eating habits were already changing before the course because of his father's diabetes.

When I asked Delmi about why she liked the Nutrition class best, she stated:

Because in this moment we had been through, with [Hilario], his operation and the [heart] attack he had suffered and the doctor, everything [the doctor] told him not to eat, they said it all in Nutrition [class] and I still learned even more from the Nutrition class.

For Delmi, the Nutrition class reinforced and expanded information she had begun to learn as a result of Hilario's heart attack. Sonia revealed that she had recently lost her brother-in-law to diabetes, and thus was trying to influence her sister to teach her children to eat healthy and maintain a healthy weight.

Ana María's husband suffered from facial paralysis the week before the class on Heart Health. Ana María attended the class at the urging of her husband, who was still recovering. In the class, she recognized all her husband's symptoms. Because they did not know the symptoms, and because of what Ana María identified as a Hispanic tendency to put off going to the doctor until the last moment, they did not heed early warning signs but waited until her husband was worse. Even when he finally went to the hospital, they did not know they could call an ambulance and Ana María did not

go with him because she still did not think his condition was serious. Reflecting on what she had learned, Ana María protested that she had never told herself that if she had taken the class before, she would have known what to do. “But I learned that there were solutions for everything, such as learning,” she concluded. At the time of the interview, Ana María was trying to help her husband recover emotionally, and what she had learned in the Mental Health session was helping her. Interestingly, it was also Ana María among all the CHWs who reported involving her family members in her work as a CHW:

I like it because now that we are working on our [group] project, I include my family also. My children who know, more than anything, how to use the computer . . . they help me a lot . . . Also I say to my husband, “How do you like this?” “Is this topic okay?” “Is this okay?” and yes they help and support me. . .

Ana María’s experience with her husband greatly reinforced the importance of what she was learning and helped her to see the value of learning itself. Ultimately, she was motivated to involve her family in her work.

Participants in the PE course also reported changes in their families’ eating and exercise habits. Speaking of the dietary changes in her multi-generational household, Lupe reported that, “in my family, the practice is on a big scale.” Lupe reported that before she participated in the course, she had cooked “*puras comidas*” (pure main dishes). “We were really accustomed to making hamburgers. I bought the meat at Costco, or whatever store . . .” She used sugar, despite having been diagnosed with diabetes several years before, and always had to have bread in the house. But now,

many things had changed. “Since I was in the study,” Lupe stated, “I have not gone back to buy hamburgers at all!” She reported she was cooking more vegetables, despite her children’s protests, and using less fat. She was encouraging her family to drink less soda, and had replaced sugar with Splenda. She realized that her family was not perfect and still needed to make more changes, “but we are going step by step.” And beyond the health benefits of the changes they had made, Lupe could see other benefits for her family. “Look, I think I am saving a lot of money,” she told me. This benefit was certainly an important one, since two adults in Lupe’s household had recently been laid off, and her hours as a janitor had been reduced.

As has been true of other variables, while CHWs from the PE group reported dietary changes among family members, they also reported a wider range of changes at the family level than were reported by the TE participants. These changes related to greater levels of independence for parents and children, and family relationships. Emiliana came to the course with her two small children. She related that previously, when she had tried to attend English classes, her older child, a daughter of about three, had experienced a lot of stress, crying and trying to vomit. For a time, Emiliana concluded she was just going to have to stay home until her children got a little older. When she heard about the CHW training course, she thought it sounded interesting but doubted whether she could really attend. Finally, one week before the course was going to start, Emiliana decided she was going to try. “I am going to try because I can’t stay here in the house with my children from sunup ‘till sundown.” During the first few weeks of the course, Emiliana felt uncomfortable, worrying about how her

children were reacting, and wondered if she had done the right thing. But about halfway through the course, Emiliana concluded she was in the right place, not only because of the changes she was seeing in herself, but also because of the changes in her children. “Well, the stress my daughter was feeling went away completely,” she stated. Whereas before her daughter always wanted to stay home with her father, now she collects her backpack and talks about going to her “school,” referring to childcare at the training course. Emiliana reported that as a result of the course, she and her children are able to experience the benefits of going out into the wider world without fear.

According to the PE participants, their participation in the course also led to changes in family relationships. Yesenia reported that her parents had always supported her. “But this time, even my father felt really proud because I finished the course and it was part of the parish. He had always wanted me to be more involved in the parish.” (Y2) Yesenia’s parents had also seen a marked change in her attitude. “Before [the course], I got up, saying . . . ‘Ay, I have to do this and it’s Saturday and I don’t want to,’ and now well no, now I get up and I’m off!” Now, Yesenia shared, she did things not because she had to, but because of her personal motivation. According to Yesenia, her father saw all these changes and commented that the course had helped her to change. “In this way, I think that . . . this course made us more unified than we were before. Now they give me a lot of support.” (Y1) In noting that “now they give me a lot of support,” Yesenia implies that while her parents were supportive before, now they express their pride, and as a result she feels more connected to them. Blanca

also reported that when she told her parents about the course, they told her they were proud of her and expressed interest in attending a similar course themselves. Perhaps partly because of the different stages of life and family relationships in which interview participants found themselves, as well as the different methodologies they had experienced, respondents from the TE group reported more changes in family members' diet and exercise habits, while participants in the PE group talked more about changes in levels of independence and family relationships.

Community Level

As mentioned above, it is often difficult to tease apart changes at the individual level from changes at the community level. Is the fact that the CHWs feel that they are part of a community a personal change or a community change? Does the fact that CHWs share health information in their community represent an individual-level shift in their self-efficacy or a community-level shift in the availability of health information? Clearly, the different levels of change are truly inseparable, as individuals become more confident and active and communities become more connected and informed as a consequence.

As a result of the training courses, actions by individual CHWs and groups of CHWs were already resulting in new opportunities and awareness at the level of the community. Mid-way through the course, CHWs from one parish initiated a walking group in which many of them were participating. By the time of the in-depth interviews, another group from the same parish had held its first nutrition class, which was attended by more people than could fit in the room. They were planning to start

smaller groups that would meet in homes, where they could cook as well as share information. They were coordinating the cooking classes with the walking group so people could attend both. Seeing the high level of participation at the first nutrition class filled Sonia with enthusiasm. “This means that people are interested . . . and I think it’s important to take advantage of the moment to move some resources in the community and make them more accessible.” As mentioned above, we attempted to address a limitation of past projects by including an experience of making change as part of the training course. As a result, by the end of the course all the CHWs were involved in some health project in their community, though they were at different stages and were addressing different topics.

In addition to these group activities that resulted directly from the training course, CHWs who had participated in the course also reported that they were making health information and education more available in their communities by sharing informally within their social networks. For example, Hilario and Delmi told me they had been to visit friends, a large extended family of 10-15 people, and shared an impromptu class on nutrition and diabetes. The couple reported that the friends were already putting what they had learned into practice. Juanita reported encouraging her friends to get preventive screening. Emiliana, from the PE group, spoke at length throughout her interview about referring people to health care and other resources. I have already mentioned how she successfully encouraged her sister to take her 10-month-old baby to urgent care. Extending this practice beyond her immediate family, she has shared information about health care resources with people who previously knew nothing

about them, and has encouraged them to go for care. Recalling Yesenia's words above about the chain of assistance which can start with the CHWs and extend out into the community, Emiliana stated:

I tell [people], "I have all, all the addresses. I have it all written down, and when you need it, share it also with your family, with your friends if you have some. Because you don't have to just stay there, with your tooth hurting all night, and saying that you don't have enough money to go to the doctor."

Like Emiliana's quotation about encouraging her friend to ask for an interpreter, members of the Project Team found this preceding quotation especially compelling. According to the team's analysis, the quotation highlights the new information that Emiliana has gained and the fact that she does not just share it, but encourages others to share it. Project Team members also expressed that the quotation reveals how common it is for community members to suffer in silence, feeling they have no place to go.

On a lighter level, Angel reported that he had told his co-workers about the classes, who asked him why he didn't invite them, to which he answered, "I didn't know you yet!" Among all the things he told his co-workers, he did not forget to talk about "all the *food* they gave us!" Along with conducting group projects like nutrition classes and walking groups, participants in the in-depth interviews reported ways in which they were individually making health information and education more available in their communities.

Differential Effects by Methodology

As noted throughout this section, some differential effects by methodology were evident in the type and intensity of changes which CHWs reported in their individual interviews. Other differential effects could be inferred from the way participants described their experience, making it clear that participants tended to internalize the spoken or unspoken values and assumptions associated with both methodologies.

For example, the facilitator for the traditional education session on Nutrition expressed many negative judgments about the “bad” food safety habits of community members. (Though the facilitator, who is Anglo-European, did not specify that she was talking about the Latino community, she made it clear that she does much of her work in the Latino community, giving the clear impression that her judgments were about Latinos.) She reinforced her judgmental spoken language with body language, actually wagging her finger at the participants on several occasions.

Not surprisingly, participants in this session came away from the session feeling culpable. “I have become aware of the *great errors* I have committed both personally and in my family and now I am aware of the importance of the combination of foods,” commented one participant soberly in her/his evaluation (emphasis added). Another said s/he had learned, “that I *have to* eat fruits and vegetables. That I *have to* maintain food and take care of it so that it does not get contaminated” (emphasis added). Juanita seems to have generalized the judgmental attitude of the Nutrition session facilitator to her entire experience of the course. Her very first comment, upon being asked in the in-depth interview what she liked about the course, was as follows:

Well, for me it was a very wonderful experience because I had never learned in all my life the importance of what is, for example, nutrition, how *badly* we sometimes eat. Well, the *bad* nutrition that we have, the *bad* health of our bodies many times, because we don't wash our hands adequately, exercise . . . We know it's important, but sometime we don't take it . . . for my part, I didn't take it very seriously. And always I remember that they told me, when I went to the clinic, they always told me to walk. Sometimes I walked, sometimes I didn't. But now with this course one becomes aware of all the *errors* that one commits (emphasis added).

Clearly, though Juanita calls the course a “wonderful experience,” what has stuck with her from the course are lessons about her errors and previous bad behavior.

Only two comments were heard or recorded that appeared to take issue with the Nutrition session facilitator's apparent assumption that knowledge would lead directly to behavior change, and they may have come from the same participant, since the participant evaluations were anonymous. During the session, one participant voiced her feeling that it is often not so simple to make the kinds of dietary changes that the facilitator was demanding. Among the narrative comments about this session on the participant evaluation was the following:

[The class would be good] if it were a little more extensive to know how to educate and change dietary habits, both in ourselves and in my family, since because of cultural, economic and social factors it is not so easy to change other people when they have not been sensitized to the topic.

This comment, which recalls the barriers to change in exercise and diet mentioned in the previous section, suggests that a more nuanced approach to behavior change is needed than was provided by this facilitator.

Another part of the dynamic of this class was the facilitator's almost constant admonitions to the participants to hurry (for example, when they were presenting work done in small groups) because time was running out. On her/his evaluation, one participant neatly sandwiched his corrective comment about this behavior between two positive ones, saying, "I think [the class] was good, we didn't participate much because the time was so short, but in reality it was good."

One could object that this judgmental behavior was more associated with a particular facilitator than with a particular methodology. However, the admonitions to popular educators against this sort of judgmental behavior are so strong that it is safe to say that a skilled popular educator would not exhibit this type of behavior. Traditional educators, on the other hand, can find justification for this sort of behavior in the epistemological stance that knowledge is a pre-existing commodity that is given by the teacher (the one who knows) to the student (the one who does not know).

Another interesting effect of the two methodologies on the participants is apparent in the participant evaluations. Participants in the Traditional Education group were fairly quick to criticize one another, whereas the participants in the Popular Education group were much more likely to express support for one another. Responses to the question, "How could this session be improved?" elicited the following responses from members of the Traditional Education group:

“[Other participants] should let us hear the class when the facilitator is speaking.”

“The organizers should remind the mothers that there is a room with a person who takes care of and entertains the children. In a nice way, [they should inform them] that they distract the students and the teacher.”

“This was a very important topic, but we got off topic and we failed to take advantage of the doctor. ‘The objectives were not covered,’ and it was the fault of the students! Not the doctor!”

“[We need to] concentrate on the topic and not get off topic with unimportant comments.”

Conversely, when participants in the popular education group were asked how sessions could be improved, they exhorted their compatriots to participate more and asked facilitators to encourage participation. “[We can improve by] participating . . . not being afraid to participate,” commented one participant. “By persuading everyone to talk,” said another. “By participating more and not being ashamed, [since] everything is valid,” said a third. “There is a lot of motivation, but it still has not been accomplished that all participate,” commented a participant after the third session. Similarly, participants expressed their desire to get to know other participants. “[The facilitator should] ask that each Saturday, people change seats to get to know different people and socialize,” suggested a participant.

These comments provide evidence that, even by the second session, participants in the PE group had begun to internalize the emphasis that popular education places on full participation by all group members. There is evidence that they were internalizing

other values and practices as well. When they perceived that facilitators were not using enough interactive techniques or putting enough emphasis on the social determinants of health, these participants were quick to point it out. For example, after the Diabetes session, one participant commented, “They should talk more about the social and political factors that cause stress, which is one of the risk factors for diabetes.” Because the Diabetes session occurred immediately after the session on Social Determinants of Health in the PE group, it seems reasonable to attribute the participant’s comment at least partially to an increased awareness gained in the previous session.

Summary

Results of the analysis of the three qualitative data sources, combined with the results of the quantitative analysis, suggest that participants in the PE group experienced a more pronounced increase in empowerment, while improvements in health behavior were more common among members of the TE group. On a wide range of domains, changes in the PE group were more multi-faceted, while changes in the TE group were more focused on health, strictly defined.

Although it is certainly dangerous to oversimplify the extremely varied and nuanced changes which the CHWs reported they experienced as a result of their participation in the course, two quotations – one from a PE participant and one from a TE participant – seem to sum up the difference in the changes that occurred in members of the two groups. Hilario, a TE participant, summarized the changes he had experienced this way: “The difference [between how I was before the course and how

I am now] I would locate it in the knowledge. That's the difference: in the knowledge that we have now." For her part, Lupe, a PE participant, characterized her own changes like this: "I have learned a lot of things that have made my life more full . . . most of all, how to be able to help people, how to participate . . ." Overwhelmingly, when I asked the TE participants what they had learned or how they had changed as a result of participating in the CHW training course, they spoke about the *facts about health* that they had learned, and how they were putting these facts – especially, facts about nutrition and exercise – to use personally and in their families. When I asked PE participants the same questions, they were much more likely than the TE participants to talk about changes in their own feelings of capacity, and how these feelings of increased capacity had led them to do things, such as talking to the priest, volunteering in their parish, or advocating for their rights, that they had never thought they could do. In addition, they talked about how they were passing on their newfound skills to others in their community. Whether these initial efforts will lead to long-term changes in the development of leadership or the organization of communities remains to be seen. The need to explore this question will be discussed in Chapter V in the section on Suggestions for Future Research.

Costs and Benefits to a CHW Training Program

Q5. From the perspective of the researcher and the project team, what costs and benefits accrue to a CHW training program as a result of being involved in a research project?

According to my own observation as recorded in my field notes and my discussions with the Project Team as recorded in the notes from our meetings, being involved in this research project produced both costs and benefits for the Parish Health Promoter Program. While some of these costs and benefits can be generalized to any CHW program that becomes involved in research, others are specific to this program and the way research was conducted in this study. Also, although I originally phrased this research question to focus on the “CHW training program,” it became clear in the course of the research that costs and benefits were experienced on both a programmatic level and a personal level, among members of the Project Team and others associated with the project. In this section, I will first consider the benefits at both of these levels and then the costs at both levels.

Benefits

Participating in a community-based research project (*La Palabra es Salud*) produced a number of benefits for the Parish Health Promoter Program and its staff. Benefits were felt at a programmatic level and a personal level.

Programmatic Level

My field notes and my notes from Project Team meetings suggest that as a result of being involved in this research study, the Parish Health Promoter Program experienced a variety of programmatic benefits, including increased quality of educational sessions, better program organization, and the creation of an Advisory Council.

Increased quality of educational sessions.

A number of processes that took place because of the research study produced higher quality educational sessions for the PHPP. In the past, while the topics of the educational sessions had been chosen by the Coordinators, facilitators had not been given specific objectives and had developed their sessions according to their own criteria and expertise. In the context of the study, partly because of the need to assure consistency between PE and TE sessions, the Project Team developed a standard list of objectives for each session (see Appendix F: Curriculum Master List). These objectives were broad and global, drawing on the experience of all members of the Project Team. While it did not occur in every case, facilitators were strongly encouraged to submit their lesson plans ahead of time, and when this occurred, lesson plans were reviewed by Project Team members. This review represented an additional level of quality control that had not existed in the past. In addition, CCC Capacitation Coordinator Teresa Rios, who is an experienced popular educator, met with many of the facilitators for the PE sessions to provide mentoring and technical assistance, further increasing the quality of those sessions. Starting all educational sessions with a spiritual or Biblical reflection was an innovation of the research study that had not occurred in the past. The Coordinators commented that this innovation produced better integration with the mission of Providence Health and Services. Also, in order to assure that spiritual and Biblical reflections in the PE group were conducted in accordance with Liberation Theology, after session three I took responsibility for planning and leading the reflections for this group, thereby increasing the fidelity to

popular education in these sessions. During the educational sessions, the presence of additional Project Team members meant that the Coordinator had time to reflect on the classes. “A benefit is that not everyone is waiting to talk to me,” Adele commented. “I don’t leave as exhausted . . . There’s more room to integrate what’s happening in the classes. So I can watch what’s happening while I’m setting up logistics in a way that wasn’t possible two years ago.” In the weekly meetings of the Project Team, we evaluated the most recent session and made changes as needed, producing a kind of continuous quality improvement that was new for the program. Further, in addition to the group evaluations that were conducted at the end of each PE class, participants in both experimental groups filled out a written evaluation at the end of every class and the results were entered into a database and analyzed. Catherine Potter, who has been the Coordinator of the PHPP on the east side of Portland for eight years, commented that she could not believe the program had not conducted this kind of systematic evaluation of classes before. Elements that resulted from the research study that contributed to the quality of the educational sessions thus included standardized objectives, review of lesson plans, technical assistance for (some) facilitators, spiritual or Biblical reflections in all classes, an opportunity for the coordinator to step back and reflect on the sessions, continuous quality improvement while the series was taking place, and individual as well as group evaluations of every session.

Better organization.

The presence of additional team members also made it possible to carry out tasks which, while not directly related to the quality of the sessions, produced a more

organized program overall. For example, I took notes on a laptop computer in all Project Team meetings. After the meetings, I reviewed the notes, clarified anything that was not clear, and e-mailed the notes to team members. Often I included a “to do” list in both the body of the e-mail and the attached notes, helping to keep the team on track. As mentioned above, after meetings in which we had brainstormed possible objectives for each session, I paired down and rationalized the objectives (although in some cases, not enough. See below, Costs.) Due to the requirements of the research study, the Project Team created documents, such as expectations of facilitators and participants, which will be useful to the program in the future. The research study contributed to the organization of the PHPP by providing notes from all planning sessions; a synthesized list of class objectives; and clear, written expectations for facilitators and participants.

Advisory Council.

Certainly one of the most important benefits to the PHPP that resulted from this study was the creation of an Advisory Council. As mentioned previously, the Advisory Council includes experienced parish health promoters as well as clergy from other parishes that are involved in the PHPP but not in the study. As well as participating in the analysis of data from the study, during their meetings Advisory Council members provided input about a wide range of topics, including how to resolve conflicts among leaders in the churches, how to integrate new CHWs into established groups, and how to redefine and reframe the word “leadership” in Latino congregations. Based on comments they heard while participating in Advisory

Council meetings, Adele and Catherine asserted that as a result of serving on the Advisory Council, parish clergy developed a better understanding of and greater appreciation for the PHPP. They expect that this improved understanding and appreciation will translate into more support for the program in the future.

Many of these innovations introduced by the study will continue. Currently, I am participating in discussions with the two Coordinators in which we are striving to integrate lessons from the study into the plan for the next training course. The Coordinators intend to use a shortened version of the pre- and post-survey and will continue to conduct individual written evaluations. They also intend to maintain the Advisory Council, though the group will meet on a less frequent basis.

Personal Level

According to my notes from Project Team meetings, all Project Team members expressed that we gained personally from being involved in *La Palabra es Salud*, with most benefits being associated with the meetings of the Project Team. Benefits included new knowledge and skills, mutual support, and personal growth, particularly in the area of cultural awareness and competency.

New knowledge and skills.

Members expressed that, as a result of participating on the Project Team, they gained new understandings and developed new skills. Catherine expressed that she had increased her knowledge about meeting facilitation: “For me, a benefit is to keep learning from your style of facilitation, Noelia. To have a weekly example of how to facilitate a meeting.” Adriana, the youngest member of the team, stated that when she

attended her first popular education workshop near the beginning of the program, “I was the color of my sweater – green!” In less than six months, Adriana was co-facilitating a popular education workshop with me. Teresa reflected that the project gave her the opportunity to “confront the reality that participatory education is not popular education. This strengthens my commitment [to popular education.]” In addition, we provided advice and consultation to one another on topics not directly related to the study, as when Catherine was preparing for a presentation at a national conference and asked Project Team members to review and provide comments. She also requested suggestions for appropriate *dinámicas*. Project Team members stated that, as a result of being involved in *La Palabra es Salud*, they increased their knowledge and skills around meeting facilitation, popular education, and the distinctions between popular and participatory education.

Mutual support.

My notes from Project Team meetings convey that team members consciously provided support for one another. This helped to allay some of the stresses caused by the research study (see below, *Costs*), as well as helping us to balance the multiple demands common to career women committed to social justice. To some degree, mutual support was inherent in the original structure we developed for our meetings, which occurred in team members’ homes and included sharing food and reflecting on a spiritual or Biblical reading. But as the pressure on all of us increased with the beginning of the two simultaneous courses, Adele suggested that we spend some time in each of our meetings talking about how we could actively support each other.

While we occasionally forgot to do this, we maintained the practice throughout most of our meetings until the courses ended in December. An example of the way we provided support to one another comes from our meeting on October 28, 2009. I had been struggling with a conflict between my commitment to lead music each Sunday at the Latino Anglican congregation I attended, and my need to have Sundays free to work on the research project. Project Team members counseled me to think seriously about withdrawing from my church commitment, at least until the courses were over, something I subsequently did, much to my relief. As Teresa commented in our meeting on September 3, 2009, at the same time that the Project Team meetings created additional stress, they also served as a place where we could vent and get support.

Personal growth.

All members commented that we experienced personal growth as a result of our participation in the project. The most significant examples of personal growth were related to increased cultural awareness and cultural competency. For example, Adele stated that as a result of “pressing up against the [Latino Catholic] culture in a new and defining way,” she realized she was neither Latina nor Catholic. A particularly defining moment related to culture came in our meeting on July 16, 2008. As we strove to complete all the tasks that needed to be completed before the courses began in early September, Catherine suggested that perhaps we didn’t always need to eat in our meetings, since this practice consumed time, or at least we didn’t need to eat so sumptuously. Teresa countered that by eating, we were observing a custom of the

community in which we were working, and that, in addition, sharing food served to strengthen the bonds of comradeship (*compañerismo*) between us. At that time, we concluded that we would reduce expectations for the food in our meetings but not cut it out altogether. However, spurred partly by Teresa, who continued to bring elaborate dishes to each meeting, we very quickly returned to the practice of sharing an entire meal.

In our meeting on October 28, 2009, we looked back on this experience in the context of a discussion about costs and benefits. Adele commented that the food was a benefit, even though it took more time. Adriana reflected that sharing food did not just build community; it also upended the normal hierarchical relationships that pertain in U.S. work culture. “How often do you meet at your boss’s house and share a meal made by them?” she asked. “It builds the relationship. The food provides sustenance for the relationship that we are creating. It was ideal.” Catherine wondered at the fact that she had ever suggested omitting the food.

This was only the most prominent example of an on-going, low-level conflict in our meetings between what would be easier vs. what would be more culturally competent. For example, on October 1, 2008, we were planning a celebration of the Day of the CHW. We were planning to have the event catered by a group from Teresa’s church, but as we contemplated all the additional materials we had to arrange (e.g. warming plates, silverware, etc.), Adele commented that it would be easier to buy food from the hospital. (We didn’t.) As we dealt with these conflicting pressures, Teresa constantly reminded us of what we were gaining. In the same discussion cited

above from October 28, Teresa concluded, “I think [the project] also gave us the opportunity to live the process and take risks. Living together (*convivir*) brings risks and benefits. It is part of the process of developing other abilities.” With this statement as with others, Teresa reminded us of the importance of fully experiencing our cultural differences, since this experience brought a range of benefits.

Cultural differences also complicated the relationship between the Project Coordinator, Adele, and the Assistant Coordinator, Adriana. Early on, Adele asked Adriana to follow-up with participants who had not returned for the second session. Adele, an Anglo-European, expected that Adriana, a Latina, would leave messages if she did not find participants at home. When this didn’t happen, Adele interpreted Adriana’s behavior as a lack of follow-through. It was only later, in the context of a discussion with the CHWs, that Adriana explained to Adele that leaving messages was not customary in her community. Differing expectations about follow-through between the Project Coordinator and the Assistant Coordinator, some of them rooted in culture, continued to be an issue through most of the course. They were also a source of learning. As Adele commented, “In the end, I am thankful for the cross cultural team and the learning from working together on the project, although throughout the training there were times that it felt like it made the work more difficult. I see how working with Adriana enriched my own cultural understanding and ability to serve the community more effectively, too.” For her part, Adriana stated: “After the discussion [with Adele] it was obvious that [the problem] was not a lack of commitment but rather a cultural difference which we worked around. I understood

that maybe in some instances it was more difficult for Adele to work with another person because she had done this on her own in the past.” These two quotations demonstrate how, as a result of “living the process” as Teresa described it, Adele and Adriana have come to understand each other’s point of view. Personal benefits that accrued to Project Team members as a result of their participation in the course included increased skills and knowledge, mutual support, and personal growth, particularly in the area of cultural competency.

Costs

Along with benefits, participation in community based participatory research can also have costs for programs and program staff. Below, I will document some of the costs that were associated with being involved in *La Palabra es Salud* for the Parish Health Promoter Program and its staff.

Programmatic Level

Conversations with my colleagues on the Project Team, documented in our meeting notes, and my own observation, documented in my field notes, revealed relatively few programmatic costs to the PHPP as a result of participating in *La Palabra es Salud*. The costs that I did identify included a possible negative effect on the relationship between the CHWs and the Coordinator, some negative implications for the curriculum, decreased flexibility, and decreased attention to existing parishes and CHWs.

Project Coordinator Adele felt concerned that, as a result of having more people involved in the program, it might take longer for participants to develop a strong

relationship with her. She worried that she might not be carrying out her role. On the one hand, results of the in-depth interviews suggest that participants did view Adele as the leader of the program and their primary contact about programmatic issues.

However, I perceive that my relationship with the participants may have affected Adele's relationship with the participants, especially as regards the PE group. I played a highly visible role with the PE group, leading reflections and intervening somewhat frequently in discussions (see below, "My positionality"). My older age, longer history working with CHWs, greater fluency in Spanish, and status as "researcher" may have caused some participants to accord me a position of greater authority relative to Adele. While I feel that the strength of my relationships with the CHWs allowed me to collect higher quality data in the in-depth interviews, it may also have displaced, to some degree, the relationship that normally would have existed between the Coordinator and the participants, especially those in the morning group.

According to Adele, this displacement represents a cost to the program because the PHPP is a volunteer program that depends heavily on the relationship between the Coordinator and the volunteers. Time and effort that would normally have been spent establishing a rapport between the Coordinator and the volunteers was instead spent connecting the CHWs to someone outside the program. Thus, after the training, the Coordinator has needed to spend additional time building a foundation and trust with the PE group.

Another cost to the program may have been an overly ambitious list of objectives, especially for some sessions. (See Appendix F: Curriculum Master List.) Just as the

involvement of a five-person Project Team brought depth and breadth to the objectives for each session, it also produced lists of objectives that were, in several cases, too long and diffuse. The cost to the program was a certain number of sessions that were overly ambitious and therefore overwhelming for participants. Participants recognized this problem, commenting in their evaluation forms that sessions like Heart Health and Mental Health covered too much material and should have been divided into two sessions. This problem could have been allayed had I been more conscientious about asking the Project Team to further reduce the initial list of objectives I produced based on our brainstorming sessions.

An additional cost was decreased programmatic flexibility. In 2006, when the Westside PHPP also conducted parallel training sessions, if a morning group participant had to miss the morning session, s/he could attend the afternoon session instead. This year, because of the need to keep the two groups distinct, doing so was impossible. The research design also meant less flexibility for assigning facilitators and accommodating their schedules. “In the past, we would go with whatever facilitator was available, and plan the schedule according to their availability,” commented Adele. Adele recognized that this need to be more “systematic and deliberate” was a benefit as well as a cost.

A final cost identified by Adele was decreased attention to existing parishes and CHWs. Because aspects of the research study (such as having two training groups) required her to dedicate a substantial amount of her time to the “new” CHWs and their training, she was not able to dedicate as much time as she felt was necessary to

existing CHWs and parish staff and leaders. Programmatic costs to the PHPP that resulted from involvement in the research study included negative impacts on the relationship between the Coordinator and the CHWs, overly ambitious objectives, decreased flexibility, and decreased attention to existing CHWs and parishes.

Personal Level

Costs associated with involvement in the PHPP were somewhat heavier on the personal level and can be summarized under the heading of increased stress for program staff, especially the Coordinator. To fully understand these costs, some background is essential. As mentioned above, in 2006, the first year of the PHPP on the west side of Portland, Adele conducted two parallel groups, one in the morning and one in the afternoon. Every week for 14 weeks, she travelled from one group of 40 participants in the morning to another group of 35 participants in the afternoon. At that time, she did not have an Assistant Coordinator. After this experience, Adele promised herself and her family that she would never again run two groups at the same time. However, once the suggestion was made to use a quasi-experimental design for the research study, Adele found herself contemplating the same prospect again. Cognizant of the burden this would place on Adele, we requested funding from Providence to hire an Assistant Coordinator, thinking that the two staff could take turns attending either the morning or the afternoon session. The funding was obtained and Adriana was hired, but in practice, both Adele and Adriana attended most sessions. In addition to the time required to run two parallel trainings, the Project Team met weekly for 2.5 hours during the time the courses were taking place. While

the suggestion to meet weekly came from Adele, it proved to be extremely helpful for the research component, as it allowed time to assure fidelity to the two methodologies, reflect on the research questions, and assure the integration of the researcher into the Project Team. Simply in terms of hours per week, the research study more than doubled the work associated with the program for the Coordinator.

The research study increased the demands on the Coordinator and other members of the team in ways that were less concrete. Project Team members reflected that working as a team requires more organization than working individually. It also required us to examine our work more closely, and sometimes left us feeling wanting. “I have a lot of feelings of, ‘I thought I was doing my job and now I am not so sure,’” commented Adele. Further, the demands of the project, some of them induced by the research study, meant that Adele sometimes had to give short shrift to her other responsibilities. Adele summarized the costs and benefits of being involved in the research study in the following quotation:

I have a different level of anxiety and insecurity because what I would have ordinarily done doesn't work. It is not necessarily going as smoothly as it would have if I had done it the old way, on my own. But, ultimately, this process will be better for the program. It's more of a stretch. Because we're working in a group, it takes a different level of time, and I am not doing other parts of my job as well. It's been a hard autumn. I have had to process a lot at home around what's going on for me and the insecurities that come up because I don't have the time to do the rest of my work as well. It affects the on-going needs of the program, not just the training

and study. . . Going through the study is causing me to have to self-reflect a lot and grow. I have no doubt we will end up with something more solid.

In this passage, Adele reflects that a process that will ultimately carry both personal and programmatic benefits has also taken a toll on her ability to complete her other tasks and feel satisfied with her own work. The passage recalls Teresa's comment that growth and change seldom occur without concomitant costs.

While the personal costs of being involved in the research study were heaviest for the Coordinator, they impacted other Project Team members as well. For Teresa, the need to assure content consistency in the two experimental groups and fidelity to the methodologies meant that she needed to meet with TE facilitators to compare objectives and PE facilitators to provide technical assistance about popular education. There may have also been some psychic costs to facilitators, who knew they were under scrutiny and their skills and teaching styles were being assessed. The facilitator for the TE session on Nutrition was clearly aware of this, commenting apologetically to me when I arrived for that session that perhaps she was not really using traditional education. Likewise, the facilitator for the TE session on Teaching Skills quickly informed me, when I arrived, that it was extremely hard to do traditional education with the afternoon group, because they were so participatory.

In my notes from Project Team meetings, it is quite easy to discern the ebb and flow of stress during the time the study took place. Like any group of five women in the beginning to middle of their careers, we were all balancing multiple responsibilities and demands. During the study, Adriana completed an undergraduate

degree, the first person in her family to do so. Teresa lost her beloved pastor and struggled to support her teenage son. Catherine sought to manage the program on the east side while also participating actively in the program on the west side. Adele co-parented three children and learned she was pregnant with a fourth. I began to cohabit with my life partner and transitioned a major initiative to a new colleague at work. Notes from the Project Team meetings reveal that in the beginning of October 2008, we were all tired and struggling with stress. By mid-October, the stress level appeared to have shifted, as we settled into the reality of our responsibilities. By late November our stress level was up again, as we neared the end of the trainings. An unusually heavy snow storm in December, which forced us to cancel one group's graduation, was greeted by all with relief and gratitude. Through it all, however, it is also possible to see how the mutual support that we offered one another allayed, at least to some degree, our feelings of stress, and made it possible to complete the trainings and the research study closer and more unified than we had been when we started.

Participating in *La Palabra es Salud* produced both benefits and costs for the PHPP and its staff. On the programmatic level, benefits included higher quality sessions, better organization, and the creation of an Advisory Council, while costs included impacts on the relationship between the Coordinator and the participants, ambitious sessions that occasionally overwhelmed participants, decreased flexibility, and decreased attention to existing CHWs and parishes. On a personal level, the primary cost was additional stress for all team members, especially the Coordinator. Benefits

included new skills and knowledge, personal growth, and mutual support which helped to allay the stress.

Elements that Contribute to the Success of CHW Training Program

Q6. From the perspective of the CHWs and the researcher, what elements contribute to the success of a CHW training program, regardless of the methodology that is used in the training?

The in-depth interviews, the Participant Evaluation forms, and my own field notes suggested that various elements contribute to the success of a CHW training course, regardless of the methodology. These include a religious/spiritual element, *convivencia* (literally, “living together” or fellowship), high quality sessions, new and complete information, and certain characteristics of the facilitator and the project team.

Religious/Spiritual Element

The Parish Health Promoter Program is sponsored by a Roman Catholic health care system (Providence Health and Services) and generally, in order to participate in training, CHWs must be members of a Catholic parish with a Spanish-speaking congregation in the greater-Portland area. Participants in the CHW training are motivated to work as unpaid volunteers primarily by their desire to help their fellow community members, a desire that, for most, grows out of their faith commitment. All classes in the training courses began with a prayer and a reflection on a spiritual or Biblical reading or a song.

Various participants from both experimental groups commented on the importance for them of the religious/spiritual element that infused the courses. According to Delmi, from the TE group, “what I liked best [about the course] was that God was at the forefront of all the meetings, that we prayed, that we shared a reading and all that . . .” Similarly, Sonia, also from the TE group, commented that, “I think it has been beautiful, important, that we start with a prayer, that music has been used.” Alejandro, from the PE group, stated that “aspects like a prayer at the start, a reflection, believe me that . . . for me it was like giving a good start to whatever activity.” Participants appreciated starting classes with religious rituals, especially prayers.

In her interview, Emiliana commented on the consequences of the religious or spiritual element of the courses. She expressed that starting with a reflection created a profound feeling that could be felt throughout the class. The reflections also helped her come to terms with her fear that her children would not adjust to being in childcare. “During the reflections,” she said, “I learned a lot, because I said [to myself], ‘I can’t solve everything myself. I know that there is Someone with much more divine power than the mother of those crying children (*esos niños chillones*) and that He is going to take care of them and He is going to know what is happening to them during the time that I am not with them.’” The inclusion of the reflections reminded Emiliana that she was not responsible for everything, and could entrust some things to a higher power. Participants in both experimental groups expressed that the religious or spiritual element of the courses contributed in an important way to their success.

Convivencia

Like the word “confianza,” the Spanish word “convivencia” has no perfect translation into English, nor is its significance in Latino culture equaled in Anglo-European culture. Literally, it means “living together.” More figuratively, it refers to pleasurable time spent with other people and is an important aspect of relationship-building in Latino culture. The *convivencia* that occurred in the courses was important to members of both experimental groups, though it was remarked on more often by popular education participants. “Spending time with (*el convivir con*) the other comrades was really nice,” commented Lupe, from the PE group. Blanca agreed: “We had the *dinámica*, then lunch, and everything was a party (*todo era un convivio*) and then we were at the end of the class, and when we arrived back home, we said, ‘We learned a lot today!’” Ana María reflected on how the facilitators contributed to the *convivencia* among the group. “So [the teachers] . . . succeeded in helping us learn step by step and in assuring that we were all relating to one another (*que todos fuéramos relacionándonos*).” Lupe linked *convivencia* to communication:

Well, I think the communication among all of us was an important point . . . [We were] all from different [groups], even races and even so, we all came to value each other. And we all related to one other (*todas convivimos*) as though we had known each other a long time.”

As she reveals in this passage, Lupe was struck by how *convivencia* allowed participants and project staff to come to value one another, despite our differences. For participants in both groups, spending pleasurable time together was an important

aspect that contributed to the success of the course. Participants' positive reactions to both the religious/spiritual element of the course and the element of *convivencia* highlight the importance of assuring congruence between the values and practices of the participants and the course.

High Quality Sessions

In addition to the more specific aspects of the courses mentioned above and below, CHW trainees identified the generally high quality of the sessions as an element that contributed to the success of the course. "Each one of the topics was fabulous, it was very well presented," commented Sonia. "Each one of the classes we had was very satisfying (*era algo que llenaba*)" concurred Lupe. For Lupe, one of the things that made the classes so satisfying was that they were more open and explicit than classes she had taken in the past. Two participants – one from the PE group and one from the TE group – attributed the relative lack of attrition from the courses to the generally high quality of the sessions. "I think all the other sessions [with the exception of "Navigating the Health Care System"] were very complete, very dynamic, so much so that, though I don't know in reality how many people attended, but I know that those from my parish . . . persisted," stated Sonia. In the opinion of the participants, high quality sessions reduced attrition and contributed to the success of the course.

New and Complete Information

Many participants from both experimental groups commented on the importance of the *new information* they had learned in the courses. "I liked the training because it taught me a lot of things that I haven't been taught before," stated Israel in his in-depth

interview. “Thank you for teaching us new things,” wrote one TE respondent on the Participant Evaluation Form (PEF) for the Teaching Skills session. An extremely common response to the first question on the PEF (What did you like or find useful?) was “the information”; information was mentioned 14 times in 16 responses to this question on the PEFs for the PE session on Diabetes. In answer to this same question, PEF respondents also frequently commented that they had been unfamiliar with the material and had learned something they didn’t know. Alluding to the role of the classes in correcting flawed information, Ana María said that she especially liked the CPR class, “because . . . I didn’t know how to take vital signs. I didn’t even know where to start. Everything I knew I had learned from television. But on television nothing is realistic.” Access to new information was an extremely positive aspect of the courses for many participants.

While facilitators’ determination to assure that all questions were answered was particularly marked in the PE group (see above, Research Question 3), in both groups facilitators’ willingness to answer questions contributed to participants’ sense that they had received complete information. Ana María, from the TE group, stated, “I liked the [teaching style] of the teachers who came to give the classes because they told us, more than anything, what we had to do and learn, and whatever question we had, we could ask.” As well as expressing Ana María’s appreciation for facilitators who answered questions, this quotation also suggests that part of what Ana María liked was that classes were practical and participants could use what they learned.

The importance of new, complete, and correct information to participants in the Parish Health Promoter Program becomes completely understandable when one considers the broader context of their lives as immigrants to a new country. “A Hispanic person arrives and is not only limited by the language,” explained Sonia, “[but also by] the fact that s/he doesn’t have documents, that s/he doesn’t know about services that are offered, that s/he doesn’t know where to go.” Community members’ lack of information puts them at risk of being exploited and creates fear of asking for help, as Blanca made clear:

That is what I see among us in the community, that we are lacking, lacking in information, and if they give us some information, we don’t know if it is correct.

“What do they want from us?” [we wonder]. “What do they do there?” No, better not [go]. We are afraid to go and look for resources . . .

This quotation from Blanca recalls the understandable aversion of Latino immigrants to “go and ask” that was discussed in an earlier section.

Immigrant Latinos’ lack of access to information and resistance to seeking it out creates a situation where special help is needed, both on an individual and a community level. As well as providing social support and motivation for health behavior change, Hilario and Delmi’s new friends from their training group are also sources of important information, as the two CHWs made clear. Hilario commented that it was important to cultivate relationships with people – like other CHWs -- who have correct information, “because they are people who are going to clarify the uncertainty in which we live” (*nos van a sacar de la duda que vivimos*). Hilario went

on to state that having good information helps to reduce stress, because you don't have to live with anxiety, and gave an example:

Like [recently] we went to check out the case with my retirement. Now I know that I don't have to apply for my retirement until I am 65. Now no one can say to me, "[You can apply] at 62," "No, it's 63." Now I am sure that I have to wait four more years.

Having ascertained the correct information, Hilario no longer has to live in doubt. For Alejandro, lack of access to information and services in the Latino immigrant community creates the need for programs like the PHPP: "It is that we don't have access to services, and that is why it is much more important to do activities like this here, and I feel, as I told you, that people should continually become more involved." Information is a particularly essential aspect of a CHW training program in the Latino immigrant community, given the community's lack of access to complete and trustworthy information.

Facilitator Characteristics

Participants identified several facilitator characteristics that help ensure the success of a CHW training course. According to participants, facilitators should be knowledgeable and charismatic, able to provide clear explanations and instructions, and should make use of effective teaching materials. In addition, I observed that participants also benefit when facilitators share their life experience and are willing to talk about it.

Knowledgeable

Logically, given the importance they placed on receiving complete and correct information, participants in the two experimental groups felt it was extremely important for facilitators to be knowledgeable. Highlighting the connection between clear information and knowledgeable facilitators, a respondent to the PEF for the TE session on Exercise Anatomy and Physiology wrote, “The information which was given in the class was plentiful and very pleasant (*amena*) and many doubts were resolved, and the facilitator knows a lot about the topic and treated it seriously.” Similarly, a respondent to the PEF for the TE session on Diabetes stated, “I think the presenter is very good and knows and understands the topic.” Some participants associated well-trained or knowledgeable facilitators with credible organizations, such as the person who stated, on the PEF for the PE session on First Aid, “I think we are well trained because the Red Cross was in charge of this [session].” Other participants lauded the skills of particular facilitators, as when Yesenia complimented the facilitator for many of the PE sessions. “I liked the people that you all decided to bring to talk about a topic; they know a lot. Teresa Rios, wow! She knows a lot!” It was important to participants that facilitators be well-trained and knowledgeable about their topics.

Charismatic

It was also important to participants that facilitators be charismatic. In the context of his comments about two particular facilitators, Hilario placed particular emphasis on the importance of charisma:

One needs some charisma. Fine, we know about this because we preach. And we see who preaches well and who doesn't. And in the same way, we start to get to know the preachers and the same way with the teachers, right? That's why I dare to speak this way, right, because these two people [the facilitators for the sessions on Navigating the Health Care System and Confidentiality] well, really in reality, well, might have had a lot of knowledge, but lacked the charisma to give us a good presentation.

Hilario contrasted the facilitators for these two sessions with the facilitator for the Diabetes session, who he felt possessed a lot of charisma. A respondent to the PEF for the same Diabetes session concurred, stating that "the way the promoter shared the class was very interesting and expressive." The facilitator for the TE session on First Aid also received positive feedback on his evaluation for having "the spark (*la chispa*) to animate everyone." While neither of these respondents used the word "charisma" to describe the quality they appreciated, being expressive and having "la chispa" are other ways of talking about the same or a similar quality.

As a result of observing the facilitators in both the TE and PE classes, my own appreciation for the importance of charisma grew. I observed that charismatic presenters could use very traditional methods and still maintain participants' interest. Facilitators who lacked this charisma tended to lose participants' interest, even though they sought to draw participants out and base instruction on what participants already knew. A good example of this contrast was provided by the two primary facilitators for the Diabetes sessions. Both knew the material very well. In the morning PE

session, the facilitator worked hard to draw participants out, but he sat down for most of the session, spoke in a quiet voice, did not use participatory activities, and lacked a logical sequence for the class. In contrast, the facilitator for the afternoon TE session spent most of the class lecturing. But he stood up, projected his voice, used humor, and told stories, and as a consequence, kept the rapt attention of his audience.

From watching these facilitators and others, I identified certain behaviors which appeared to embody and define charisma. I have already mentioned humor. For example, the facilitator for the TE session on Diabetes told a humorous story about his first prostate exam. The facilitator for the TE session on Exercise Anatomy and Physiology also used humor well, and I noted that it seemed to put participants at ease. The facilitator for the TE First Aid session, who was also quite popular with participants, asked them at one point, “If you ask a person to breathe deeply and it hurts, will you tell them to continue breathing that way? Only if you don’t like them!” Humor is one element of charisma.

Another aspect of charisma is the ability to project confidence. I observed that this ability depended on knowing the material very well, and was not necessarily associated with a loud voice or an imposing personality. One of the facilitators for the PE session on Nutrition and the facilitator for the TE session on Heart Health were both able to project confidence despite speaking relatively softly. Finally, charismatic facilitators like the ones for the TE sessions on First Aid and Exercise Anatomy and Physiology also used their bodies and the physical space to maintain interest, by standing up, sitting down, and moving around the room.

Clarity of communication

Both participants' comments and my own observation identified the ability to provide clear explanations as an important facilitator characteristic. In their Participant Evaluation Forms, respondents commented often about facilitators' ability to explain concepts clearly, especially complicated ones. "I liked that everything was explained clearly," stated a respondent to the PEF for the PE session on the Role of the CHW. "[Facilitator name] explains it very well," stated a participant in the TE session on Teaching Skills. Of the same facilitator, I noted that she had been able to explain Vigotsky's concept of the Zone of Proximal Development (ZPD) better than I had ever heard it explained before.

As I observed the classes, I also appreciated facilitators' ability to respond to questions concisely and admit it when they didn't know the answer. The facilitator for the TE session on Heart Health was able to explain the difference between an ischemic and a hemorrhagic stroke extremely clearly, but demurred from answering two other questions she felt she could not answer well. In answer to a question, the facilitator for the TE session on Diabetes gave a clear explanation of why exercise done at work does not provide the same benefit as exercise done on free time. Other communication skills which appeared to me to be particularly beneficial for participants were the ability to give clear instructions before beginning an activity and the ability to prepare participants for transitions with comments such as "Okay, I'll take two more comments and then we will move on." Facilitators who could give clear instructions and explanations elicited approving comments from participants.

Good Use of Educational Materials

Good educational materials were more often commented on in their absence than in their presence by participants. However, facilitators' use of effective educational materials caught my attention, as when the facilitator for the TE Diabetes session spontaneously produced drawings and diagrams to illustrate his points. The two facilitators for the PE Heart Health session had clearly spent many hours preparing their materials; the most effective was a colorful and well-executed drawing of the heart. The facilitator for the TE Heart Health session provided an example of a skillful Power Point presentation, in that it was well-organized, employed a large font, used a dark background and white letters, and included effective graphics. This facilitator also provided copies of her slides for the participants. As noted above, the facilitator for the TE Nutrition session made good use of realia, like food boxes, cartons, and measuring spoons. Good educational materials, whether pre-made, collected, or created in the moment, are another aspect of an effective training course.

Shared Life Experience

In both the TE and PE groups, it was possible to observe the benefits to the group when facilitators shared participants' culture and/or life experiences and used these experiences as part of their teaching. For example, participants visibly responded by nodding their heads when the facilitator for the TE session on Exercise Anatomy and Physiology told a very moving story about his Puerto Rican grandmother, who lost two legs to diabetes and was on dialysis but still did not want to give up her traditional foods. The facilitator for the PE session on Navigating the Health Care System

demonstrated her knowledge of the cultural context by commenting on how easy it is to acquire medications over the counter in Mexico, eliciting similar nods of recognition from participants.

Participants also commented on the power of shared life experience. One of the younger participants in the PE group was required to attend the course by her parents. She agreed to go to the first two classes grudgingly, to see what would happen. But she expressed that there was something in the first class that pulled her in. When I asked her what it was, she responded, “I don’t know, I can’t explain it, the atmosphere, I felt good, the encounter with other people who have [worked in the community] for so long.” While the participant did not say it explicitly, based on other comments she made I interpreted her to be referring especially to the Latina CHWs on the team, who had worked in the community for a long time. Facilitators who shared participants’ life experience were able to draw on a shared cultural context and serve as role models for participants.

Characteristics of the Project Team

Participants identified certain characteristics of the team that conducted the training as especially important to the training’s success. Though participants did not mention it overtly but rather implied it, first among these was the presence of a coordinator and a project team who built relationships with participants. The Latino cultural value known as *personalismo*, or the importance of personal relationships, was very apparent in the way that participants spoke about Adele, the Project Coordinator. Sonia commented that the course had helped her reconnect to and become known in

the community so that people would approach her. “This is the opportunity that Adela has given me,” she concluded. Ana María explained that her motivation to learn to use the computer came from her desire to respond to a personal card Adele had sent her, probably when her husband became ill. Extending this *personalismo* to the whole team, Lupe stated, “For my part, I am very happy with all of you, with Adela, with Adriana, with Teresa and with you.” Had Adele and other members of the Project Team not been able or willing to relate to participants on this personal level, participants would not have made these personally appreciative comments about Project Team members.

Along with this ability to make personal relationships, participants’ appreciated Project Team members’ sense of equality and willingness to become part of the community, and their familiarity with Latino culture. “One came to feel esteem for you because, for example, any one of you is equal with everyone else and whatever doubt we had, we could ask you,” stated Lupe. Sonia summarized her feelings about the project team this way:

I think that a very important point is that both Adela and you, from the first moment, have made us feel, you have made yourselves one of us. The worry, the thing that makes you say, “wait” . . . there hasn’t been this culture shock. Your experience [made us think], “Oh, look, she worked in El Salvador, she knows my background (*conoce mi trasfondo*).”

According to Sonia, because Project Team members made themselves “one of us,” they overcame the boundary normally created by culture and participants were able to

trust them. On a less personal note, participants also commented that the members of the Project Team were professional and well-prepared.

In the quotation above, Lupe alluded to Project Team members' determination that all participants should understand the information. Yesenia also appreciated this characteristic of the Project Team. "[I liked] the way you all supported us, you gave us information, you tried to help us understand . . . you explained about the study that you were doing . . . that it was to help us, so that there would be more promoters in our community." (Y1) She also appreciated the diversity and shared purpose of the Project Team:

That was what captivated me the first time, in the first class, seeing so many people from different races, but all working . . . to arrive at the same goal, that everything be better for the community, not just the Hispanic community but for everyone in general. (Y1)

In the Project Team, Yesenia saw a group of people from different backgrounds working together to create a more just society.

Undoubtedly, the long-standing bonds among members of the Project Team contributed to the sense of cohesion experienced by participants. Teresa Rios, Capacitation Coordinator for the Community Capacitation Center and I have worked together for over 18 years, and I have known and worked with Catherine Potter, Eastside Coordinator for the PHPP for over 10 years. Members of the Project Team began to meet regularly over a year before the project began, and in our meetings, which took place in members' homes, we consciously sought to deepen our bonds by

sharing food, starting meetings with a personal check-in, and engaging in spiritual reflections. As mentioned above, Adele's young daughter Amalia was also a regular attendee at our meetings, increasing the sense that we were not only colleagues, but also family. On the first day of training, Catherine, Teresa, and I carpooled from Portland together. When we all converged on the parking lot outside the school where the training would be held, Adele suggested that we gather together and offer a prayer for the success of the training. I took a moment afterwards to acknowledge with Teresa how long and how far we had come together. I share Adriana's sentiment, quoted above, that this is the best team with which I have ever worked, and it has set the (perhaps unreasonably high) standard for my future work.

Data from the in-depth interviews, the Participant Evaluation Forms, and my field notes suggested that the elements that contribute to the success of a CHW training course in the Latino immigrant community, regardless of the methodology, include a religious or spiritual component, *convivencia* or fellowship, high quality sessions, new and complete information, certain qualities of the facilitators (knowledge, charisma, clarity, use of effective materials, and shared life experience), as well as certain characteristics of the Project Team, such as *personalismo* and shared purpose.

Other Results

La Palabra es Salud combined both qualitative and quantitative methods to seek answers to six pre-determined research questions, the results of which have been reported above. It is the nature of qualitative research that the researcher often unearths themes that he or she was not seeking, but which are of importance to the

community participating in the investigation. In the case of *La Palabra es Salud*, in-depth interviews with the participants revealed two additional themes: the prominence of stress in the lives of Latino immigrants at this historical moment, and the deep meaning of the course for the popular education participants. Below, I will report on these themes. In addition, although I did not systematically investigate fidelity to the curriculum and the two interventions in this study, I did attempt to keep track of this topic as I conducted participant observation. Thus, I will report on my qualitative impressions concerning fidelity, mostly to provide grist for some suggestions about measuring fidelity in Chapter V. Finally, I will offer some observations about measuring empowerment in the Latino immigrant community.

Stress

This intervention occurred at a time when Latino immigrant families were confronting multiple causes of stress, over and above the “normal” stresses associated with the immigrant experience (e.g. culture shock, social isolation, language barriers, distance from and longing for family and friends, discrimination, etc.) The intervention took place in the waning months of the second Bush Administration. The newly renamed Immigration and Customs Enforcement (ICE) office had been ramping up enforcement against individuals for about two years, leading to major raids such as one that occurred at the Del Monte plant in North Portland in 2007. Immigrants, especially undocumented immigrants, were experiencing a high level of fear and uncertainty about their future in the U.S.

Also in the fall of 2009, the global economy was experiencing the worst recession since the Great Depression. The effects of the economic downturn were being experienced severely by the Latino immigrant community. This was brought home to me in a compelling way when I visited participants for in-depth interviews. In three of ten cases, one of the first things participants told me after I entered their homes was, “Noelia, we may lose the house.” In all three cases, this was not because participants had taken risky mortgages, but rather because breadwinners and other family members had lost jobs and therefore could no longer make mortgage payments. Three participants (not all the same ones who feared they might lose their homes) told me they were contemplating moving back to Mexico because, “at least there we won’t starve.”

Needless to say, these experiences were producing high levels of stress among participants and their fellow community members, and the topic of stress was one of high interest among participants. Israel emphasized the economic causes of stress and suggested adding a session focusing on this topic:

I’ve noticed that a lot of people are under a lot of stress, especially with the way the economy is going, a lot of people are under stress and worried about stuff like if they are going to have enough money for the next meal or to keep their family safe. And a session on how they can control their stress, and how they can find ways to find help for stress could be good for another session.

Sonia highlighted more familiar causes of stress for immigrants and pointed to their effect on her own health:

Well, I have been gaining weight in the last year, for certain reasons, personal reasons . . . well, the stress that one experiences, culture shock, the change, all of that. So, this causes one to live in stress . . .

Both Sonia and Israel signaled the importance of stress in the lives of Latino immigrants and diagnosed some of its causes.

As participants developed awareness about the prevalence and causes of stress in their community, they reported that they took both individual and collective actions to meet this challenge. Emiliana recognized the role of stress in her life and decided she must do something about it:

I think it was like . . . two classes after the one about CPR . . . we started to focus more on diabetes and the consequences of diabetes. One of the principal causes is stress. I said, “No, it is even more important for me to look for more information and see how I can prevent it,” and I can use the information, to help myself, because . . . there I learned that what I was going through was like a circle of stress. And that the same thing, the same thing couldn’t continue, that I had to, in some way, change it a little.

Newly aware of the connections between stress and diabetes, Emiliana recognized that she was caught in a cycle of stress and became determined to get out.

Given the prominence of stress in the community, it was not surprising that, of six groups that formed during the course of the training to undertake health promoting actions in their community, four groups decided to focus on stress and mental health. Stress associated with U.S. immigration policies and the economic crisis was an

important cause of ill health in the Latino immigrant community during the time of the course. The course provided an opportunity to learn more about stress and its causes, and a forum for taking action both on a personal and community level.

The Meaning of the Course for Popular Education Participants

It was clear from their comments in the in-depth interviews that the parish health promoter training course held a special significance in the lives of the popular education participants. While I cannot say definitively that the course did not hold the same significance for the participants in the traditional education group, what I can say is that the TE participants did not make the kind of statements about the significance of the course that were made by the PE participants. For some participants, their feeling was mainly one of gratitude and determination to use what they had learned to help their community. This was the case for Lupe:

Well, I give thanks to God for putting me in this path, and God willing we are going to get a lot of benefit out of this course, out of these discussions, out of these interviews, out of everything we had, we are going to “get the juice out,” as they say over there.

I found notable the fact that Lupe included all aspects of the course, including the research study, in her description of her experience.

Other PE participants compared the significance of the PHPP training course to other significant events in their lives, and judged the training course even more significant. Alejandro, the physician, expressed this point of view:

I want you to pay attention to the fact (*fíjate*) that this little diploma [the diploma from the PHPP course], what it means to me is so important [that] . . . a photograph of it went to Brazil. There is a photograph of it in Guatemala. It is with my best friends and of course, my daughter has it in her hands. And I tell my wife, look . . . I am so excited about this diploma that I have shown it to half the world . . . and I have given it a party (*le he hecho un festín*) . . . that I didn't even give to my diploma of medicine . . .

For Alejandro, his diploma from the PHPP outranks his medical diploma in importance, and therefore he has sent copies to friends and family in many parts of the world.

Emiliana stated that in the early classes, she wasn't sure she should be attending, partly because it was so difficult to get herself and her children to the course each Saturday morning. But by the mid-point of the course, she felt guilty about her former doubts and realized the course was changing her life:

Yes . . . all the information from that point on was very specific, so that afterwards I felt like . . . 'Oh, I am sorry Lord, I am sorry!' I know I don't have to be this way. I know that this [course] is something you had [planned] for me and if I was there on the first day it was because I was going to find something for myself. Thus it was that my life made a big change during the capacitation.

In the process of taking the course, Emiliana recognized that she was meant to be there. She attributed a "big change" in her life to her experience in the course ("the capacitation").

During her interview, Yesenia spoke at length about the significance for her of finding immigrant Latina role models involved in the PHPP. As she looked back on the course, she spoke about how it had changed her in a fundamental way, and expressed her desire to become one of those role models:

This course was something that – wow! – yes, it changed me a lot. I hope you all will continue to conduct [the courses], I hope to be able to help at some time if it is necessary, to tell someone who maybe is in the same situation as I was, who attends because they make her attend, that if one gives oneself the chance to learn, it is really interesting. (Y2)

Because of its significance in her own life, Yesenia expresses here a desire that the PHPP continue, and that she may someday be part of the Project Team. Participants in the PE course expressed clearly that the course had great significance for them, that it had changed their lives, and that they were determined to make the same experience possible for others in their community.

Fidelity to the Curriculum and the Two Methodologies

To ensure consistency between the popular education and traditional education classes, we developed a standard list of objectives for all classes (see Appendix F: Curriculum Master List). In addition, we provided all facilitators with a list of the questions related to their topic that were included in the health knowledge section of the CHW Questionnaire. To ensure fidelity to the two methodologies, we developed side by side comparisons of popular education and traditional education (Appendix A) based on the popular education literature and my own experience. We provided these

documents to facilitators along with a list of expectations, one of which was that they do their best to cover all the objectives and maintain fidelity to the methodologies. Once we had taken these steps we did not make a systematic effort to assess fidelity to the two methodologies. I did, however, attempt to keep track of fidelity or lack thereof in the field notes from my participant observation. In this section, I will briefly review my observations about fidelity to the curriculum, and then share some impressions about fidelity to the two methodologies.

Fidelity to the curriculum.

Generally, I observed that facilitators who were newer to their fields or their subjects were more likely to maintain fidelity to the curriculum, while facilitators who had taught their subjects for many years were more likely to disregard the list of objectives and cover topics they deemed important. For example, the facilitator for the TE session on Heart Health was a newly-graduated nurse, and the facilitators for the analogous PE session were two CHWs who are not specialists in this topic. There was good consistency between the two sessions, although unfortunately this meant that all facilitators tried to cover too much material because we had identified too many objectives. The facilitator for the TE session on Exercise Anatomy and Physiology was an undergraduate in Community Health who was also a personal trainer. He was extremely careful to cover the specific topics we had asked him to cover. For example, he emphasized that a strict diet is not the best way to lose weight and that to be in good condition it is not necessary to go to a gym, both questions that were included on the CHW Questionnaire. I expected that there might not be good

consistency between this session and the analogous PE session, which was taught by an experienced CHW who is a trained NIA and aerobics instructor but who has not studied the topic in an academic setting. However, in practice, the correspondence between the two sessions was quite good.

I observed that a lack of consistency resulted from different amounts of preparation, and strong convictions on the part of facilitators. For example, the facilitators for the PE session on Diabetes, who were generally unprepared, did not provide any handouts, while the facilitator for the TE session did provide handouts. We made an effort to redress these disparities by ensuring that all participants received the same written materials.

An instructive lack of consistency, bound up in culture, was observed between the two sessions on the Role of the CHW. Both sessions were taught by immigrants from Mexico. However, the facilitator for the TE session had been a corporate trainer in Mexico, whereas the facilitator for the PE session was a long-time CHW and popular educator who remains closely connected to recent immigrants with little formal education. After observing the two sessions, I was concerned, because whereas the TE facilitator had had no reticence about identifying CHWs as leaders, the PE facilitator seemed to suggest that leaders were bad and CHWs were good. From my own experience, I understood that the word “leader” holds negative connotations for many Latin Americans, especially those who have been systematically shut out of leadership because of race/ethnicity or class. I also knew, however, that it was possible to differentiate between traditional, authoritarian leaders and empowering

leaders, and that we had successfully drawn this distinction in the past. My worry was that if we did not challenge PE participants to redefine leadership and appropriate the word “leader,” then people in the PE session would be left with the idea that they couldn’t and didn’t want to be leaders, while the people in the TE group would believe they could and should be. This impression, it seemed to me, could lead to different behaviors in parent groups in public schools and other kinds of civic groups.

After discussing my concern with the PE facilitator, who is a member of both the Project Team and the Advisory Council, I brought the topic to these two groups. It was clear that the word “leader” did have negative connotations for most or all of the immigrant Latinas in both groups. However, there was a difference of opinion among them about whether and how to try to reclaim the word. Ultimately, we decided to do a session on types of leadership in the first follow-up meeting in January, though we later had to postpone that session because the desired facilitator was not available. Factors that appeared to promote fidelity to the curriculum included a lack of attachment to the content and careful preparation.

Fidelity to the two methodologies.

In my field notes, I tended to note fidelity to the two methodologies more in its absence than in its presence. However, to the degree that these characteristics are included in the comparison chart, the elements identified in answer to Research Question 3 (“How does popular education work?”) represent fidelity to popular education methodology. I observed a lack of fidelity to popular education in session one, where we sat for far too long and the introduction to the PHPP was not

interactive. The PE session on Diabetes was similarly sedentary and included too few activities. Participants noted this in their individual evaluations of the class, requesting “more dinámicas,” “more sociodramas,” “more visuals,” “more practice,” and “more participation.” Nor did the facilitators take into account the social justice philosophy of popular education, which led one participant to request “that [the facilitators] speak more about the social and political factors that cause the stress that is one of the factors that influence the prevalence of diabetes.” The facilitator for the PE session on the Social Determinants of Health did not have a good grasp of her topic. She focused far too much on individual approaches to improving health and virtually ignored societal responses, which we had intended as the central focus of the session.

Facilitators for the TE sessions who were more comfortable with popular or at least participatory education found it hard to adhere to a strictly traditional methodology. In the session on Social Determinants of Health, which was extremely popular with participants, the facilitator pushed participants to think critically, in a way that is more typical of popular education. An exchange about the unequal distribution of food sounded like this:

Facilitator: And why do we go now to the food bank?

Participants: Because of the economic recession.

Facilitator: But people have gone to food banks for 50 years, even when there was not a recession.

This facilitator also made an effort to balance participation among participants, not usually a practice of traditional educators. The facilitator for the TE session on Exercise Anatomy and Physiology started the class in fine popular education form, asking participants what they already know or do about exercise. The facilitator for the TE session on Teaching Skills, a committed popular educator, did her best to maintain fidelity to her methodology by emphasizing theory and having participants fill out worksheets. Nonetheless, in a discussion about social constructivism, participants related this philosophy to the methodology they were experiencing, which was not exactly our intent! I have mentioned above that the facilitator for the TE Nutrition session apologized to me when I arrived for not really adhering to her assigned methodology. In addition to posting a colorful agenda with timeframes on the wall, this facilitator included an activity in which four participants held a rope (to suggest the digestive system) and read cards with information about different digestive organs. The facilitator for the TE session on Diabetes, who has also been exposed to popular education, took copious notes on flip chart paper and effectively used diagrams and pictures which he created in the moment. Facilitators' past experience using popular or participatory education made it difficult for them to adhere to traditional education.

As mentioned previously, another reason it was difficult to maintain fidelity to traditional education with the afternoon group was that the group was extremely self-confident and eager to participate. The facilitator for the CPR session, who facilitated the same session for the PE group, commented that in order to maintain fidelity to the

two methodologies, he frequently had to “put the brakes on (*frenar*)” the TE group. In the TE session on Navigating the Health Care System, which was universally acknowledged to be the worst TE session, I commented in my notes that it hardly mattered that the facilitator was sleep-deprived, since the group could almost facilitate itself. In general, the members of the TE group asked each other many questions, and the larger size of the group contributed to keeping the group lively, even though the sessions took place in the afternoon.

In sum, I observed notable lapses in fidelity to the two methodologies. The most common problems in the PE group were a lack of interactive activities and a lack of emphasis on the social causes of ill health. In the TE group, problems were caused primarily by facilitators’ discomfort with traditional education and therefore, their tendency to encourage critical thinking and use participatory activities. These problems of fidelity were compounded by the PE group’s small size and relative shyness, and the TE group’s confidence and determination to participate.

Measuring Empowerment in the Latino Immigrant Community

As was mentioned in Chapter III, two questions from the empowerment scale on the CHW Questionnaire produced strong negative reactions that began to catch my attention as I entered the data. Below, I will report on those questions and participants’ interpretations of them. In Chapter V, I will discuss the implications of these findings for doing research in the Latino immigrant community. While I recognize that some portions of the text that follows more properly concern

methodology than results, I offer the entire discussion here to make it easier for the reader to follow.

As we set out to develop the empowerment scale for our CHW questionnaire, it was clear that we would need to make some changes to the empowerment scale developed by Romero (2006) in order to make it relevant to the community in which we were working. For example, as was discussed above, we chose to delete the sub-scale intended to measure empowerment at the organizational level, since the CHWs in our study were not part of a formal organization. We chose to keep the items that assessed empowerment at the community level, and to define “community” as the Latino congregation at the CHW’s parish. We felt that this definition would produce the most realistic assessment of the CHWs’ perceptions of empowerment at the community level, since it was a group over which they could expect to exercise some control or influence. We felt that to define “community” as the Latino community in the U.S. would have been meaninglessly broad, while trying to identify and define some smaller unit of identity (e.g. recent Latino immigrants in Oregon, first generation Latino immigrants in the U.S.) would have been too complicated and ultimately arbitrary. We sought consistency by defining “community” the same way for the sub-scale that assessed sense of community.

In choosing the wording for our questionnaire items, we generally followed Romero’s (2006) conventions. However, we did make one change, and the item that included this change produced some interesting results. Romero provided the precedent for this change. To develop her empowerment scale, Romero combined

previously developed sub-scales designed to measure sense of community (Chavis & Wandersman, 1990), psychological empowerment or self-efficacy (Zimmerman & Zanhiser, 1991), and perceived control at the organizational and community level (Israel et al., 1994). In the case of the 12 items from the Israel et al. scales, in six cases Romero changed the word “influence” to the word “control,” as in the item, “This organization has control/influence over decisions that affect my life.” (Romero made additional changes from the original Israel et al. scale, such as changing the word “affect” to “involve” in the item, “My community has influence over choices that affect/involve my life.”) While Romero has not explained in print why she chose to make the change from “influence” to “control,” the change appeared desirable to us since the word “influence” is less common than the word “control” and we knew that many participants in our study would have little formal education, making the simpler word the more desirable word. Since we did not use the five items from the Romero scale that assessed control at the organizational level, we were left with only one item where Romero had maintained the word “influence.” This was in the item, “My community has influence over the decisions that affect my life.” We chose to make all the items in the scale consistent by changing the word “influence” to “control” in this item as well.

I was alerted to the importance of this item early, when I began data entry. The empowerment scale began at item 20, and this item was item 26. It followed the sub-scale on sense of community. At baseline, respondents generally rated the items dealing with sense of community as “strongly agree” or “agree,” located on the left-

hand side of the page. However, when they reached item 26, they veered precipitously to the right-hand side of the questionnaire, rating this item “disagree” or “strongly disagree.” Many respondents subsequently returned to the middle or left-hand side of the scale for the remaining items. My initial impressions were substantiated by the statistical analysis of these items. Whereas the mean for item 26 was 2.23 for all groups at baseline, the mean for the scale that included this item was higher (2.56) and the mean for the empowerment scale as a whole was higher still (2.87).

To understand why respondents had reacted so strongly against the idea of their community having control over their lives, I added a question about this item to the in-depth interview guide (see Appendix G1). I explained the strong reaction against this item to the interviewees, and asked them how they would have responded and why. It was clear that the most common interpretation of the item was that it indicated an unjust and undesirable imposition over the individual by the community. Delmi said she disagreed with the item “because we have freedom, right? There is freedom. There is not oppression.” Her husband Hilario concurred, stating he would have disagreed “because I understand that this refers to an imposition, right?” Hilario stated that people might go along with something that was imposed on them, but they would do it grudgingly. “Why? Because it is affecting your freedom of expression and your freedom of action. Because we can’t allow ourselves to be dominated.” The fact that Hilario and Delmi came from a country with a long history of oppressive military dictatorships may have influenced the vehemence of their answers. Israel, who was born and raised in the U.S., also disagreed with the item, but for different

reasons: “I would have probably disagreed, because I am more independent, and I like to make my own decisions myself and not base it on other people’s opinions.”

Though not born in the U.S., Lupe expressed a similar sense of independence. “I don’t believe [the community has control], she stated, “because if I want to do something, I do it!” Ana María expressed the opinion that if the community made a decision with which she disagreed, she would simply ignore it: “Yes, if the community for example were to decide something that I didn’t agree with, I know that I am independent and in the end it wouldn’t affect me because I am me.” Likewise, Yesenia felt that her decisions were hers alone: “If I decided to go to school, if I decided to go to work, if I decided to do something else, for me, those were my decisions and I said, ‘Well, my community doesn’t have anything to do with the decisions I make for my life.’” (Y2) Although I did not do it systematically, I did ask one participant whether she felt that using the word “influence” would have made a difference in how respondents rated this item, and she answered that she did not feel it would have made a difference.

This line of questioning in the in-depth interview motivated a different kind of response from Sonia. Her response was instructive, both as it relates to how respondents defined community and how some Latino immigrants feel about their parish communities. Sonia appears to have interpreted community, at least in this item, as referring to the parish community as a whole. She agreed that there are times when the community has control over her life, such as when the Parish Council, which is dominated by Anglos, makes decisions that affect the Latino community without

really understanding their situation or their needs. “Sure, there may be one or two Hispanics on the Council, but it’s not the same when decisions are made, there’s not a balance . . .” Sonia contrasted this situation to the situation in her home country, where the parish priest took input from the parish council, but made the final decisions himself. Sonia also lamented that there was no one working in the parish office who could speak Spanish and help Spanish-speakers with their needs. For Sonia, this question evoked her frustration over Anglos making decisions for Latinos, whose reality they do not fully understand.

Another item that evoked surprisingly negative reactions was the item, “People in my community share the same values,” which was part of the sense of community sub-scale. The mean for this item at baseline among all respondents was 2.85, whereas the mean for sense of community as a whole was 3.25. Participants’ reflections on this item in the in-depth interviews suggest that, unlike item 26 described above, this item does measure the construct it is intended to measure; participants simply take a dim view of the values held by others in their community.

For Ana María, the interpretation was relatively straightforward: community members do not share the same values. “I think I did not agree with that statement, because I think my community isn’t . . . I have seen that we don’t have the values that one would wish [we had], for example to support, or guide another person.” Seeming to generalize “community” to Latino immigrants as a whole, Hilario and Delmi expressed that immigrants arrive with the same values, but lose them as they spend more time in the U.S. “Unfortunately we may have a lot of good values in our

countries; the problem is when we come here,” stated Hilario. Clearly interpreting “community” to mean the Latino congregation at her parish, Sonia stated that people in her community could have the same values if they had more formation and spiritual education. Alejandro agreed that with more spiritual formation, community members would be more likely to hold the same values, and attributed participants’ responses to what they see around them:

Look, I feel that right now, there is like a generalized pessimism in many people who, even though they have a lot of values inside, are acting as though they don’t want anything, they don’t believe in anything, they won’t do anything for themselves. And well, we run into these people on a daily basis, but I think that these people can be rescued and what is lacking is a lot of help from God, a lot of work in relation to this, but maybe [the answers on the questionnaire are] a response to what we see, because a lot of young people don’t even get close to the church.

For Alejandro, the generalized feeling that Latino community members do not hold the same values results from seeing people on a daily basis who appear not to believe in anything. These people, and thus presumably the feeling, can change with more help from God and more work from community members.

Perhaps due to his experience as a younger person born in the U.S., Israel’s perspective differed notably on this question:

I'd say, for the most part, yeah [we share the same values], because like . . . my values are to get educated, be hard-working and helpful, and a lot of people in my community are helpful and are already focused on their education.

Unlike many of his classmates in the training course, Israel expressed that members of his community do share the same values, such as getting an education and being hard-working and helpful. Overall, however, participants in the in-depth interviews agreed with respondents to the CHW Questionnaire that many members of their community do not share the same values.

Responses to two questions in the in-depth interviews suggested that whereas a question on the collective efficacy scale did not tap the domain it was intended to tap among this group of respondents, another question on the sense of community scale did measure the construct it was intended to measure. The implications of these findings for doing research in the Latino community will be discussed in Chapter V.

Summary of Chapter IV

The purpose of *La Palabra es Salud* was to determine whether exposure to either of two different educational methodologies (popular education and traditional education) was associated with different outcomes among parish-based Latino Community Health Workers. We sought to answer this question both from a statistical perspective, using a quantitative questionnaire, and from the perspective of the CHWs and the researcher, using qualitative methods such as in-depth interviews and participant observation. In addition, using several qualitative methods, we sought to determine what specific elements contribute to the effectiveness of popular education, if indeed it is effective.

Finally, the study attempted to identify benefits and costs that may accrue to a CHW training program as a result of being involved in research, and the elements that contribute to the success of a CHW training course, regardless of the methodology. In Chapter IV, I have reported on the findings of the study. In addition to addressing all six research questions, I have reported on two themes – stress and the meaning of the course for the popular education participants – that arose organically from the qualitative data. Finally, I have provided some initial impressions about fidelity to the curriculum and the two methodologies, and reported participants' explanations of responses to two notable items on the CHW Questionnaire. I will provide a thorough summary of the results at the beginning of Chapter V.

CHAPTER V: DISCUSSION

In this final chapter, I will present a summary of the findings from *La Palabra es Salud* and conclusions that grow out of those findings. I will suggest some implications that the study may hold for a variety of groups, including groups to which I alluded in Chapter I. Next, I will share some of the lessons learned from the study about conducting research in the Latino immigrant community and reflect on my own positionality and how it may have affected the study. Two final sections will acknowledge limitations of the study and offer suggestions for future research.

Summary of Findings and Conclusions

The goal of *La Palabra es Salud* was to conduct a rigorous comparison of the relative effectiveness of popular education vs. traditional education for enhancing health knowledge and skills, increasing empowerment, and improving health status and behavior among Latino, parish-based Community Health Workers (CHWs). In addition, we sought to determine what elements contribute to the differential effects of popular education, if those exist, and what costs and benefits accrue to a CHW training program as a result of being involved in research. Finally, we wished to explore what elements contribute to the success of a CHW training program, regardless of the methodology that is used.

To achieve these goals, we employed a quasi-experimental, three-cell design, mixed methods, and a community-based participatory research (CBPR) approach. Outcomes among members of a Popular Education (PE) group (n=15) and a Traditional Education (TE) group (n=29) were compared to each other and to

outcomes among a control group (n=24). The primary quantitative instrument was a questionnaire which participants completed at baseline and after the completion of the training course. The primary qualitative method was in-depth interviews conducted with a purposive sample of CHWs from both experimental groups (six from each group) after the completion of their training.

Results of a mixed factorial ANOVA demonstrated that members of both experimental groups made statistically significant increases in health knowledge compared to members of the control group. The mixed factorial ANOVA revealed no significant interactions with implications for the experimental groups, meaning that type of instruction was not significantly associated with any changes in the outcome variables. However, paired t tests revealed that participants in the PE group made statistically significant gains in four domains: health knowledge, self-reported ability to promote health, concientization, and a global measure of empowerment. Participants in the TE group improved significantly in five domains: health knowledge, control at the personal level (self-efficacy), concientization, self-reported health status, and self-reported health behavior. When considering these results, it is important to keep in mind that the TE group was almost twice as large as the PE group. This meant that almost identical gains among participants in the PE and TE groups on some scales (such as self-reported health status) reached statistical significance in the TE group but not in the PE group. All members of the PE group increased their health knowledge from baseline, while this was not the case for members of the TE group.

Regarding effects of participating in the training on the participants and differences in these effects by methodology, results of the analysis of in-depth interviews with the CHWs and other qualitative sources bear out and substantially deepen the results of the quantitative analysis. CHWs from both experimental groups reported experiencing positive changes at the individual, family and community level. Changes at the individual level included improvements in a variety of components of empowerment, knowledge, and health behavior. At the family level, CHWs reported improvements in diet and exercise habits and family relationships. CHWs averred that they were changing knowledge and behavior at the community level both through organizing activities and sharing information informally in their social networks.

Generally, TE participants emphasized learning particular facts about health, while PE participants focused on learning new skills, such as how to empower other community members. TE participants appeared to have made more specific improvements in diet and exercise at the individual and family level. PE participants spoke more frequently than members of the TE group about improvements in their general empowerment and used more evocative language to describe the changes. In addition, PE participants made statements related to increases in collective efficacy and participation, while TE participants did not. The interviews also suggested that participants tended to internalize the spoken or unspoken values and assumptions associated with both methodologies, with TE participants being more judgmental of themselves and others while PE participants exhorted each other to participation.

Results of in-depth interviews with the participants, Participant Evaluation Forms conducted after every class, and my own participant observation suggested that popular education brings about change by setting the stage (through mechanisms such as posting an agenda and seating participants in a semi-circle), building trust (using methods like *dinámicas* and developing group norms), drawing out and affirming what participants already know, encouraging open communication (by validating contributions and assuring all questions are answered), creating an environment of equality, using a variety of interactive techniques, encouraging and balancing participation, and creating a sense of community.

Involvement in *La Palabra es Salud* produced both costs and benefits for the staff of the Parish Health Promoter Program, according to field notes from team meetings and training sessions. Benefits at the programmatic level included increased quality of educational sessions, better program organization, and the creation of an Advisory Council. Among the benefits at the personal level were new knowledge and skills, mutual support, and personal growth, particularly in the area of cultural awareness and competency. A possible negative effect on the relationship between the CHWs and the Coordinator, some negative implications for the curriculum, and decreased flexibility were the primary costs we identified at the programmatic level. The primary cost at a personal level was increased stress for all Project Team members.

The in-depth interviews, the Participant Evaluation forms, and my field notes also provided information about elements that contribute to the success of a CHW training program, regardless of the methodology. These included a religious/spiritual element,

convivencia (literally, “living together” or fellowship), high quality sessions, new and complete information, and certain characteristics of the facilitator (knowledge, charisma, clarity, use of effective materials, and shared life experience) and the project team (*personalismo* and shared purpose).

The qualitative methods provided additional information about topics that were not specifically addressed in the research questions. For example, the prevalence and health impacts of stress in the Latino community was a topic of high interest and concern among the CHWs, who undertook both individual and collective actions to reduce stress in their own lives and in their community. Responses in the in-depth interviews made it clear that the parish health promoter training course held a special significance in the lives of the popular education participants. They expressed gratitude and determination to use what they had learned to help their communities, stated that the course had changed their lives, and showed willingness to be involved as role models and guides for future CHWs.

My participant observation suggested that fidelity to the curriculum was enhanced by being relatively new to the topic or the field, while fidelity was diminished by lack of preparation and strong convictions about particular topics. Barriers to fidelity to the assigned methodology included lack of familiarity with the topic, lack of preparation, resistance to using traditional education, and the highly activated and participatory nature of the TE group. Responses to questions in the in-depth interviews with the CHWs suggested that a statement in the CHW questionnaire designed to measure collective efficacy did not tap that domain among this group of respondents, while a

statement about shared community values that also elicited negative reactions did measure the construct it was intended to measure.

Results of this research suggest that popular education can be *at least as effective* as traditional education for increasing knowledge. At the same time, study results suggest that popular education can be *more effective* than traditional education for achieving a variety of other goals, including increasing empowerment and sense of community and producing multi-faceted skills and understandings. Findings demonstrate, further, that popular education achieves its aims through particular practices that can be intentionally taught and applied. Below, I will reflect on some of the implications of these conclusions for a variety of groups.

Implications

In Chapter I, I proposed that wider use of popular education in the U.S. and the industrialized world could produce benefits for multiple groups. The results of this study support that contention. For example, I proposed that popular education could help public school teachers resist their own deskilling and provide alternatives to “teaching to the test.” Our finding that popular education can be just as effective as traditional education for increasing knowledge provides evidence that teachers do not have to fall back on traditional education to ensure that students do well on tests. All of our popular education participants increased their scores on the health knowledge portion of the questionnaire, except for one participant who made a perfect score both times. This finding is important, since in the U.S., popular education has been regarded more as a method for developing political awareness than as a method for

sharing content. Given that the focus of mainstream education in the U.S. is the acquisition of content knowledge, and given that our goal was to explore the potential of popular education for wider use among mainstream educators in the U.S., it was crucial to compare popular and traditional education as modes for imparting content knowledge. Our findings suggest that popular education is an effective method for increasing content knowledge, as effective, in fact, as traditional education.

I further suggested that for educators in a variety of settings, popular education could make the underlying philosophy and principles of critical pedagogy more accessible and offer practical examples of how to apply those principles in the classroom. In this study, we were able to identify specific elements and practices of popular education that contribute to its effectiveness. Practices such as setting the stage by arranging chairs in a circle, drawing out what students know through the use of brainstorming and other techniques, and creating trust through the use of *dinámicas* can be taught to students in teacher education programs and to practicing teachers during in-service workshops. Specific practices should be linked to the principles they embody and support, both to make the principles come alive as well as to ensure that popular education techniques are not reduced to a “bag of tricks.”

I hypothesized, in Chapter I, that popular education can help students develop the critical thinking skills they will need to confront the challenges of a complex and globalized world. While *concientization* was one of the outcomes on which both PE and TE participants made statistically significant gains, and members of both groups alluded to some changes in their way of thinking, our study suggests that to help

students substantially improve their critical thinking skills, teachers will need to more consistently connect students' realities to realities at the national and global level and encourage students to make these connections.

The positive responses of members of both experimental groups in our study to the religious and spiritual component of the training reaffirms the importance, mentioned in Chapter I, of breaking down the false dichotomy between spirit and intellect in Western education, particularly when working with students who are not members of dominant culture. The findings remind us, as well, of the importance of coherence between culture and spiritual practices; prayers and Biblical reflections elicited highly positive responses among this group of CHWs because they are members of Roman Catholic parishes and were motivated to become CHWs as part of their religious commitment.

One of the most important assertions made in Chapter I was that greater use of popular education could result in particular benefits for students who are not from dominant culture, or who for a variety of reasons enter the educational setting at a disadvantage when compared to other students. All of the participants in our experimental groups were from non-dominant culture, in that all were Latino and most were immigrants, and we did not compare their experience to the experience of adults from dominant culture. However, popular education did prove to be successful – more successful than traditional education – at increasing empowerment among this group. Why was this so?

A discussion that took place in our Project Team sheds substantial light on this question. In our meeting on June 19, 2009, I distributed quotations from the in-depth interviews with the PE participants to members of the team and asked them to assign the quotations to Research Questions 3, 4, and 6. We strove to distinguish between elements that are unique to popular education and elements that contribute to the success of a class, regardless of the methodology. In response to a particular quotation, Catherine, a middle class Anglo-European, proposed that consciousness-raising is not a practice unique to popular education, but can occur in traditional education as well. She provided the example of her own experience at a progressive liberal arts college, stating that while professors at the college did not use popular education, they did raise her consciousness, by teaching her to think critically and connecting her personal experience to larger global and national realities. In response, Adriana, a Latina who recently became the first person in her family to graduate from college, pointed out that different life experiences position us differently to learn to think critically. “You were already empowered when you went to school,” she stated. Adriana explained her perspective further:

It’s a difference of ethnicities. Your parents already had education. You felt identified; you were already part of the community. Popular education gives people a sense of their rights and tries to make people feel more included. This is not part of traditional education. My teachers were good but didn’t care if I “got it.” Consciousness is raised by giving feedback, padding your perspective with

more insulation, which is empowerment. It's a kind of attention not given in traditional education.

In this quotation, Adriana eloquently points out some of the ways in which popular education and traditional education are different, and why popular education is especially useful for students who do not come to the educational setting already feeling empowered. According to Adriana, by placing certain values and epistemological positions front and center, popular education helps disempowered students to feel that they are part of the community and provides the extra support, the “padding” as she puts it, to allow them to come to believe that their perspectives and experience are equally valid and important.

With her statement that “[in traditional education] my teachers were good but didn't care if I ‘got it,’” Adriana suggests another reason that popular education is so effective in increasing empowerment and building skills among members of disempowered communities and another way it is different from traditional education. A participant in a recent popular education workshop summed up this difference more succinctly than I ever could have. During the initial brainstorm, I asked participants to compare what they had already experienced that morning to what they had experienced in previous educational settings. A participant with a developmental disability put it this way: “Here, in this class, the teacher really cares about whether you learn.” In previous classes, this participant, a member of another marginalized group, had not felt teachers extending themselves to her to make sure that she understood. In a popular education setting, she perceived that the teacher really cared.

While it would be unfair to say that teachers in traditional settings do not care whether their students learn, the consistent message from participants in this study and in other workshops should not be ignored. Students – perhaps especially students who enter the educational system at a disadvantage – often feel that they are being left to sink or swim. Popular education, correctly practiced, provides “a kind of attention not given in traditional education,” making students feel that their learning matters.

The findings of our study suggest that popular education is an effective methodology for use in settings where the majority of participants come from marginalized groups, such as adult basic education programs, ESL classes, and special education classes. However, when they described their experience with traditional education, neither Adriana nor the participant with a developmental disability were describing settings where the majority of participants were marginalized. They were describing their experience in public schools and university classrooms. These settings are becoming increasingly diverse. More and more, the students sitting in public school classes have diverse abilities and disabilities. Increasingly, university classes include first generation college students as well as students for whom university attendance was a foregone conclusion. We need look no further than the “equity gap” (sometimes mislabeled the “achievement gap”) to see that current methods of education are not succeeding in creating a level playing field for students from marginalized communities. Our study suggests that popular education shows real promise for leveling the playing field and creating educational equity.

The implications for educational leaders are clear. As a result of helping students who come to the educational setting at a disadvantage to succeed, society as a whole will benefit. And, since our findings suggest that popular education can be just as effective as traditional education at increasing knowledge, greater use of popular education should have no negative effects on students from dominant culture. Indeed, the experience of members of our Project Team suggests that greater use of popular education in mainstream settings could help diverse students to better understand one another, benefiting all.

The final group for whom I suggested, in Chapter I, that popular education could provide benefits are community organizers and political activists. The results of our study support that claim as well. In our study, popular education was shown to be effective in helping participants develop a sense of community and a feeling of collective efficacy, both of which are necessary prerequisites to working together to identify and solve community problems. More time and practice spent working together for change could have helped translate these feelings into actual skills.

In addition to the groups mentioned in Chapter I, our study also has implications for training programs that use popular education, such as the Community Capacitation Center (CCC) and the Parish Health Promoter Program (PHPP). For many years, my colleagues and I have engaged in a running debate about whether it is preferable to employ trainers who know their subject matter and teach them to use popular education, or to employ trainers who know how to use popular education and support them to learn the subject matter. The results of this study have finally convinced me

that teaching content experts to use popular education is ultimately more effective. Observing the sessions, I perceived that when the facilitator really dominated the material, the participants all seemed to relax, as though they could sense they were in good hands. The facilitator's extensive knowledge allowed them to ask questions and generally get answers in the moment. Additional support for this position comes from the participants, who emphasized again and again the importance of new and complete information. This kind of information is more likely to be provided by a content expert than by a popular educator who learns the material in order to teach a class. Finally, the fact that so many of the trainers for the TE group were content experts as well as engaging teachers may explain to some degree why participants in the TE group learned the material and were able to apply it to their lives and the lives of their families, despite the traditional methodology.

Three caveats should be added here. One is that content expertise need not be gained through formal education, but can be gained through experience. To state otherwise would be to ignore the underlying epistemological principles of popular education and overlook the excellent classes in this series presented by CHWs who did not gain their knowledge in an academic setting. A second caveat is that, as several participants emphasized, content expertise is not enough; experts also need to be engaging and charismatic presenters. A final caveat is that the need for content expertise applies to the training of trainers, but not necessarily to the presentation of health education and other classes for community groups. In the latter case, it may

well be more important for the presenter to be a trusted community member and someone to whom the participants can relate than a content expert.

If, as our findings suggest, content expertise trumps methodological expertise when conducting training of trainers, then programs like the CCC will need to budget more dollars for consultant facilitators. The experienced popular educators on our staff will need to spend more of their time training others to use popular education and providing one-on-one technical assistance, and less of their time learning about new content areas. Programs like the PHPP, which generally do not pay their trainers, will either need to convince volunteer content experts of the value of attending popular education training on their own time, or they will need to pay content experts to learn to use popular education. If they cannot provide the popular education training and technical assistance to trainers themselves, they will need to contract with another organization to do these tasks.

In sum, the results of this study suggest that greater use of popular education can provide benefits for multiple groups, including but not limited to educators in a variety of settings, students from marginalized groups, and society as a whole. Further, the results suggest that training programs that use popular education should dedicate resources to helping content experts learn to use popular education, rather than helping popular educators develop content expertise.

Innovations and Concordance with Previous Research

Our study possessed at least two important innovations when compared to previous research about popular education, empowerment, and health. First, it explored the

association between use of popular education and improvements in empowerment and health among parish-based Latino health workers, most of them immigrants. While some previous studies had included Latinos and/or immigrants (Arenas-Monreal, Paulo-Maya & López-González, 1999; Ferreira-Pinto & Ramos, 1995; Minkler & Cox, 1980; Rivera, 2003; Romero et al., 2006; Wallerstein & Bernstein, 1988; Weinger & Lyons, 1992), only one (Weinger & Lyons, 1992) appeared to focus exclusively on Latino immigrants in the U.S., and that study did not measure changes in empowerment using a quantitative questionnaire. Thus, our adaptation and use of a questionnaire based on the Israel et al. (1994) empowerment scale with a group of primarily immigrant Latinos represents an innovative extension of the research in this field.

Second, our study employed a quasi-experimental, three-cell design, in which outcomes among members of two experimental groups were compared to each other and to outcomes among a control group. As I discussed in Chapter II, while previous studies had suggested that popular education could help members of marginalized communities achieve a number of desirable goals, those studies were hampered by the lack of a control or comparison group. Thus, our study overcame the most serious limitation of previous studies exploring the role of popular education and our findings represent new information not previously reported in the literature.

While our study was innovative in two important ways, previous studies that explored the relationship between popular education and empowerment have reported similar results, including people taking more control over their lives and their health

(Arenas-Monreal, Paulo-Maya, & López-González, 1999; Chang, 2004), increased participation (Chang, 2004; Minker & Cox, 1980), improvement on a wide-ranging battery of empowerment-related factors (Romero et al, 2006; Wiggins et al., 2009), and development of critical consciousness (Minker & Cox, 1980). Studies that explored the relationship between popular education and health also found similar results, including increased health knowledge (Romero et al., 2006). Our study contributes to the growing body of research demonstrating the usefulness of popular education for increasing empowerment and improving health.

Methodologically, this study reinforced the findings of other studies which found that mixed methods are both desirable and necessary to capture the outcomes of a popular education intervention (Arenas-Monreal et al., 1999; Ferreira-Pinto & Ramos, 1995). In this study, findings based on qualitative methods both affirmed and expanded on findings of the quantitative component of the study.

Doing Research in the Latino Immigrant Community

This research produced important lessons about doing research in the Latino immigrant community. The first lesson concerned the use of consent forms. In Chapter III, I discussed some of the opposition that arose to completing the consent form and the baseline survey in the PE group. I had already developed my data collection plan and had it approved by Portland State University's Institutional Review Board when I learned that it is becoming increasingly common and acceptable to employ a passive consent form that does not require a signature, especially in communities with especially acute and well-grounded fears about the confidentiality

of their information (Garcia et al., 2008). I wish I had known this and employed this type of consent form, since it appeared to me and other members of the project team that the consent form engendered far more fear and opposition than did the survey itself. I do not think it is overstating to say that, had we employed a less intimidating type of consent form, we might have had better retention in the popular education group, and thus more ability to find statistically significant results.

A second set of lessons concerns measuring empowerment in the Latino immigrant community. As mentioned above, while some previous studies that assessed the association between the use of popular education and changes in empowerment did take place in multi-cultural communities that included Latinos (Romero, 2006; Rivera, data), we were unable to locate studies that measured changes in empowerment in communities composed mainly or solely of recent Latino immigrants. Thus, this study represents the first major effort to assess the association between use of popular education and changes in empowerment in this community.

As discussed in Chapter IV, two statements on the CHW Questionnaire evoked notably negative responses from participants. The first statement read: “My community has control over decisions that affect my life.” Explanations of the participants in the in-depth interviews suggested that this item did not measure respondents’ perception of control at the community level; rather, it assessed their *willingness to be controlled by the community*. To determine whether the item should be retained in future scales used to measure empowerment among Latino immigrants, it would be helpful to convene a focus group to compare two alternate wordings of the

item. If an item containing the word “influence” evokes similarly negative reactions, the item should be dropped.

A second item that evoked a negative reaction stated, “People in my community share the same values.” Participants’ responses in the in-depth interviews revealed that many believed that the process of immigration and a lack of spiritual education had led to a degrading of values within their community. Their responses also revealed that they interpreted the word “community” in a variety of ways, despite the instructions in the questionnaire. In general, respondents’ varying interpretations of the word “community” despite explicit instructions suggest that measuring perceived control at the community level with a quantitative instrument among recent Latino immigrants will pose challenges and should always be supplemented with qualitative data. As mentioned in Chapter III, the new scales created to measure critical awareness of the social context and action for change appeared to function well among this group of Latino immigrants, and we recommend that they be maintained in future studies.

This research produced lessons about doing research in the Latino immigrant community. Specifically, the study added more weight to a growing movement to use passive consent procedures in communities with a well-founded fear about confidentiality. Second, it raised questions about standard items used to measure empowerment, particularly an item that is used to measure perceived control at the community level. Thus, it reinforced the importance of using both qualitative and quantitative instruments to measure empowerment in this community and signaled the

need to use additional strategies, such as focus groups, to further assess the usefulness of items designed to measure empowerment.

Reflections on My Positionality

In Chapter 1, I quoted Lather (1983) on the need to protect my research from my “enthusiasms and incompetencies” (p. 67), so that my ideological commitments could strengthen rather than weaken the usefulness of my conclusions. As I moved through this project over the course of the last year, I made an effort to keep track of how I was feeling about the project, how my ideological commitments were affecting my behavior, and how my behavior might influence the project, and to document these factors in my field notes.

While I occasionally worried that I was being too directive on the Project Team, I was most aware of how my positionality affected my participation in the popular education group. I was certainly much more involved in the PE group than in the TE group. To some degree, this was due to the methodology; there was more *room* to be involved in the PE group than the TE group. Unquestionably, however, it was also due to my determination to maintain fidelity to popular education as defined in Chapter 2, so that the comparison between the two methodologies would be valid.

I became concerned about fidelity to the popular education or Liberation Theology model for spiritual or Biblical reflections in the first session, when the facilitator did not ask participants to relate the Biblical verse to their own lives, a hallmark of reflections according to Liberation Theology. Subsequently, I offered to plan and lead the reflections in the PE group, since I felt that the reflections were integral to the PE

methodology and I did not feel they were being used optimally. My feeling about the reflections was only the most obvious manifestation of the frustration I felt when I perceived that something was being done “wrong” from a popular education point of view. Other examples I noted were when a colleague asked a participant to lead a reflection when it appeared clear to me the participant was not ready to do so, or asked another participant to lead a *dinámica* without ensuring ahead of time that he knew how to do it.

By the third session, I was concerned about the comparative quality of the PE vs. the TE sessions. It appeared to me that we had chosen a very skilled group of TE facilitators, something Hilario affirmed to me during a break in one of the TE sessions. Because of the relative paucity of skilled popular educators, our options were fewer, and thus many sessions had to be conducted by a limited group of facilitators, some of whom were not experts in their assigned topics. Perceiving this disparity, I involved myself in the PE sessions in a variety of ways. On various occasions, I participated in the discussion. In the session on Heart Health, I jumped in to clarify the definition of “risk factor.” In the Navigating the Health System session, I intervened to assert that migrant and community health centers could be part of the public health system. During the session on Diabetes, I worried that I was contributing too much, but felt compelled to do so in order to make connections to the previous week’s session on the Social Determinants of Health.

On some occasions, I acted in the facilitator role. For example, during the first cooperative learning activity with the PE group, I encouraged group members to move

their chairs into a circle so that they could see one another. When I perceived that the facilitator for the PE session on Social Determinants of Health was focusing too much on individual approaches to improving health, I jumped in to ask the group to think not only as individuals but also as a community. At the invitation of the facilitator for the Role of the CHW session, I played a role in a sociodrama. In another session, when it appeared we would have no food for lunch, I went to the store and quickly bought enough food for the group.

As a popular educator, affirming the capacity of all members of the community is something I do almost without thinking. I did it at least twice during the course of the study. In one session, when a facilitator asked for someone to lead an opening prayer, I interjected, “¡Todos pueden!” (Everyone can.) It worked; a shy participant volunteered. The facilitators for the PE Nutrition session were two experienced CHWs who had never taught a class in the curriculum before. My desire to affirm their thoughtful preparation and skilled facilitation led me to show my “methodological hand” in a rather obvious way. Before I left for the afternoon group, I thanked the facilitators and stated that, in my experience, the best teachers for CHWs are other CHWs. Many times, I stated, we think we need someone from outside, who is different from us, who has a title, in order to learn something new, but that these two facilitators had demonstrated that wisdom exists in the community.

I believe that my active participation in the PE group had both positive and negative consequences. First, it helped me to develop a strong relationship with group members. During the reflection in the seventh session, one of the participants

complimented me greatly by saying that I was a model of treating people equally, since I am so different from them and yet treated them the same. When I returned to the tenth session after missing the previous session, various participants told me they had missed me. In the same session, the facilitator asked people to share why they had come to the session. I shared that I had come because I loved spending time with the group, and a number of people clapped.

On the one hand, I believe that expressing my dedication to certain popular education principles did not introduce bias, since participants were never asked to compare the two methodologies, and would not have had a basis to do so, since they only experienced one type of training and all data collection was concluded before the debrief with the two groups. Participants in the TE group did not observe me in the PE group, nor vice versa, so participants were not aware of how my behavior in the two groups differed.

On the other hand, in the in-depth interviews, one participant revealed that he had heard something about how the afternoon group differed from the morning group, though he was careful to say that the person who had talked to him had not expressed that one methodology was better than another. By stating openly my belief in certain popular education principles – for example, that facilitators should share the life experience of the participants – I may have made this participant less willing to express doubts or complaints about his own experience in the PE group.

Overall, I do not believe that my positionality unduly affected the outcomes of the quantitative data or the findings from the qualitative methods. Rather, I believe that

my close connection to the program and the participants increased the quality of the data I was able to collect. I will share one additional experience in support of this contention.

In one of the analysis meetings that I held with the Community Advisory Council, upon hearing a quotation from one of the interviews in which the respondent reflected on how profoundly she had been changed by her participation in the training program, a visitor who was not part of the Council but who was well-connected to the program commented that this was not the sort of thing one usually says to a stranger. This comment led to a discussion of the benefits of having research done by someone or a group who are either members of a given community or closely connected to that community. Concurrently with this study, I was conducting a much smaller evaluation study which also involved interviews with Latino community members. In that case, while I was known to the interview subjects, I had not developed a relationship with them; I had only visited their group twice as compared to attending almost every session as I did in the La Palabra study. The contrast between the level of depth achieved in the two sets of interviews convinces me once again of the veracity of the statement, “Bias is the other side of wisdom.” In other words, while one may sacrifice some academic objectivity when one becomes connected to a group of study participants, one also gains immeasurably in terms of the depth of the data collected.

Limitations of the Study

This study possessed a number of limitations which should be addressed in future studies seeking to validate or expand its results. First among those was the small sample size, particularly in the popular education group, which made it harder to detect statistically significant changes, especially between the two experimental groups in the mixed factorial ANOVA. The small sample size also made it impossible to assure that the assumptions of normality, homogeneity of variance, and independence of observations were met. Regarding this last assumption, a larger sample size combined with more time points would have made it possible to use multi-level analysis, which could have corrected for group effects, e.g. the fact that each participant in each experimental group was affected by every other participant in their respective group, meaning that their scores on the CHW Questionnaire were not truly independent.

A second important limitation was our inability to follow the CHWs over time. We were able to assess their feelings about changes in themselves, their families and their communities, but only immediately after the training. Will these feelings remain stable or change over time? Will motivation to use what they had learned increase or decrease? Will some of the differences in emphasis and learning between the two groups lead them to act in different ways in their communities? We cannot answer these questions because we only collected data at two time points.

The final question in the paragraph above – will CHWs act differently in their communities based on the training methodologies to which they were exposed? –

suggests perhaps the most important limitation of this study. We were only able to assess changes among the CHWs. We did not assess changes among community members. Experienced CHWs involved in the project repeatedly emphasized that the real test of the effects of the two methodologies would come when the CHWs began their work in their communities. We can make some hypotheses about differences we might have seen on the basis of what members of the two groups said about how they would approach their work. Members of the TE group spoke of informing, educating, and telling people to do the right thing, while members of the PE group intended to offer options that community members could try and suggest pathways to arrive at better health. These phrases suggest that members of the two groups will approach their work in different ways. However, in the absence of data from the community members served by the program, we can neither test these hypotheses, nor determine whether different ways of working affect community members in different ways.

In our study, measuring change at the community level was prohibited by lack of funding as well as my own need to complete my dissertation within a reasonable amount of time. However, even had we had the money and the time, there are certain programmatic, practical, and ethical barriers to this further level of assessment that need to be carefully considered. Measuring change among community members would have required keeping both the CHWs and members of their communities separate for the entire length of the experiment. This would be difficult from a programmatic point of view, since it would mean the Coordinator would have to meet at least monthly with two groups instead of one. It would also be somewhat

impractical, because membership in the Latino congregations is fluid, with members often attending Mass at whichever parish is more convenient on a given day.

Measuring change at the community level would also require continuing to use only traditional education with the TE group and popular education with the PE group.

Doing so would present ethical challenges for members of the Project Team, who have a strong commitment to empowering communities to address their own needs rather than taking a more traditional, top-down approach.

An additional limitation of the study was the lack of a systematic way to assess fidelity to both methodologies. This limitation made it harder to attribute changes in each group to the methodology that was used in that group. It also made it impossible to explore any sort of “dose-response” effect, e.g. whether closer adherence to either model enhanced or strengthened the observed changes in that group.

A final limitation concerned the intervention itself. In Chapter II, I identified the absence of an experience of making change together as a limitation of previous empowerment interventions. We did attempt to address this limitation by involving members of both experimental groups in health promotion projects in their parishes. In the popular education group, our intent was to emphasize identifying and addressing the underlying social determinants of health. However, several factors prevented us from avoiding this limitation to the extent we would have wished. We introduced the group projects in the session on Social Determinants of Health. As noted above, this session was among the weakest sessions in the PE series, because the facilitator lacked expertise in her topic and tended to emphasize individual over collective actions.

Thus, the stage was not set effectively for the group projects in the PE group. An additional problem was that, though we intended to set aside sufficient time in subsequent sessions for participants to work in their small groups, it was impossible to do this and cover the necessary content at the same time. Thus, the group projects received short shrift and most groups, even those in the PE condition, fell back on fairly traditional health education approaches in their projects. In sum, limitations of the study included a small sample size, inability to measure change over time or among community members, and failure to assess fidelity to the two methodologies.

Suggestions for Future Research

Future studies should more systematically assess fidelity to both popular education and traditional or conventional education. While we did bring both our long experience using popular education and our comparative list of traits of popular and conventional education to our participant observation, our assessment of fidelity to both philosophies/methodologies was essentially impressionistic and not systematic. This fact, combined with our small sample size, makes it impossible for us to compare outcomes among participants by the degree to which either methodology was or was not used.

Future studies should also, when possible, include qualitative interviews at baseline to assess participants' level of empowerment in their own words and according to their own criteria. These interviews might also produce statements that could be used to improve quantitative questionnaires, by making them reflect more closely how real people in given communities think and talk about empowerment. For example,

statements that might be devised based on quotations from participants in our study include, “I feel able to talk to people with power about things that need to be changed,” “I have many skills and talents,” and “I feel able to use all the skills that I have.” Similarly, as mentioned previously, in my analysis of in-depth interviews, I found evidence of changes which seemed to fit the general definition of empowerment, but did not fit within a previously-identified domain. Future studies should further explore domains such as “general empowerment” and “personal growth,” and, if they are borne out, they should be operationalized and measured.

La Palabra es Salud represented only a small-scale, initial effort to systematically compare the outcomes of popular education and traditional education, and it did so only among Latinos, most of them immigrants. In order to have faith in its conclusions, we need many more experimental and quasi-experimental studies, conducted with larger and more diverse groups of participants. These studies should continue to combine qualitative and quantitative methods to assure that important outcomes are not overlooked. When possible, they should measure longitudinal change among those who participate in the educational interventions, as well as any others who are affected by them. They should seek to determine whether CHWs and others who participate in training using popular education practice their craft differently than those who receive their training using traditional education.

Finally, studies are desperately needed which firmly establish the causal pathway that leads from empowering interventions such as popular education, to greater community empowerment, to action for change at the personal and policy level, and

ultimately to improved social outcomes (e.g. better health and increased educational attainment) and decreased inequities across a range of axes of diversity. Such studies will require long-term funding and a clear philosophical commitment to creating more equitable social conditions.

Table 1.

Reliability Levels of Scales and Sub-scales

Scale	Cronbach's Alpha (Standardized)
Ability to promote health	.758
Empowerment	.883
Sense of community	.833
Perceived control at the community level	.656
Perceived control at the personal level (self-efficacy)	.759
Concientization	.743
Action for change	.719
Health behavior	.746

Table 2.
Correlation Matrix for Empowerment Sub-scales

		1	2	3	4	5	6	7	8	9
1.Health Knowledge	Pearson	1	-.070	.061	.090	.186	.291**	.051	.149	.255*
	Sig.		.510	.568	.398	.078	.006	.630	.155	.014
	N	92	92	90	90	91	89	92	92	92
2. Ability to Promote Health	Pearson	-.070	1	.330**	.192	.384**	.205	.050	.214*	.142
	Sig.	.510		.001	.070	.000	.054	.637	.041	.178
	N	92	92	90	90	91	89	92	92	92
3. Sense of Community	Pearson	.061	.330**	1	.470**	.394**	.238*	.457**	.224*	.193
	Sig.	.568	.001		.000	.000	.026	.000	.034	.069
	N	90	90	90	88	89	87	90	90	90
4.Control at Community Level	Pearson	.090	.192	.470**	1	.393**	.506**	.267*	.220*	.129
	Sig.	.398	.070	.000		.000	.000	.011	.038	.225
	N	90	90	88	90	90	88	90	90	90
5.Control at Personal Level	Pearson	.186	.384**	.394**	.393**	1	.560**	.477**	.450**	.370**
	Sig.	.078	.000	.000	.000		.000	.000	.000	.000
	N	91	91	89	90	91	88	91	91	91
6.Concienti-zation	Pearson	.291**	.205	.238*	.506**	.560**	1	.388**	.242*	.247*
	Sig.	.006	.054	.026	.000	.000		.000	.022	.020
	N	89	89	87	88	88	89	89	89	89
7.Ability to Act for Change	Pearson	.051	.050	.457**	.267*	.477**	.388**	1	.166	.241*
	Sig.	.630	.637	.000	.011	.000	.000		.113	.020
	N	92	92	90	90	91	89	92	92	92
8.Health Status	Pearson	.149	.214*	.224*	.220*	.450**	.242*	.166	1	.218*
	Sig.	.155	.041	.034	.038	.000	.022	.113		.037
	N	92	92	90	90	91	89	92	92	92
9.Health Behavior	Pearson	.255*	.142	.193	.129	.370**	.247*	.241*	.218*	1
	Sig.	.014	.178	.069	.225	.000	.020	.020	.037	
	N	92	92	90	90	91	89	92	92	92

Note. *p≤.05, **p≤.01 (2-tailed)

Table 3.

Correlation Matrix for Global Empowerment Scale

		1	2	3	4	5
1. Health knowledge	Pearson	1	-.070	.149	.255*	.185
	Sig.		.510	.155	.014	.089
	N	92	92	92	92	86
2. Ability to promote health	Pearson	-.070	1	.214*	.142	.327*
	Sig.	.510		.041	.178	.002
	N	92	92	92	92	86
3. Health status	Pearson	.149	.214*	1	.218*	.365*
	Sig.	.155	.041		.037	.001
	N	92	92	92	92	86
4. Health behavior	Pearson	.255*	.142	.218*	1	.343*
	Sig.	.014	.178	.037		.001
	N	92	92	92	92	86
5. Empowerment	Pearson	.185	.327**	.365**	.343**	1
	Sig.	.089	.002	.001	.001	
	N	86	86	86	86	86

Note. *p≤.05, **p≤01 (2-tailed)

Table 4.

Descriptive Statistics and Significant Differences for Continuous Demographic Variables at Baseline

		PE Group Total N=24	TE Group Total N=37	CG Group Total N=31	One-way ANOVA		
					F	df	p
Age	Valid N	23	37	31	.824	2	.442
	Mean	37	41	39			
	SD	12	12	12			
	Skewness	.473	-.409	.712			
Years in US	Valid N	24	37	30	.197	2	.821
	Mean	16	15	16			
	SD	8	10	12			
	Skewness	.860	.836	1.868			
Years of formal schooling	Valid N	24	36	29	1.829	2	.167
	Mean	11.5	12	10			
	SD	3	4	4			
	Skewness	.059	-.098	.156			
No. of children	Valid N	24	37	31	5.810	2	.004
	Mean	1.8	2.0	3.0			
	SD	1.2	1.2	1.8			
	Skewness	-.429	.388	.978			

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.

Table 5.

Three Categorical Demographic Variables at Baseline									
	PE Group		TE Group		Control Group		Chi-Square		
	N	%	N	%	N	%	X ²	df	p
Gender									
Male	5	21	4	11	15	48	12.817	3	0.002
Female	19	79	33	89	16	52			
Country of Origin									
Mexico	17	70.8	23	62.2	24	77.4	16.296	14	0.296
LA Other	3	12.5	12	32.4	4	12.9			
US	4	16.7	2	5.4	3	9.7			
Preferred Language									
Spanish	19	79.2	31	83.8	21	67.7	7.241	4	0.124
English	0	0	4	10.8	5	16.1			
Both	5	20.8	2	5.4	5	16.1			
Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.									

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.

Table 6.

<i>Marital Status at Baseline</i>			Single	Partnered	Married	Divorced	Widowed	Other	Separated	Total
Group	PE	Count	5	3	13	1	1	1	0	24
		%	20.8%	12.5%	54.2%	4.2%	4.2%	4.2%	.0%	100.0%
	TE	Count	7	2	19	4	1	1	3	37
		%	18.9%	5.4%	51.4%	10.8%	2.7%	2.7%	8.1%	100.0%
	CG	Count	4	6	20	1	0	0	0	31
		%	12.9%	19.4%	64.5%	3.2%	.0%	.0%	.0%	100.0%
Total		Count	16	11	52	6	2	2	3	92
		%	17.4%	12.0%	56.5%	6.5%	2.2%	2.2%	3.3%	100.0%

Note. $X^2(12) = 12.418$, $p = .413$.

PE= Popular Education, TE= Traditional Education, CG= Control Group.

Table 7.

Employment Status at Baseline with First Responses

Group (N)		Work- ing	Sick / ^a ML	Seeking Work	Home- maker	Un- employed	Taking Classes	Retired	^b Not Working	Other
PE	Count	14	0	2	5	1	2	0	0	0
(24)	%	58.3%	0%	8.3%	20.8%	4.2%	8.3%	0%	0%	0%
TE	Count	23	1	3	5	0	3	0	2	0
(37)	%	62.2%	2.7%	8.1%	13.5%	0%	8.1%	0%	5.4%	0%
CG	Count	21	0	1	5	0	2	1	0	1
(31)	%	67.7%	0%	3.2%	16.1%	0%	6.5%	3.2%	0%	3.2%
Total	Count	58	1	6	15	1	7	1	2	1
(92)	%	63.0%	1.1%	6.5%	16.3%	1.1%	7.6%	1.1%	2.2%	1.1%

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.

^a ML=Maternity Leave. ^b Not working because of disability.

Table 8.

Employment Status at Baseline with All Responses

Group (N)		Work- ing	Sick / ^a ML	Seeking Work	Home- maker	Un- employed	Taking Classes	Retired	^b Not Working	Other	Total Responses
PE	Count	14	0	2	7	1	6	0	0	0	30
(24)	%	58.3%	0%	8.3%	29.1%	4.2%	25%	0%	0%	0%	124.9%
TE	Count	23	1	3	7	0	5	0	2	0	41
(37)	%	62.2%	2.7%	8.1%	18.9%	0%	13.5%	0%	5.4%	0%	110.8%
CG	Count	21	1	1	6	0	2	1	0	1	33
(31)	%	67.7%	3.2%	3.2%	19.3%	0%	6.5%	3.2%	0%	3.2%	106.3%
Total	Count	58	2	6	20	1	13	1	2	1	104
(92)	%	63%	2.2%	6.5%	21.7%	1.1%	14.1%	1.1%	2.2	1.1%	113%

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.

^a ML=Maternity Leave. ^b Not working because of disability.

Table 9.

Income Levels at Baseline

Group (N)		< \$2000	\$2000- \$4999	\$5000- \$9999	\$10000- \$14999	\$15000- \$19999	\$20000- \$24999	\$25000- \$29999	\$30000- \$39999	\$40000- \$49999	≥ \$50000
PE	Count	1	2	1	4	3	5	3	4	0	0
(23)	%	4.3%	8.7%	4.3%	17.4%	13%	21.7%	13%	17.4	0%	0%
TE	Count	5	5	2	3	4	3	4	4	2	4
(36)	%	13.9%	13.9%	5.6%	8.3%	11.1%	8.3%	11.1%	11.1%	5.6%	11.1%
CG	Count	6	1	1	2	2	7	4	2	3	3
(31)	%	19.4%	3.2%	3.2%	6.5%	6.5%	22.6%	12.9%	6.5%	9.7%	9.7%
Total	Count	12	8	4	9	9	15	11	10	5	7
	%	13.3%	8.9%	4.4%	10%	10%	16.7%	12.2%	11.1%	5.6%	7.8%

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group.

Table 10.

Parish Affiliation at Baseline with First Responses

Group (N)		SAT	SP	SM	SEAS	SC	SAFG	MAA	SA	DA	Other
PE (24)	Count	2	6	4	0	1	3	5	1	0	2
	%	8.3%	25.0%	16.7%	.0%	4.2%	12.5%	20.8%	4.2%	.0%	8.3%
TE (36)	Count	11	0	2	19	1	0	2	1	0	0
	%	30.6%	0%	5.6%	52.8%	2.8%	0%	5.6%	2.8%	0%	.0%
CG (31)	Count	0	0	0	0	0	0	0	0	31	0
	%	0%	0%	0%	0%	0%	0%	.0%	0%	100.0%	.0%
Total (91)	Count	13	6	6	19	2	3	31	7	2	2
	%	14.3%	6.6%	6.6%	20.9%	2.2%	3.3%	34.1%	7.7%	2.2%	2.2%

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group, SAT = St. Anthony Tigard, SP = St. Pius, SM = St. Matthew, SEAS = St. Elizabeth Ann Seton, SC = St. Cecilia, SAFG = St. Anthony Forest Grove, MAA = St. Michael and All Angels, SA = St. Alexander, DA = Don't attend, Other = Other.

Table 11.

Parish Affiliation at Baseline with All Responses

Group (N)		SAT	SP	SM	SEAS	SC	SAFG	MAA	SA	DA	Other	Total Responses
PE (24)	Count	2	6	4	0	1	3	0	6	1	2	25
	%	8.3%	25.0%	16.7%	.0%	4.2%	12.5%	0%	25%	4.2%	8.3%	104.2%
TE (36)	Count	11	0	3	21	2	0	0	3	1	0	41
	%	30.6%	0%	8.3%	58.3%	5.5%	0%	0%	8.3%	2.8%	.0%	113.8%
CG (31)	Count	0	0	0	0	0	0	31	0	0	0	31
	%	0%	0%	0%	0%	0%	.0%	100.0%	0%	0%	0%	100.0%
Total (91)	Count	13	6	7	21	3	3	31	9	2	2	97
	%	14.3%	6.6%	7.7%	23.1%	3.3%	3.3%	34.1%	9.9%	2.2%	2.2%	106.6%

Note. PE= Popular Education, TE= Traditional Education, CG= Control Group, SAT = St. Anthony Tigard, SP = St. Pius, SM = St. Matthew, SEAS = St. Elizabeth Ann Seton, SC = St. Cecilia, SAFG = St. Anthony Forest Grove, MAA = St. Michael and All Angels, SA = St. Alexander, DA = Don't attend, Other = Other.

Table 12.

Results of Paired T Tests and Wilcoxon Signed Rank Tests

Outcome Variable	Paired T Tests						Wilcoxon Signed Rank Tests			
	PE Group			TE Group			PE Group		TE Group	
	t	df	Sig.	t	df	Sig.	Z	Sig.	Z	Sig.
Health knowledge	-5.87	14	.000**	-5.33	28	.000**	-3.34	.001*	-4.02	.000**
Ability to promote health	-2.51	14	.025*	-1.75	28	.091	-2.23	.026*	-1.66	.098
Sense of community	-.392	13	.702	-1.18	27	.250	-.436	.663	-.924	.355
Control at community level	-1.76	14	.101	-1.36	25	.185	-1.66	.098	-1.23	.220
Control at personal level	-1.83	14	.089	-2.25	27	.033*	-1.58	.114	-1.99	.047*
Conscientization	-2.22	13	.045*	-2.16	26	.040*	-1.96	.050*	-2.10	.036*
Ability to act for change	-.32	14	.751	-.76	28	.455	-.489	.625	-.528	.597
Empowerment (global)	-2.44	13	.030*	-1.72	24	.098	-2.14	.033*	-1.34	.180
Health status	-1.70	14	.111	-3.52	28	.001**	-1.67	.096	-2.97	.003**
Health behavior	-1.66	14	.119	-4.12	28	.000**	-1.63	.104	-3.42	.001**

Note. * $p \leq .05$, ** $p \leq .01$ (2-tailed)

PE = Popular Education, TE = Traditional Education.

References

- Aguilar, J.V. (1992). *El neoliberalismo* (Neoliberalism). San Salvador, El Salvador: Asociación Equipo Maíz.
- Alinsky, S. (1989). *Reveille for radicals*. New York: Vintage Books.
- Anderson, G.L. (1989). Critical ethnography in education: origins, current status, and new directions. *Review of Educational Research*, 59 (3), 249-270.
- Asociación Equipo Maíz (2003), *Tratado de Libre Comercio (TLC) entre Centroamérica y Estados Unidos* (The Free Trade Agreement between Central America and the United States), San Salvador, El Salvador: Asociación Equipo Maíz.
- Arenas-Monreal, L., Paulo-Maya, A., & López-González, H. E. (1999). Educación popular y nutrición infantil: experiencia de trabajo con mujeres en una zona rural de México. (Popular education and child nutrition: experience of work with women in a rural area of Mexico.) *Revista de Saúde Pública (Journal of Public Health)*, 33(2), 113-121.
- Austin, R. (1999). Popular history and popular education: El consejo de educación de adultos de America Latina (The advisory board for adult education of Latin America). *Latin American Perspectives*, 26, 4, pp. 39-68.
- Baumeister, R.F. (2003). Writing a Literature Review. In M.J. Prinstein and M.D. Patterson (Eds.), *The portable mentor: Expert guide to a successful career in psychology* (pp. 57-71). New York: Kluwer Academic/Plenum Publishers.

- Becker, M. (1996). *Setting the virgin on fire: Lázaro Cardenas, Michoacán peasants, and the redemption of the Mexican revolution*. Berkeley/Los Angeles/London: University of California Press.
- Bernstein, E., Wallerstein, N., Braithwaite, R., Gutierrez, L., Labonte, R., & Zimmerman, M. (1994). Empowerment forum: A dialogue between guest editorial board members. *Health Education Quarterly*, 21, 281-294.
- Bolton, B. (1985). Review of the book *Andragogy in action: applying modern principles of adult learning*. *Personnel Psychology*, 85, 403-406.
- Bralich, J. (1994). *Educación popular: Historia y conceptualización*. Montevideo, Uruguay: Ediciones Populares para América Latina (EPPAL).
- Brasil de fato: Uma visão popular do Brasil e do mundo. (Brazil in fact: A popular vision of Brazil and the world.)* Ano 5, No. 219. 10-16 de maio de 2007. São Paulo.
- Bumiller, E. (2009, July 17). Defense chief criticizes bill to add F-22s. *The New York Times*, p. A13.
- Burns, E.B. (1980). *The poverty of progress: Latin America in the nineteenth century*. Berkeley/Los Angeles/London: University of California Press.
- Caldart, R. S. (2004). *Pedagogia do Movimento Sem Terra (Pedagogy of the Landless Movement)*. São Paulo: Editora Expressão Popular.
- Chang, L., Li, I., & Liu, C. (2004). A study of the empowerment process for cancer patients using Freire's dialogical interviewing. *Journal of Nursing Research*, 12, 1, 41-49.

- Clare, R.C. (2006). Putting faith into action: A model for the North America middle class. *Religious Education*, 101(3), pp. 368-389.
- Community Health Scholars Program (2001). Definition of Community-Based Participatory Research. Website currently unavailable. Can be retrieved from <http://www.sph.umich.edu/chsp/program/index.shtml>
- Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: design and analysis issues for field settings*. Boston: Houghton Mifflin Company.
- de Kadt, E. (1970). *Catholic Radicals in Brazil*. London/New York: Oxford University Press.
- DeSalvo, K. B., Bloser, N., Reynolds, K., He, J., & Muntner, P. (2006). Mortality prediction with a single general self-rated health question. *Journal of General Internal Medicine*, 21, 267-275.
- Driscoll, M.P. (2000). *Psychology of learning and instruction*. Boston: Allyn and Bacon.
- Eisenberg, L. (1984). Rudolf Ludwig Karl Virchow, where are your now that we need you? *The American Journal of Medicine*, 77, 524-532.
- Erickson, F. (1986). Qualitative methods in research on teaching. In Wittrock. M.C. (Ed.), *Handbook of research on teaching*. (3rd Ed., pp.119-161). New York: Macmillan Publishing Co.
- Ferreira-Pinto, J.B., & Ramos,R. (1995). HIV/AIDS prevention among female sexual partners of injection drug users in Cuidad Juarez, México. *AIDS Care*, 7(4), 477-488. Retrieved 1/12/07 from

<http://web.ebscohost.com/ehost/delivery?vid=41&hid=12&sid=f760ffba-06ae-4e23-88f2-9>

- Fontana, A., & Frey, J. H. (2005). The interview: from neutral stance to political involvement. In Norman K. Denzin and Yvonna S. Lincoln (Eds.), *The Sage handbook of qualitative research, third edition* (pp. 695-727). Thousand Oaks, CA: Sage Publications.
- Freire, P. (1978). *Pedagogy in process: The letters to Guinea-Bissau*. New York: Seabury.
- Freire, P. (1985). *The politics of education*. South Hadley, Mass: Bergin and Garvey.
- Freire, P. (1992). *Conversando con educadores (Conversing with educators)*. Montevideo, Uruguay: Editorial Roca Viva.
- Freire, P. (2003). *Pedagogy of the oppressed*. New York: Continuum. (Originally published 1970)
- Gadotti, M. (1994). *Reading Paulo Freire*. Albany, New York: State University of New York Press.
- Galeano, E. (1973). *Open veins of Latin America: Five centuries of the pillage of a continent*. New York/London: Monthly Review Press.
- Garcia, C.M., Gilchrist, L., Centro Campesino, Raymond, N., Naughton, S., Guerra de Patino, J. (2008). Using community-based participatory research to develop a bilingual mental health survey for Latinos. *Progress in Community Health Partnerships: Research, Education, and Action*, 2(2): 105-120. Retrieved November 7, 2009 from

http://muse.jhu.edu.proxy.lib.pdx.edu/journals/progress_in_community_health_partnerships_research_education_and_action/v002/2.2.garcia.pdf

Giroux, H.A. (1985). Introduction. In P. Freire, *The politics of education* (pp. xi-xxv). South Hadley, MA: Bergin and Garvey.

Gómez, M., & Puiggrós, A. (1986). *La educación popular en América Latina 1*. Mexico, D.F.: Secretaria de Educación Pública.

Guba, E.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd Edition) (pp. 191-216). Thousand Oaks, CA: Sage Publications.

Gutierrez, G. (1988). *A theology of liberation*. Maryknoll, NY: Orbis Books.

Harnecker, M. (2002). *Sin tierra: Construyendo movimiento social*. (Without land: Constructing a social movement.) Madrid, Spain: Siglo XXI de España Editores.

hooks, b. (2003). *Teaching community: A pedagogy of hope*. New York/London: Routledge.

Highlander Research and Education Center (2008). Current programs. Retrieved 01-12-08 from <http://www.highlandercenter.org/programs.asp>

Horton, M. (2003). *The Miles Horton reader: Education for social change*, ed. Dale Jacobs (pp. xi-xxviii). Knoxville: The University of Tennessee Press.

Horton, Myles, Kohl, Judith & Kohl, Herbert (1990). *The long haul: An autobiography*. New York: Teachers College Press.

- International Council for Adult Education (ICAE) (2008). About us. Retrieved May 31, 2008, from <http://www.icae.org.uy/>
- Israel, B.A., Checkoway, B., Schulz, A., & Zimmerman, M. (1994). Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly*, 21(2): 149-170.
- Jacobs, D. (2003). Introduction. In M. Horton, *The Miles Horton reader: Education for social change*, ed. Dale Jacobs. Knoxville: The University of Tennessee Press.
- Kane, L. (2001). *Popular education and social change in Latin America*. London: Latin
- Karasek, R., & Theorell, T. (1990). *Healthy work: stress, productivity, and the reconstruction of working life*. New York: Basic Books.
- Kawachi, I., & Kennedy, B.P. (1997). Health and social cohesion: why care about income inequality? *British Medical Journal*, 314, 1037-40.
- Keiffer, C. (1984). Citizen empowerment: A developmental perspective. In Julian Rappaport, Carolyn Swift & Robert Hess (Eds.) *Studies in empowerment: Steps toward understanding and action* (pp. 9-36). New York: The Haworth Press.
- Kincheloe, J. (2005). *Critical pedagogy primer*. New York: Peter Lang.
- Knowles, Malcolm (1988). *The modern practice of adult education: from pedagogy to andragogy*. Englewood Cliffs, NJ: Cambridge Adult Education.

- Kohl, H. (1997). Paulo Freire: Liberation pedagogy. *The Nation*, May 26.
- Kreiger, N., Rowley, D.L., Herman, A.A., Avery, B., & Phillips, M.T. (1993). Racism, sexism, and social class: Implications for studies of health, disease, and well-being. *American Journal of Preventive Medicine*, 9, 82-122.
- Krugman, P. (2009, July 17). The joy of Sachs. *The New York Times*, p. A19.
- Kuhn, Thomas (1996). *The structure of scientific revolutions*. Chicago: The University of Chicago Press.
- Ladson-Billings, G., & Tate, W. (1997). Toward a critical race theory of education. *Teachers College Record*, 97, 47-68.
- Lather, P. (1983). *Feminism, Teacher Education and Curricular Change: Counter-Hegemony and the Possibility for Oppositional Schooling*. Unpublished doctoral dissertation, Indiana University, Bloomington.
- Lather, P. (1986). Issues of validity in openly ideological research; between a rock and a soft place. *Interchange*, 17, 63-84.
- Lugo, N.R. (1996). Empowerment education: A case study of the Resource Sisters/Compañeras program. *Health Education Quarterly*, 23, 281-289.
- Macedo, D. (2003). Introduction. In P. Freire, *Pedagogy of the Oppressed* (pp. 11-27). New York/London: Continuum.
- Mariátegui, J.C. (1928/1981). *Siete ensayos de interpretación de la realidad peruana*. Lima, Perú: Impresa Editora Amauta. (Originally published 1928)
- Marx, K. (1978). The German ideology. In R.C. Tucker (Ed.), *The Marx-Engels reader* (pp. 146-200). New York/London: W.W. Norton and Company.

- Maton, K.I., & Rappaport, J. (1984). Empowerment in a religious setting: A multivariate investigation. *Prevention in Human Services*, 3, 37-70.
- Maxwell, Joseph A. (2005). *Qualitative research design: an interactive approach*. Thousand Oaks, CA: Sage Publications.
- Mayo, P. (1999). *Gramsci, Freire, and Adult Education*. London/New York: Zed Books.
- McLaren, P. & Giarelli, J. M. (Eds.). (1995). *Critical theory and educational research*. Albany, NY: State University of New York Press.
- McQuiston, C., Larson, K., Parrado, E. A., Flaskerud, J. H. (2002). AIDS knowledge and measurement considerations with unacculturated Latinos. *Western Journal of Nursing Research*, 24(4), 354-372.
- Mezirow, J. (2000). *Learning as Transformation*. San Francisco: Jossey-Bass.
- Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis: an expanded sourcebook*. Thousand Oaks, CA: SAGE Publications.
- Minkler, M., & Cox, K. (1980). Creating critical consciousness in health: Applications of Freire's philosophy and methods to the health care setting. *International Journal of Health Services*, 10, 2, pp. 311-322.
- Minkler, M., & Wallerstein, N. (2003). Introduction to community based participatory research. In M. Minkler and N. Wallerstein (Eds.), *Community based participatory research for health* (pp. 3-26). San Francisco: Jossey-Bass.
- Narayan, U. (1988). Working together across difference: Some considerations on emotions and political practice. *Hypatia* 3(2): 31-47.

- Newsom, J. (2006). Basic threats to internal validity. Unpublished handout provided to students in USP 634, Data Analysis I, Spring, 2006.
- Núñez Hurtado, C. (2004). Aportes para el debate latinoamericano sobre la vigencia y proyección de la educación popular. In Consejo de Educación de Adultos de América Latina, Debate Latinoamericano Sobre Educación Popular II: Vigencia de la Educación Popular: Reflexiones de educadores y educadoras de América Latina. (pp. 13-20.) México, D.F: CEAAL.
- Nutbeam, D. (1998). Health promotion glossary. *Health Promotion International*, 13(4), 349-364.
- Paley, Julia (2001). *Marketing democracy: Power and social movements in post-dictatorship Chile*. Berkeley: University of California Press.
- Pappas, G., Queen, S., Hadden, W., & Fisher, G. (1993). The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986. *New England Journal of Medicine*, 329, 103-109.
- Phillips, D.C. & Soltis, J.F. (2004). *Perspectives on learning*. New York: Teachers College Press.
- Prochaska, J.O. & DiClemente, C.C. (1983). Stages and processes of self change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 5, pp. 390–395.
- Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, 9, 1, pp. 1-25.

- Rappaport, J. (1984). Studies in empowerment: Introduction to the issue. In Julian Rappaport, Carolyn Swift & Robert Hess (Eds.) *Studies in empowerment: Steps toward understanding and action* (pp. 1-7). New York: The Haworth Press.
- Ribeiro, Darcy (2007). As Américas e a civilização: Processo de formação e causas do desenvolvimento desigual dos povos americanos. (The Americas and civilization: The process of formation and the causes of unequal development of the American peoples.) São Paulo, Brazil: Editora Schwarcz Ltda. (Originally published 1970).
- Rich, A. (2001). *Arts of the possible*. New York/London: W.W. Norton and Co.
- Rivera, L. (2003). Changing women: An ethnographic study of homeless mother and popular education. *Journal of Sociology and Social Welfare*, 30(2), pp. 31-51.
- Robertson, A., & Minkler, M. (1994). New health promotion movement: A critical examination. *Health Education Quarterly*, 21, 295-312.
- Romero, L., Wallerstein, N., Lucero, J., Fredine, H.G., Keefe, J., & O'Connell, J. (2006). Woman to woman: Coming together for positive change – Using empowerment and popular education to prevent HIV in women. *AIDS Education and Prevention*, 18, 390-405.
- Serrano-García, I. (1984). The illusion of empowerment: Community development within a colonial context. In Julian Rappaport, Carolyn Swift & Robert Hess (Eds.) *Studies in empowerment: Steps toward understanding and action* (pp. 173-200). New York: The Haworth Press.

- Sfard, A. (1998). On two metaphors for learning and the dangers of choosing just one. *Educational Researcher*, 27, 2, pp. 4-13.
- Smith, Christian (1991). *The emergence of liberation theology: Radical religion and social movement theory*. Chicago: The University of Chicago Press.
- Stédile, J. P. & Fernandes, B.M. (1999). *Brava gente: A trajetória do MST e a luta pela terra no Brasil*. (Brave people: The trajectory of the MST and the struggle for land in Brasil.) São Paulo, Brasil: Editora Fundação Perseu Abramo.
- Steinhauer, J. (2009, July 16). California near budget deal, slashing money for schools and cities. *The New York Times*, p. A14.
- Stiglitz, J. (2002). *Globalization and its discontents*. New York/London: W.W. Norton and Company.
- Stone, D. (2002). *The policy paradox: The art of political decision making*. New York/London: W.W. Norton and Company.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Swift, C. (1984). Foreword. Empowerment: An antidote for folly. In Julian Rappaport, Carolyn Swift & Robert Hess (Eds.) *Studies in empowerment: Steps toward understanding and action* (pp. xi-xv). New York: The Haworth Press.
- Tashakkori, A. & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications.
- Thompson, G. (2009, July 17). Some terms reached in Honduras dispute. *The New York Times*, p. A9.

U.S. Public Health Service. Healthy people 2010: 11 Health Communication.

Retrieved January 2, 2008, from

<http://www.healthypeople.gov/Document/HTML/Volume1/11HealthCom.htm>.

Wallace, R.A., & Wolf, A. (2006). *Contemporary sociological theory: Expanding the classical tradition*. Upper Saddle River, NJ: Pearson-Prentice Hall.

Wallerstein, N. B. (1988). Empowerment education: Freire's theories applied to health: a case study of alcohol prevention for Indian and Hispanic youth.

Unpublished doctoral dissertation, University of California, Berkeley.

Wallerstein, N. (1992). Health and safety education for workers with low-literacy or limited-English skills. *American Journal of Industrial Medicine*, 22(5), 751-765.

Wallerstein, N. (1992a). Powerlessness, empowerment, and health: Implications for health promotion programs.

Wallerstein N. (2002). Empowerment to reduce health disparities. *Scandinavian Journal of Public Health*, 30, pp. 72-77.

Wallerstein, N. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network Report: [http: www.euro.who.int/Document/E88086.pdf](http://www.euro.who.int/Document/E88086.pdf), accessed 01 February 2006).

Wallerstein, N., & Auerbach, E. (2004). *Problem-posing at work: Popular educator's guide*. Edmonton, Alberta: Grass Roots Press.

- Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly*, 15 (4), 379-394.
- Wallerstein, N., & Duran, B. (2003). The conceptual, historical, and practice roots of community based participatory research and related participatory traditions. In M. Minkler and N. Wallerstein (Eds.), *Community based participatory research for health* (pp. 27-52). San Francisco: Jossey-Bass.
- Ware, J.E. (2008). *SF-36 health survey update*. Retrieved May 31, 2008, from <http://www.sf-36.org/tools/SF36.shtml>
- Weinger, M. & Lyons, M. (1992). Problem-solving in the field: An action-oriented approach to farmworker education about pesticides. *American Journal of Industrial Medicine*, 22(5), 677-690.
- Werner, D., & Bower, B. (1982). *Helping health workers learn*. Palo Alto, CA: The Hesperian Foundation.
- Wiggins, N. & Borbón, A. (1998). Core roles and competencies of community health workers. In E.L. Rosenthal, N. Wiggins, N. Brownstein, & S. Johnson (Eds.), *Final report of the national community health advisor study*. Baltimore: Annie E. Casey Foundation, 15-49.
- Wiggins, N., & Ballentine, P. (2006). American Heart Association (AHA), Search Your Heart (SYH) and De Corazón a Corazón (DCAC), Final Report for January 1, 2006 through June 30, 2006. Unpublished report, Portland, Oregon.
- Wiggins, N., Johnson, D., Avila, M., Farquhar, S.A., Michael, Y.L., Rios, T., and López, A. (2009). Using popular education for community empowerment:

- Perspectives of Community Health Workers in the *Poder es Salud*/Power for Health program. *Critical Public Health*, 19, 11-22.
- Williams, A. B., Burgess, J. D., Danvers, K., Malone, J., Winfield, S. D., & Saunders, L. (2005). Kitchen table wisdom: A Freirian approach to medication adherence. *Journal of the Association of Nurses in AIDS Care*, 16 (1), 3-12.
- Wilson, N., Minkler, M., Dassho, S., Carrillo, R., Wallerstein, N., & Garcia, D. (2006). Student facilitators and collaborative teams for participation: Training student facilitators in the Youth Empowerment Strategies (YES!) Project. *Journal of Community Practice*, 14, 1/2, 201-217.
- Wright, B., & Wiggins, N. (2008). *La palabra es salud: A comparative study of popular education vs. traditional education in a parish-based Community Health Worker program*. Unpublished grant proposal submitted to the Natl. Institutes of Health, Agency for Healthcare Quality and Research.
- Young, M. (1999). Multifocal educational policy research: Toward a method for enhancing traditional educational policy studies. *American Educational Research Journal*, 36(4), 677-714.
- Youngman, F. (1986). *Adult education and socialist pedagogy*. London: Croom Helm.
- Zimmerman, M. A. (1990). Taking aim on empowerment research: On the distinction between individual and psychological control. *American Journal of Community Psychology*, 18, 169-177.

- Zimmerman, M. A., & Rappaport, J. (1988). Citizen participation, perceived control, and psychological empowerment. *American Journal of Community Psychology, 16*(5): 725-750.
- Zimmerman, M. A. & Zahniser, J. H. (1991). Refinements of sphere-specific measures of perceived control: Development of a socio-political control scale. *Journal of Community Psychology, 19*, 189-204).

Appendix A: Comparison of Popular Education and Traditional Education

Popular Education	Traditional Education
Emphasis on social change/just society	Emphasis on learning topic of class
The purpose of education is to empower participants to think critically and make change at the personal and collective levels.	The purpose of education is to equip students with the skills they will need to succeed in the marketplace.
Experiential knowledge is as important as academic knowledge.	Academic knowledge is more valuable than experiential knowledge.
Knowledge is constructed in the interaction between people.	Knowledge is pre-existing.
It is important to create an atmosphere of trust so that people feel comfortable sharing ideas and experiences.	The atmosphere or feeling tone of the educational setting is not emphasized.
Participants' life experience is the most important content for learning.	Subject matter selected by the teacher is the most important content.
Everyone is a teacher; everyone is a student.	There is one teacher and many students.
Egalitarian learning environment	Teacher is the expert and has higher status.
Democratic decision-making	Hierarchical decision-making
Careful listening is an essential behavior for all.	Careful listening is an essential behavior for students.
Teachers need to share participants' life experiences.	Teachers do not need to share participant's life experiences.
Learning is both an intellectual and an emotional process.	Learning is an intellectual process.
Interactive methods are used, including games, simulations, dinámicas, sociodramas, and cooperative small group work.	Primary techniques are lecture, memorization, and drills.
Variety of learning styles and literacy levels are accommodated.	There is one preferred learning style, which is auditory and passive. A visual learning style is accommodated to some degree.
Extensive use of the arts (drama, music, visual art)	Limited use of the arts.
Participants are members of a community.	Participants are a collection of individuals.

Sources: Bralich, 1994; Ferreira-Pinto & Ramos, 1995; Freire 1970/2003; Horton, 2003; Nuñez, 2004; Weinger, 1992.

Appendix B1: *La Palabra es Salud* (The Word is Health) CHW Questionnaire

SECTION ONE

The questions in Section 1 have to do with your knowledge about health and health care.

Check true or false for the following statements:

1. Type I diabetes is ordinarily diagnosed in children and young adults.
True _____ False _____
2. Most of the differences in the health of different groups in society are due to their personal choices.
True _____ False _____
3. To be physically fit, it's necessary to go to a gym.
True _____ False _____
4. Income level is considered a "social determinant of health."
True _____ False _____
5. Liquid oils for cooking are generally healthier than solid fats (like lard).
True _____ False _____
6. Generally, you should eat more meat than grains every day.
True _____ False _____
7. The best way to lose weight is by following a strict diet.
True _____ False _____
8. The American Heart Association recommendation for physical activity for all healthy adults between 18 and 65 is 15 minutes of moderate physical activity 5 times a week.
True _____ False _____
9. Obesity by itself increases the risk of heart disease.
True _____ False _____
10. If you go to the doctor with a virus, you should receive a prescription for medication.
True _____ False _____

11. In general, Latinos in the U.S. are at higher risk for diabetes than Anglos/Whites.
True _____ False _____

Check the one correct answer to the questions below:

12. Which of the following is the most desirable blood pressure level?
____ 130/90
____ 180/110
____ 140/80
____ lower than 120/80
13. The main cause of high blood pressure is:
____ Stress
____ Aging
____ Unknown
____ Obesity
14. Which of the following is **NOT** a common sign of depression?
____ Loss of interest in normal daily activities
____ Excessive worry
____ Loss of interest in sex
____ Irritability
____ Difficulty making decisions
15. Major risk factors for heart disease and stroke include: (check only one)
____ High blood pressure
____ High cholesterol
____ Smoking
____ Family history of heart disease
____ All of the above
16. Which of the following is a symptom of diabetes? (check only one)
____ Excessive worry
____ Frequent urination
____ Eating a lot of salt in your food
____ Rapid heart rate
17. Which of the following is a law that concerns confidentiality of medical records?
(check only one)
____ Americans with Disabilities Act
____ HIPAA
____ Patriot Act
____ Patient Navigator Act

SECTION TWO

The questions in Section 2 have to do with your feelings about yourself and your community.

Check to indicate how much you agree or disagree with the following statements.

In these statements, the word “community” refers to the Latino congregation at the parish you most often attend.

18. I feel quite confident about my ability to *share health information* in my community.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

19. I feel quite confident about my ability to *promote health* in my community.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

20. I think my community is a good place to participate.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

21. People in my community share the same values.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

22. I feel at home in this community.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

23. It is very important to me to participate in this particular community.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

24. I expect to participate in this community for a long time.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

25. My community is a good place for my kids to grow up and thrive.

Agree strongly ____ Agree _____ Disagree _____ Disagree strongly _____

26. My community has control over decisions that affect my life.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
27. I can control decisions that affect my community.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
28. By working together, people in my community can control decisions that affect the
 community.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
29. People in my community work together to control decisions on the state or
 national level.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
30. I am satisfied with the amount of control I have over decisions that affect my
 community.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
31. I have control over the decisions that affect my life.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
32. I am satisfied with the amount of control I have over decisions that affect my life.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
33. I am often a leader in groups.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
34. I find it very easy to talk in front of a group.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
35. I can usually organize people to get things done.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____

36. I am a person who believes in myself. I can make it in this world.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
37. I understand quite well how my individual problems are connected to bigger
 problems at the state, national and global level.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
38. I can explain to others in my community how our problems as a community are
 connected to bigger problems at the state, national, and global level.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
39. I understand quite well how historical factors affect my life today.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
40. I feel very motivated to work with others to solve problems in my community.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
41. I have worked with others in my community to solve community problems.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
42. By working together, we (people in my community and I) have been able to solve
 community problems.
 Agree strongly ____ Agree _____ Disagree _____ Disagree
 strongly _____
43. I am a member of one or more boards of directors, advisory committees, parish
 councils, etc.
 Yes _____ No _____

SECTION THREE

The questions in Section 3 have to do with your health and your health habits.

44. In general, would you say that your health is: (check only one)
 Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

45. Have you smoked at least a hundred cigarettes in your entire life?
 Yes _____ No _____

46. Do you now smoke cigarettes every day, some days, or not at all?
 Every day _____ Some days _____ Not at all _____

How often do you take the following actions?

47. I get 30 minutes or more of physical activity at least five times a week.
 Never _____ Sometimes _____ Usually _____
 Always _____

48. I eat 5 or more servings of fruits and vegetables per day.
 Never _____ Sometimes _____ Usually _____
 Always _____

49. I make an effort to manage my weight in a healthy manner.
 Never _____ Sometimes _____ Usually _____
 Always _____

50. I find healthy ways to respond to stress.
 Never _____ Sometimes _____ Usually _____
 Always _____

51. I limit the amount of saturated fat in my diet.
 Never _____ Sometimes _____ Usually _____
 Always _____

52. I limit the amount of refined sugar in my diet.
 Never _____ Sometimes _____ Usually _____
 Always _____

Please answer the following questions about your health care.

53. Where do you usually go to receive medical care?
Mark only one.
 _____ A private doctor's office or clinic

- ☐ A public health clinic, community health center, or tribal clinic
☐ A hospital-based clinic
☐ A hospital emergency room
☐ An urgent care clinic
☐ Some other place not listed here
 (where?) _____
☐ I don't have a usual place
☐ I don't know

54. What is a reason you might go to the emergency room for care?

Mark all that apply.

- ☐ I need emergency care
☐ Doctors' offices/clinics are closed
☐ I can't get an appointment to see a regular doctor soon enough
☐ I don't have a personal doctor
☐ I can't afford the co-pay to see a doctor
☐ I need a prescription drug
☐ I don't know where else to go
☐ Some other reason: _____
☐ I don't know
☐ I never go to the emergency room

**The following questions help us understand your particular situation.
Remember, your answers will be kept confidential.**

55. How old are you? _____

56. What is your gender? Male _____ Female _____

57. Where were you born?

City/Town/Village _____ State _____ Country _____

58. How many **years** have you lived in the United States? _____

(If you have lived in the United States several different times, add the different times together to come up with the total time you have spent living in the United States.)

59. Are you (mark only one):

Single, never married _____ Married _____ Widowed _____
 Partnered _____ Divorced _____ Other (specify): _____

60. Which one or more of the following would you say is your ethnicity?

Mark all that apply.

Hispanic/Latino _____ American Indian _____
 White/Anglo _____ Black/African American _____
 Asian/Pacific Islander _____ Other (specify): _____

61. Are you (*mark all that apply*):

Working _____ Unemployed _____
 Temporarily laid off _____ Student taking classes _____
 On sick/maternity leave _____ Retired _____
 Looking for work _____ I do not work because of disability _____
 Homemaker _____ Other (explain): _____

62. Please circle the highest grade of school or year of college you completed:

GRADE OF SCHOOL											COLLEGE				
0	1	2	3	4	5	6	7	8	9	10	13	14	15	16	17+
11	12														

63. How many children do you have? _____

64. What language do you prefer to speak?

Spanish _____ English _____ Other (specify): _____

65. Please check the box next to the amount that comes closest to your total family income last year, before you paid taxes. Be sure to count monies of all family members living at home. Count social security, disability or unemployment benefits, help from relatives – all the ways you can get money.

- ☐ Under \$2000 (1) ☐ \$40000-\$49999 (9)
- ☐ \$2000-\$4999 (2) ☐ \$50000 or more (10)
- ☐ \$5000-\$9999 (3)
- ☐ \$10000-\$14999 (4)
- ☐ \$15000-\$19999 (5)
- ☐ \$20000-\$24999 (6)
- ☐ \$25000-\$29999 (7)
- ☐ \$30000-\$39999 (8)

66. Which parish do you most often attend? (choose one)

St. Anthony's (Tigard) ☐

St. Elizabeth Ann Seton ☐

St. Pius ☐

St. Cecilia ☐

St. Alexander's ☐

St. Anthony's (Forest Grove) ☐

St. Matthews ☐

St. Michael and All Angels ☐

I don't attend a parish ☐

Other (Name): _____

**This is the end of the survey.
Thank you very much for your time!**

Appendix B2: *La Palabra es Salud*: Cuestionario para Promotores/as de Salud

SECCION 1

Las preguntas en la primera sección tienen que ver con su conocimiento acerca de la salud y el cuidado de salud.

Marque para indicar si las siguientes frases son ciertas o falsas:

1. Por lo general, el Diabetes Tipo I es diagnosticado en niños y adolescentes.
Cierto ____ Falso ____
2. La mayoría de diferencias de salud en los diferentes grupos de la sociedad se deben a las decisiones personales.
Cierto ____ Falso ____
3. Para estar en buena condición física, es necesario ir a un gimnasio.
Cierto ____ Falso ____
4. El nivel de ingresos es considerado un “determinante social de salud.”
Cierto ____ Falso ____
5. Generalmente, los aceites líquidos para cocinar son mas saludables que los sólidos (como manteca).
Cierto ____ Falso ____
6. En general, se debe de consumir más carne que granos diariamente.
Cierto ____ Falso ____
7. La mejor manera de bajar de peso es seguir una dieta estricta.
Cierto ____ Falso ____
8. La recomendación de la Asociación Americana del Corazón para actividad física para todos los adultos saludables entre 18 y 65 años es 15 minutos de ejercicio moderado 5 veces a la semana.
Cierto ____ Falso ____
9. La obesidad por si sola aumenta el riesgo de enfermedades del corazón.
Cierto ____ Falso ____

10. Si ud. va al doctor y tiene un virus, ud. debe recibir una receta para medicina.

Cierto _____ Falso _____

11. En general, los Latinos en los Estados Unidos están a más alto riesgo para la diabetes que los Anglos/Blancos.

Cierto _____ Falso _____

Escoja la única respuesta correcta a las siguientes preguntas:

12. ¿Cuál es el nivel de presión arterial más deseable?

- _____ 130/90
- _____ 180/110
- _____ 140/80
- _____ Menos de 120/80

13. La causa principal de la presión arterial alta es:

- _____ Estrés
- _____ La edad
- _____ No se sabe
- _____ Obesidad

14. De las siguientes opciones, ¿cuál **NO** es una señal común de depresión?

- _____ Pérdida de interés en las actividades cotidianas
- _____ Preocupación extremada
- _____ Pérdida de interés en sexo
- _____ Irritabilidad
- _____ Dificultad para tomar decisiones

15. Los mayores factores de riesgo para enfermedades del corazón y derrames cerebrales incluyen: (Marque solo una)

- _____ Presión alta
- _____ Colesterol alto
- _____ Fumar
- _____ Una historia familiar de enfermedad del corazón
- _____ Todo lo anterior

16. De las siguientes opciones, ¿cuál es un síntoma de la diabetes? (Marque solo una)

- _____ Preocupación extremada
- _____ Orinar frecuentemente
- _____ Comer mucha sal en la comida
- _____ Latidos rápidos de corazón

17. De las siguientes opciones, ¿cuál es una ley que concierne la confidencialidad de los archivos médicos?

- ___ Acta de Americanos con Discapacidades
- ___ HIPAA
- ___ Acta de Patriotas
- ___ Acta de los Navegantes de Salud

SECCION 2

Las preguntas en la sección 2 tienen que ver con sus sentimientos acerca de si misma y su comunidad.

Marque para indicar cuanto está de acuerdo o en desacuerdo con las siguientes declaraciones.

En estas declaraciones, la palabra “comunidad” se refiere a la congregación Latina de la parroquia que más asiste.

18. Me siento bastante seguro(a) en mi capacidad de ***compartir información de salud*** en mi comunidad.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

19. Me siento bastante seguro(a) en mi capacidad de ***promover la salud*** en mi comunidad.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

20. Creo que mi comunidad es un buen lugar para participar.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

21. La gente de mi comunidad comparte los mismos valores.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

22. Me siento como en mi casa en esta comunidad.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

23. Para mi es muy importante participar en esta comunidad en particular.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

24. Espero participar en esta comunidad por un largo tiempo.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

25. Mi comunidad es un buen lugar para que mis hijos(as) crezcan bien.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

26. Mi comunidad tiene control sobre decisiones que afectan mi vida.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

27. Yo puedo controlar decisiones que afectan a mi comunidad.

Muy de acuerdo ___ De Acuerdo ___ En Desacuerdo ___ Muy en desacuerdo ___

28. Trabajando juntos, la gente de mi comunidad puede controlar decisiones que afectan a la comunidad.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
29. La gente en mi comunidad trabajan juntos para controlar decisiones a nivel estatal o nacional.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
30. Estoy satisfecho(a) con la cantidad de control que tengo sobre las decisiones que afectan a mi comunidad.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
31. Tengo control sobre las decisiones que afectan mi vida.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
32. Estoy satisfecho(a) con la cantidad del control que tengo sobre las decisiones que afectan mi vida.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
33. A menudo soy el(la) líder en grupos.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
34. Tengo facilidad para hablar frente a un grupo.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
35. Normalmente puedo organizar a las personas para hacer cosas.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
36. Soy una persona que creo en mi mismo(a). Puedo seguir adelante en este mundo.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
37. Entiendo muy bien como mis problemas individuales están conectados a problemas mayores a nivel estatal, nacional y global.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
38. Yo puedo explicarle a otros en mi comunidad cómo nuestros problemas como comunidad están conectados a problemas mayores a nivel estatal, nacional y global.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
39. Yo entiendo muy bien cómo los factores históricos afectan mi vida hoy día.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
40. Me siento muy motivado(a) para trabajar con otras personas para resolver problemas en mi comunidad.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
41. Yo he trabajado con otras personas en mi comunidad para resolver problemas en mi comunidad.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____

42. Al trabajar juntos, nosotros (mi comunidad y yo) hemos podido resolver problemas de la comunidad.
Muy de acuerdo ____ De Acuerdo ____ En Desacuerdo ____ Muy en desacuerdo ____
43. Soy miembro/a de uno o más mesas directivas, comités de asesoría, consejos de la parroquia, etc.
Sí ____ No ____

SECCION 3

Las preguntas en la sección 3 tienen que ver con su salud y sus hábitos de salud.

44. ¿Diría ud. que su estado de salud general es: (marque solo una)
Excelente ____ Muy bueno ____ Bueno ____ Regular ____ Malo ____
45. ¿Ha fumado al menos 100 cigarrillos en toda su vida? Si ____ No ____
46. Actualmente, ¿fuma cigarrillos todos los días, algunos días o nunca lo hace?
Todos los días ____ Algunos días ____ Nunca lo hace ____

¿Con cuánta frecuencia tome las siguientes acciones?

47. Hago alguna actividad física por 30 minutos o más por los menos 5 veces por semana.
Nunca ____ A veces ____ Usualmente ____ Siempre ____
48. Como 5 porciones o más de frutas y verduras todos los días.
Nunca ____ A veces ____ Usualmente ____ Siempre ____
49. Hago un esfuerzo para manejar mi peso de una forma saludable.
Nunca ____ A veces ____ Usualmente ____ Siempre ____
50. Encuentro formas saludables para responder al estrés.
Nunca ____ A veces ____ Usualmente ____ Siempre ____
51. Limito la cantidad de grasa saturada en mi dieta.
Nunca ____ A veces ____ Usualmente ____ Siempre ____
52. Limito la cantidad de azúcar en mi dieta.
Nunca ____ A veces ____ Usualmente ____ Siempre ____

Por favor, responda a las siguientes preguntas acerca de su cuidado de salud.

53. ¿Adónde va usted generalmente para recibir atención médica?

Marque sólo una respuesta.

- ☐ Consultorio médico o clínica privada
- ☐ Clínica de salud pública, centro comunitario de salud o clínica de salud del tribu
- ☐ Clínica que es parte de un hospital
- ☐ Sala de emergencias de un hospital
- ☐ Clínica de atención urgente
- ☐ Otro lugar que no está en esta lista (¿dónde?) _____
- ☐ No tengo un lugar donde usualmente recibo atención medica
- ☐ No sé.

54. ¿Qué es una razón para la cual usted iría a la sala de emergencias para atención médica?

Marque todas las que correspondan.

- ☐ Necesito atención de emergencia
- ☐ Los consultorios médicos/clínicas están cerrados/as
- ☐ No puedo conseguir una cita para ver a un doctor con la rapidez necesaria
- ☐ No tengo un doctor
- ☐ No puedo pagar el co-pago para ir a ver un doctor
- ☐ Necesito un medicamento recetado
- ☐ No sé adónde más ir
- ☐ alguna otra razón: _____
- ☐ No sé
- ☐ Nunca voy a la sala de emergencias

Las siguientes preguntas nos ayudan a entender su situación en particular. Recuerde que sus respuestas son confidenciales.

55. ¿Cuántos años tiene ud.? _____

56. Sexo: Masculino _____ Femenino _____

57. ¿En dónde nació?

Ciudad/Pueblo/Aldea _____ Estado _____ País _____

58. ¿Por cuántos **años** ha vivido en los Estados Unidos? _____

(Si ha vivido por temporadas diferentes en los Estados Unidos, sume las temporadas y ponga el total.)

59. ¿Es ud. (marque uno):

Soltero(a) _____ Casado(a) _____ Viudo(a) _____ Divorciado(a) _____
Acompañado(a)/Unión Libre _____ Otro(a) (especifique): _____

60. ¿Cuál o cuáles de las siguientes diría que es el grupo étnico al que ud. pertenece?
(Marque cuántos aplican)

Hispano(a)/Latino(a) _____ Indio-americano(a) (indígena) _____
Anglo(a)/Blanco(a) _____ Afro-americano(a) _____
Asiático(a)/Islas del Pacífico _____ Otro(a) (especifique): _____

61. ¿Es/Está ud. (marque los que apliquen):

Trabajando _____ Desempleado(a) _____
Temporalmente despedido _____ Tomando clases (estudiante) _____
Enfermedad/Maternidad _____ Jubilado(a) _____
Buscando trabajo _____ No trabajo por razones de discapacidad _____
Ama de casa _____ Otro (especifique): _____

62. Por favor, circule el nivel escolar más alto que completó:

Año Escolar (primaria, secundaria, etc.)												Universitario				
0	1	2	3	4	5	6	7	8	9	10	11	13	14	15	16	17+
						12										

63. ¿Cuántos hijos(as) tiene? _____

64. ¿Qué idioma prefiere hablar?

Español _____ Inglés _____ Otro (especifique): _____

65. Marque la cajita al lado de la cantidad que es más cerca al total de ingresos de su familia el año pasado, antes de pagar impuestos. Asegure de contar todo el dinero de todos los familiares que viven con ud. Cuente el seguro social, beneficios de discapacidad o desempleo, ayuda de los familiares – todas las formas que ud. adquiere dinero.

☐ Menos de \$2000 (1)

☐ \$2000-\$4999 (2)

☐ \$5000-\$9999 (3)

☐ \$10000-\$14999 (4)

☐ \$15000-\$19999 (5)

☐ \$20000-\$24999 (6)

☐ \$25000-\$29999 (7)

☐ \$30000-\$39999 (8)

☐ \$40000-\$49999 (9)

☐ \$50000 o más (10)

66. ¿A qué parroquia asiste con más frecuencia? (escoja una)

San Antonio (Tigard)

☐

Sta. Elizabeth Ann Seton

☐

San Pius

☐

Sta. Cecilia

☐

San Alejandro

☐

San Antonio (Forest Grove)

☐

San Mateo

☐

San Miguel y Todos los Angeles

☐

No asisto a ninguna parroquia

☐

Otro (Nombre): _____

**Aquí termina el cuestionario.
¡Muchas gracias por su tiempo!**

Appendix C: Guide for Informing Prospective CHWs

QUÈ SE ESPERA DEL ENTRENAMIENTO DE PROMOTORES DE SALUD

- ❖ Todas las clases son en español, gratis y no importa tu estado legal. (si tienes o no tienes “papeles”) La información es confidencial.
- ❖ Es un programa de voluntarios y una oportunidad de entrenamiento para hacer ministerio. NO es un entrenamiento para conseguir un trabajo.
- ❖ Se proporciona cuidado de niños. Por favor traer todo lo necesario: pañales, botellas con alimento para bebés, bocadoillos, etc.
- ❖ Al terminar el curso, se proporcionará un certificado del grupo médico Providence y de la Arquidiócesis.

Queremos que usted esté enterado de lo siguiente:

- ❖ En este otoño, se va a hacer una evaluación del programa que se le va a explicar con mas detalle durante las clases. Se le va a pedir llenar una evaluación anónima (sin poner su nombre) que usted deberá llenar durante las clases.

¿Qué se espera?

- ❖ Las clases van a empezar a tiempo. Por favor llegar 15 minutos antes, para registrarse y saludar a los compañeros.
- ❖ Usted deberá atender TODAS las clases. Puede solo faltar a 3 clases por algún motivo urgente y arreglado con la coordinadora de antemano, para que se le pueda dar su certificado. La clase de RCP/primeros auxilios es obligatoria si se desea recibir el certificado.
- ❖ Debe atender la Misa de Graduación.
- ❖ Hay un compromiso de dar servicio con el grupo parroquial del ministerio de salud. Aproximadamente 4 horas por mes, como mínimo.
- ❖ Crédito en PSU, el costo es de \$55 por crédito/hora. Esto es opcional.
- ❖ Se deben dar reportes mensuales de las actividades realizadas. Todo la información relativa/personal debe ser CONFIDENCIAL. Con frecuencia se pide que se atiendan programas de capacitación y juntas en la parroquia.
- ❖ El entrenamiento que se proporciona es para mejorar la salud y aprender, pero no para hacer diagnósticos o curaciones.

- ❖ No se permite hacer negocios, ventas, solicitar donaciones o recaudar dinero.

Para contactar las Coordinadoras del Programa de Providence – 503-216-7192

- ❖ Adela Hughes, Directora del Programa de Promotores de Salud de la Iglesia
- ❖ Adriana Rodriguez, Co-coordinadora de la Capacitación

**Appendix D: *La Palabra es Salud* (The Word is Health)
Informed Consent for Training and CHW Questionnaire**

You are invited to participate in a research study being conducted by Noelle Wiggins. Noelle is working on her doctorate in Education at Portland State University and she is doing this research in order to partly fulfill the requirements of her program. Noelle is supervised by Dr. Karen Noordhoff, a Professor in the Graduate School of Education at PSU.

The purpose of this study is to learn whether different kinds of training affect Community Health Workers differently. For example, do CHWs learn more from one kind of training than from another kind of training? Various organizations are participating in this project. They include Providence Health and Services, El Programa Hispano, the Multnomah County Health Dept., and the Parish Health Promoter Program.

You were selected as a possible participant in this study because you participate in the Latino/Spanish-speaking community at [name of parish] and are able and willing to complete the CHW training and carry out health promotion activities in your parish community.

If you decide to participate, you will be asked to participate in one of two training series that will be held over the course of 14 Saturdays, starting on September 6, 2008, and ending on December 13, 2008. Each class will be four hours long. In addition, you will be asked to complete a questionnaire. The questionnaire will cover the following topics:

- Your general health
- Your sense of community in your Spanish-speaking congregation
- Your health knowledge and ability to share health information
- Your own feelings about your ability and your community's ability to make change
- Your health behaviors

While participating in the training, you may participate in physical activities that involve a small physical risk. Some of the things you hear or think during the training may be different from things you have been taught. Some things you learn might cause you to act differently with family members, parish leaders, and others. We will do all we can to support you to use your new information for the good of you, your family and your community.

While completing the questionnaire, you may feel uncomfortable because of some of the questions we ask. If you do agree to complete the questionnaire, you don't have to answer any questions you don't want to. You can stop at any time.

As a result of participating in the training, you should learn new information and skills that are useful to you and your community. You may not receive any direct benefit from completing the questionnaire, but the information we collect may help us and others to provide more effective training for Community Health Workers.

Your privacy is very important to us. What you tell us will be kept confidential. This means your name will not be given to anyone else and we will only report or summarize what you say in a way that no one would know it was you who said it. Only the researchers will be able to connect your name with your answers to the questionnaire. Your personal information, which we will need in order to connect your answers on the pre-questionnaire to your answers on the post-questionnaire, will be kept in a locked file cabinet. There is one exception to this rule. If, during your participation in this study, you tell us that you are, or are intending to, harm yourself or others, we are ethically and legally required to notify the appropriate authorities.

Your participation is voluntary. You do not have to participate in the training or the questionnaire. If you chose not to participate, it will not affect your ability to participate in your parish community or in any of the programs offered by Providence Health and Services, the Multnomah County Health Department, or El Programa Hispano. You can also stop participating in the training at any time without it affecting your relationship with your parish leaders.

If you have concerns or questions about your participation in this study or your rights as a research participant, please contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 600 Unitus Building, Portland State University, (503) 725-428. If you have any questions or concerns about this particular study, the training, the questionnaire, or this form, you can call Noelle Wiggins at (503) 988-6250, x26646.

Your signature means:

- You have read and understand what this forms says, or it has been read to you;
- You are willing to participate in the training and complete the questionnaire;
- You know that you do not have to participate in this study. Even if you agree, you can change your mind and stop at any time; and
- You will get a copy of this form to keep for yourself.

Participant Signature: _____

Participant name, printed: _____

Date: _____

Appendix E: Parish Health Promoter Program Expectations for Facilitators

Thank you very much for agreeing to facilitate one or more sessions during the 14-week training for Community Health Workers (CHWs, also called *promotores de salud*) being presented by the Parish Health Promoter Program (PHPP) of Providence Health and Services. As you know, this year the PHPP is participating in a research study titled, *La Palabra es Salud*.

Study Purpose, Design, and Potential Outcomes

The primary purpose of the study is to determine whether one of two educational methods (popular education or traditional education) is more effective at helping CHWs to build their skills, improve their health behavior and health status, and increase their own empowerment. In addition, the study should provide information about the elements that contribute to the success of a CHW training program. The study will employ a quasi-experimental design, mixed methods, and a community-based participatory research (CBPR) framework. We hope that this study will increase the quality of training that CHWs receive, thus increasing their effectiveness in their communities. Ultimately, this may result in better health for the marginalized communities that CHWs most often serve.

Expectations of Facilitators

In order to safeguard the scientific integrity of the study, it is necessary to assure that a number of conditions are met by the facilitators:

- The content covered in the two analogous sessions (popular education and traditional education) must be the same. A content outline for your session will be provided to you.
- Facilitators must adhere to the characteristics of their particular philosophy and methodology, as described in the table, “Comparison of Popular Education and Traditional Education.”
- Please allow time for participants to ask questions and include a review of key content at the end of the session.
- A researcher may be present in your session as a participant observer. It is appropriate to acknowledge her presence and allow her to introduce herself; however, she will not participate in small group activities so that she can observe all groups.

All lesson plans will be reviewed for content and methodology. To provide time for review, please submit your lesson plan one month before your session is scheduled. We recognize that you are offering your time as a volunteer facilitator and want to express our gratitude to you for assisting us by submitting your lesson plan one month in advance.

Your Role as a Facilitator

This study will take place with the approval of the Human Subjects Research Review Board of Portland State University, and all study participants will be required to sign an informed consent. As a facilitator, you are not a study participant; therefore, no informed consent is needed. In other words, your individual facilitation is not being studied, but it is extremely important for the sake of the study that you follow the “facilitator expectations” listed above.

Thank you again! We couldn't do this study without you!

Appendix F: Curriculum Master List

Note: Due to limitations in facilitator availability, sessions did not occur in exactly this order in both groups. Overall, however, this list represents the general order in which topics were addressed.

Topic	Objectives (By the end of the session, participants will . . .)
Session 1: Orientation to Program and Research Project	<ol style="list-style-type: none"> 1. Know essential information about the Parish Health Promoter Program (history, current status, purpose); 2. Know essential information about <i>La Palabra es Salud</i>, the research study about the PHPP; and 3. Understand what is expected of participants in the program and the research study and how they may benefit.
Session 2: The CHW as Community Leader	<ol style="list-style-type: none"> 1. Be familiar with the history of the CHW profession, both in the U.S. and around the world; 2. Know more about the roles that CHWs play; 3. Understand that the call to be a CHW is a call to leadership and ministry; 4. Be aware of the similarity between the qualities and skills of a CHW and the qualities and skills of a leader; and 5. Understand that “health” includes physical, mental, and spiritual health.
Session 3: Teaching Skills	<ol style="list-style-type: none"> 1. Be able to identify and use at least 3 educational methods; 2. Enhance their understanding of how people learn (educational psychology); 3. Know the steps necessary to plan and present a successful class; 4. Be able to create a lesson plan; and 5. Understand the importance of evaluation and know some basic evaluation techniques.
Session 4: Exercise Anatomy and Physiology	<ol style="list-style-type: none"> 1. Be familiar with the body parts and body processes that are most related to exercise, especially the cardiovascular system; 2. Be familiar with the benefits of exercise; 3. Have ideas for how to include an exercise routine in daily life, including the benefit of having an exercise partner; 4. Understand the significance of vital signs such as pulse and blood pressure. (They will be able to take a pulse); 5. Understand terminology used in this field; 6. Be familiar with the exercise pyramid and how it can help us; 7. Understand how social determinants such as public safety and the built environment can hinder or encourage people to exercise.
Session 5: Nutrition and Food Safety	<ol style="list-style-type: none"> 1. Be able to define “good nutrition”; 2. Be familiar with the nutrition pyramid, the concept of food groups, and how many servings from each group are recommended per day;

	<ol style="list-style-type: none"> 3. Understand why it is important to eat sufficient fruits and vegetables; 4. Understand the interaction between nutrition and exercise; 5. Be familiar with healthy ways to lose weight; 6. Be familiar with barriers to good nutrition and have ideas for overcoming these barriers; 7. Understand the value of a traditional Latin American diet, how immigration can impact diet, and how to adapt to living in the U.S. while maintaining a good diet; 8. Be familiar with key concepts of food safety, such as: hand-washing before cooking and eating, proper methods of storing food, temperature, separation of food when cutting, etc; and 9. Understand how social determinants such as the availability of healthy and inexpensive food in our neighborhoods impact our ability to eat a healthy diet. <p>Supporting materials List of farmers' markets and days and hours of operation</p>
Session 6: Social Determinants of Health	<p>BEGIN GROUP PROJECTS</p> <ol style="list-style-type: none"> 1. Be familiar with the phrases “health inequities” and “social determinants of health”; 2. Be able to identify some of the health inequities that affect the Latino community, both locally and nationally; 3. Understand the role of social conditions (along with biology and behavior) in creating health disparities; 4. Be aware that we have been socialized to focus most on how our <i>individual behavior</i> affects our health, and less on how <i>society's behavior</i> affects our health; 5. Be able to create and use a work plan (or an action plan) to resolve a health problem in the community, including mobilizing the community identifying problems, choosing a problem on which to focus, identifying underlying causes of the problem, identifying strategies, creating a timeline, monitoring and measuring success. <p>Supporting materials Glossary with definitions and examples of inequities</p>
Session 7: Diabetes	<ol style="list-style-type: none"> 1. Understand the following things about diabetes: <ol style="list-style-type: none"> a. What it is b. Types (I, II, and gestational) c. How to prevent it d. Causes/risk factors e. Signs and symptoms f. How to manage it (exercise, diet, medical visits) g. Medications used to manage it h. Possible complications

	<ol style="list-style-type: none"> 2. Understand the relationship between stress and depression and diabetes; 3. Be able to differentiate between traditional remedies for diabetes that help, those that don't help but don't hurt, and those that can hurt; 4. Know that Latinos/as are at greater risk for diabetes than Anglos and understand the factors that create this disparity.
Session 8: Heart Health/Hypertension	<ol style="list-style-type: none"> 1. Know what heart disease is: <ol style="list-style-type: none"> a. Be familiar with the anatomy and physiology of the cardiovascular system b. Understand the concepts of "heart health" and "heart disease" c. Be familiar with common forms of heart disease, including tachycardia, blood clots, and stroke 2. Know the risk factors for heart disease and stroke (obesity, smoking, high cholesterol) 3. Know how to prevent heart disease (exercise, physical activity) 4. Understand the concepts of low, high and normal blood pressure and the risks associated with the first two 5. Understand how the social determinants of health affect people's ability to have a healthy heart
Session 9: Mental and Emotional Health/Self-Care	<ol style="list-style-type: none"> 1. Be able to define mental health in a positive way, including debunking myths such as the fact that only crazy people seek mental health services; 2. Receive support for a holistic vision of mental health that recognizes that mental and physical health are not separate (may use Medicine Wheel); 3. Be familiar with the mental illnesses that are most common in the Latino immigrant community (e.g. stress, depression, anxiety, bipolar disorder, PTSD) and their symptoms; 4. Be able to identify and share accessible methods to promote and maintain our own mental health, such as exercise, sufficient sleep, decreasing caffeine intake, etc. 5. Be familiar with and able to use counseling strategies (such as active listening and key phrases) that are appropriate for CHWs to use to promote mental health; and 6. Know when and how to make mental health referrals.
Session 10: First Aid and CPR	
Session 11: Navigating the Health Care System/When	<p>By the end of the session, participants will know:</p> <ol style="list-style-type: none"> 1. What to do before going to the doctor: <ol style="list-style-type: none"> a. How to decide whether a service is needed b. How to differentiate between a virus and a bacteria

to go to the doctor	<ul style="list-style-type: none"> c. How to decide what service is needed: urgent care, ER, primary care clinic, Essential Health Clinic, etc. d. Why is preventive care (e.g. well-child checks, mammograms, colon cancer screening) important? e. How to make an appt. <p>2. What to do and expect in the doctor's office:</p> <ul style="list-style-type: none"> a. What questions to ask and how b. What are reasonable expectations (e.g. if you have a virus, the doctor probably won't give you medicine) c. Understand the doctor's limitations (e.g. limited time, many patients, pressure for productivity) <p>3. What to do after going to the doctor:</p> <ul style="list-style-type: none"> a. Medication: importance of taking as prescribed, dangers of sharing meds.
Session 12: Confidentiality/Making referrals/Advocacy Skills	<ul style="list-style-type: none"> 1. Understand the importance of confidentiality in their role as CHWs, including: <ul style="list-style-type: none"> a. The damage that can be caused by rumor b. What it is appropriate to share and what it is not appropriate to share c. Limits to confidentiality (in cases of eminent danger) 2. Know what HIPAA is and how it affects them as CHWs; 3. Know what "warm" referrals are and when and how to make them, including understanding the limits of their role as volunteers; 4. Be able to advocate effectively, including: <ul style="list-style-type: none"> a. Not doing things for someone that s/he could do for her/himself (i.e. not becoming paternalistic) b. Not alienating people who you need or who can help; c. How to help both "sides" of the advocacy relationship (i.e. community member and service provider) understand each other better 5. Be aware of the role of culture and be able to practice important cross-cultural skills (such as??)
Session 13: Hospital Visit/Financial Assistance	
Session 14: Ceremonia de Compromiso	<p>Grupo de la mañana: 9-12</p> <p>Grupo de la tarde: 1-4</p> <p>5:30: Misa de graduación en Sta. Elizabeth</p> <p>12:00, 12-14-08, Misa de Graduación en San Antonio</p>

Appendix G1: La Palabra es Salud (English)

Community Health Worker In-depth Interview Guide

Introduction

Thank you for agreeing to participate in this interview.

As you may remember from our previous conversations, the purpose of this interview is to find out more about your experience as a participant in the Parish Health Promoter Training Program. We are interested in your perspective on the training – what was good about it, what was not so good, and how it can be improved. We also want to know whether and how you feel you were affected by the training. We want to learn some things we could not learn through the survey questionnaire that you filled out at the beginning and end of the training.

Before we go any further, I'd like to review an informed consent form and, if you are comfortable with it, have you sign it. This form will look a lot like the one you signed when you first began the training. [Review informed consent for in-depth interview.]

As I mentioned, I would like to tape this interview. That way, I will have a record of exactly what you said. I or someone else will type up the interview. If someone else does it, they are covered by the same confidentiality requirements that we talked about. Is it okay if I turn on the tape recorder? [If yes, turn on tape recorder.]

Your experience of the training

Okay, first I would like to ask you some questions about your experience with the training.

1. What did you like about the training? [Probe: Were there particular aspects of the training that were helpful to you – that enhanced your learning, made you feel good, changed the way you think about things, etc.]
2. What did you NOT like about the training? [Probe: Were there particular aspects of the training that were NOT helpful to you – that impeded your learning, made you feel bad, made you bored, etc.]
3. In your opinion, how could the training be improved?
4. What were some of the main things you learned as a result of the training?
5. Was this training different in any way from other trainings you have experienced? If so, how?

Effects of the training

Now, I'd like to find out about any effects the training might have had.

6. Did your participation in the training affect you in any way? If so, how?
7. Did your participation in the training affect your family in any way? If so, how?
8. Did your participation in the training affect your ability to serve your community? If so, how?
9. Do you feel differently about yourself now than you did before the training? If so, how?

Your interpretation of the survey

I have already reviewed the surveys which the participants in the training completed. Some answers were interesting to me, and I would like to understand a little better how the participants interpreted some questions. For that reason, I am going to ask two questions about the survey.

10. How did you interpret the statement, "The people in my community share the same values"? [Probe: Many people answered "disagree" or "strongly disagree" to that statement. Why do you think they answered that way?]
11. How did you interpret the statement, "My community has control over decisions that affect my life"? [Probe: Many people answered "disagree" or "strongly disagree" to that statement. Why do you think they answered that way?]

Anything else you want to say

Before we end, I'd like to ask you one last, very important question.

12. Is there anything else about the training that you would like to tell me?

Conclusion

I have asked you a lot of questions. Do you have any questions for me, about the study or anything else?

Thank you very much for sharing your time and your opinions with me. I want to remind you again that I will protect your confidentiality, so you don't need to worry about anything you have told me here. Your answers will be very important for us and others as we try to improve future trainings for Community Health Workers. On the Informed Consent Form that you signed, you have my name and phone number.

Please feel free to call me if you think of anything else you want to say or have any other questions.

Appendix G2: La Palabra es Salud

Guía de la Entrevista con los Promotores de Salud

Introducción

Gracias por estar de acuerdo a participar en esta entrevista.

Como te mencioné cuando hablamos por teléfono, el propósito de esta entrevista es aprender más acerca de tu experiencia como un(a) participante en el curso de capacitación para promotores de salud. Nos interesa tu perspectiva acerca del curso – qué fue bien, qué no fue tan bien, y como lo podemos mejorar. También nos interesa saber si tú piensas que el curso te afectó de alguna forma. Queremos aprender algunas cosas que no podíamos aprender por medio de la encuesta que tú llenaste al principio y al final del curso.

Antes de seguir adelante, me gustaría repasar una forma de consentimiento informado y, si tú estás de acuerdo, dejar que tú la firmes. Esta forma es muy semejante a la forma que tú firmaste cuando comenzaste el curso. [Repasar forma de consentimiento informado para entrevistas.]

Como mencioné, me gustaría grabar esta entrevista. Así, tendré un record exacto de lo que tú dijiste. Yo u otra persona pasará la entrevista por la computadora. Si otra persona lo hace, queda cubierta por los mismos requisitos de confidencialidad que ya mencionamos. ¿Está bien que yo comience a grabar? [Si la respuesta es “sí,” prender la grabadora.]

Tu experiencia acerca del curso

Bueno, primero me gustaría hacerte algunas preguntas acerca de tu experiencia con el curso.

1. ¿Qué te gustó del curso? [Para profundizar: ¿Habían ciertos aspectos del curso que fueron de ayuda para ti – aspectos que aumentaron tu aprendizaje, que te hicieron sentir bien, o cambiaron la forma en que tú ves las cosas?]
2. ¿Qué NO te gustó del curso? [Para profundizar: ¿Habían ciertos aspectos del curso que NO fueron de ayuda para ti – aspectos que impidieron tu aprendizaje, que te hicieron sentir mal, o que fueron aburridos?]
3. En tu opinión, ¿cómo podríamos mejorar el curso?
4. ¿Cuáles fueron algunas de las cosas más importantes que tú aprendiste como resultado del curso?

5. ¿Este curso fue diferente de alguna forma de otros cursos que tú has experimentado? Si es así, ¿cómo? [Para profundizar: ¿El estilo de enseñanza fue diferente?]

Efectos del curso

Ahora, me gustaría aprender acerca de algunos efectos que el curso puede haber tenido.

6. ¿Tu participación en el curso te afectó de alguna forma? Si es así, ¿cómo?
7. ¿Tu participación en el curso afectó a tu familia de alguna forma? Si es así, ¿cómo?
8. ¿Tu participación en el curso afectó tu capacidad de servir a tu comunidad? Si es así, ¿cómo?
9. ¿Te sientes diferente acerca de ti mismo ahora de cómo te sentiste cuando comenzaste el curso? Si es así, ¿cómo?

Tu interpretación de la encuesta

Ya repasé todas las encuestas que los participantes en el curso llenaron. Algunas respuestas fueron interesantes para mí, y quisiera entender un poco mejor cómo los participantes interpretaron algunas preguntas. Así que te voy a hacer dos preguntas acerca de la encuesta.

13. ¿Cómo interpretaste la declaración, “La gente de mi comunidad comparte los mismos valores”? [Para profundizar: Varias personas contestaron “en desacuerdo” o “muy en desacuerdo” a esta declaración. ¿Por qué piensas que contestaron así?]
14. ¿Cómo interpretaste la declaración, ‘Mi comunidad tiene control sobre decisiones que afectan mi vida’? [Para profundizar: Varias personas contestaron “en desacuerdo” o “muy en desacuerdo” a esta declaración. ¿Por qué piensas que contestaron así?]

Cualquier otra cosa que quieras compartir

Antes de terminar la entrevista, me gustaría hacerte una última pregunta importante.

15. ¿Hay alguna cosa más que te gustaría decirme acerca del curso?

Conclusión

Yo te he hecho varias preguntas. ¿Tú tienes alguna pregunta para mí, acerca del estudio u otra cosa?

Muchas gracias por compartir tu tiempo y tus opiniones conmigo. Quiero recordarte de nuevo que voy a proteger tu confidencialidad, así que no te tienes que preocupar acerca de ninguna cosa que me has dicho aquí. Tus respuestas serán de mucha importancia para nosotros y otros cuando tratamos de mejorar futuros cursos para promotores de salud. En la forma de consentimiento informado que tú firmaste, tienes mi nombre y número de teléfono. Por favor, háblame por teléfono si tú piensas en otra cosa que quieres decir o si tienes cualquier pregunta.

Appendix H: Answers to Research Questions Preliminary Report for Advisory Committee

Q1. Is type of instruction (popular education vs. traditional education) associated with any changes in health knowledge and skills, psychological empowerment, self-reported health status, and health behavior among participants in a parish-based Community Health Worker training program? If so, what is the nature and strength of the association?

Participants in the PE group made statistically significant gains in four domains:

- health knowledge,
- self-reported ability to promote health,
- conscientization,
- global measure of empowerment.

Participants in the TE group improved significantly in five domains:

- health knowledge,
- control at the personal level (self-efficacy),
- conscientization,
- self-reported health status,
- self-reported health behavior.

Type of instruction was not significantly associated with any changes in the outcome variables.

However, it is important to keep in mind that the TE group was almost twice as large as the PE group; for some domains, there were exactly twice as many valid responses for the TE group as for the PE group. This meant that almost identical gains among participants in the PE and TE groups on some scales (such as self-reported health status) reached statistical significance in the TE group but not in the PE group.

Likewise, it is important to note that *all* participants in the PE group improved their health knowledge scores from baseline to follow-up, while this was not the case for the TE group.

Q2. Do any changes from baseline to follow-up among parish-based CHWs who participate in training differ systematically from temporal changes that may occur among members of a comparable parish community who do not participate in any type of training?

Results indicate that changes in health knowledge from baseline to follow-up differed systematically and significantly between parish-based CHWs who participated in training and members of a comparable parish community who did not. In addition, whereas members of the two experimental groups made significant gains on a number of scales from baseline to follow-up, the only significant improvement for the control group was in sense of community, and this result could well have been related to other factors present in the environment of the control group and to Hawthorne effect.

Q3. From the perspectives of the participants and the researcher, how does popular education work, if it does? What elements of popular education contribute to its differential effects, if indeed these exist?

How does popular education work? To answer this question, I had to differentiate between the characteristics that contribute to the success of popular education specifically, and the characteristics that contribute to the success of a CHW training course regardless of the methodology (Research Question 6). The criteria I used to identify the characteristics that contribute to the success of popular education were that: 1) the characteristic only existed in the PE course, or 2) the characteristic is a defining characteristic of PE according to the comparison chart (Appendix A) or the principles chart.

1. *It sets the stage.*

Popular educators:

- wrote objectives on flip chart paper, posted them on the wall, and reviewed them at the beginning of the class
- arranged participants in a semi-circle so that all participants could see one another

A participant linked the practice to the development of trust within the group:

. . . the way the chairs were arranged, it was like we were all united. It wasn't like in a line, instead it was like in a circle, and we could all see each other. On the other hand, if you are in a line, it's like okay, I am seeing the back of the person but I am not seeing her/his face, I am not seeing the gestures they are doing when they are talking. But when we are [in a circle], we all see each other, we all focused and we could make eye contact. This maybe I think was also something that helped us to have trust [in the group].

2. *It builds trust (confianza)*

A participant said:

We were a small group and it was like from the first day you all made us start to have *confianza* between all of us . . . [we always started] with a prayer and each reflection made us reflect on why we were there. Next the *dinámicas* made us relax and made us have *confianza* with the people who were there. Therefore I think this course was better, because we were all relaxed and we had *confianza* because we knew that everything we said was confidential and wasn't going to get out. I knew that the person who was sitting beside me was not going to laugh at what I was saying and because we made rules, something that in other courses we are never going to have rules, that you are going to listen to what the other person says and respect it. I think this was one of the positive things about this course.

Various participants in the PE group commented about how relaxed they felt in the class. Contrasting her experience in school to her experience in the course, one participant stated, “This course was very different, I liked it a lot, because of the way you taught us. The whole atmosphere was more relaxed than in any other course I have taken.”

3. *It starts with what people know.*

The practice of basing the educational process on people’s lived experience is at the heart of popular education. Participants in the PE group commented on this practice and how it affected them. According to a participant, the PE practice of finding out what people already know “makes people have self-confidence and say, ‘This is what I know, this is what I can contribute,’ by saying from the start, ‘No one here is all-knowing, we all have an idea and we can all succeed.’” (I2)

Facilitators reinforced this message in various ways. They:

- stated, “You know more than me,” or “You can learn from each other”
- reinforced participant contributions during a brainstorm by commenting briefly and supportively on several of the answers people gave
- turned questions back around to the group

4. *It encourages open communication.*

Popular educators used a number of practices and strategies to encourage open communication. For example they:

- validated and refused to pass judgment on what participants say

“Well, here we all participated and all the questions we asked were valid. No one said that that was good, that that was bad. It was very different.”

- made a particular effort to make sure all questions were answered

“when you don’t understand something, you ask, and [the teachers] are willing to answer.”

- used an “*Almacen de Preguntas*,” a “Question Warehouse”
- created an atmosphere where participants felt comfortable sharing their opinions

“We had some discussions and they allowed us to talk and say, ‘I like this, I don’t like that . . . This is what we know about the topic, this is what we don’t know about the topic.’”

5. *It creates an environment of equality.*

I proposed a contrast between what one participant had experienced and an educational experience in which an Anglo professor arrived in a suit and tie and gave a lecture about diabetes with no *dinámicas* and no spiritual reflection. The participant related this description back to a course she had taken 35 years previously. “It was exactly like that,” she said. When I probed further about how this course was different from the course 35 years ago, the participant answered:

[Here] the teachers are like us, and before, that person that you described, I had him on an altar . . . so now, [in] this course it was like all of us were equal, not *like*, because we all *are* equal. All of us were on the same level, with the exception that you all know a lot more.

6. *It uses a variety of interactive techniques.*

Dinámicas

“The *dinámicas* made us happy, content . . . they woke us up when we had been sitting for a long time. And the *dinámicas* make one *open up* more to what we are doing.”

Were used to move participants into a topic. In the Nutrition session, as participants entered the classroom, they were given pictures of different vegetables which they pinned to their clothing. Then, the facilitators for the session led a *dinámica* in which the leader stood in the center of the circle and said, “My name is x and I made a salad with . . .” and went on to name one or more vegetables. The people whose vegetables were named had to stand up, move around the circle and find another seat, while the leader also looked for a seat. Whomever was left standing led the next round.

Sociodramas

“Porque ustedes hicieron una *dinámica* de como hablar con la gente, de como empezar a tratar a la gente, para poder tratar con alguien como empezar y como le acabo de decir a mí me gusta mucho, esas cosas de ayudar, entonces yo me dí ideas de “hola, comadrita,” esto, lo otro; entonces esas fueron una de las clases que sobresalieron para mí, de cuando hicieron esa *dinámica*.”

The variety of activities held participant’s attention.

You know what? Each day I thought about it at the end of the day and the only thing I didn’t like was that the time passed so quickly. (Laughter.) That I wanted it to go on. It wasn’t enough. But when I realized how much information we were given, or that my brain is becoming so . . . it’s absorbing everything. This is not a negative thing. Because it’s so interesting, time passes and you don’t realize it and you want more.

7. It encourages and balances participation.

“As the classes went on, I am seeing all the information and how all of us participated; no one was left behind. As you all said, ‘all questions are valid,’ so that no one would fail to participate [so that] we would leave feeling more encouraged.”

PE facilitators encouraged and balanced participation in a variety of ways:

- They intentionally made space for people who had not yet shared an opinion
- They intentionally divided up cliques that had been developing in the group
- They sought to involve participants as leaders

Participatory activities encouraged participants to interact:

For example, in the beginning if I had been there, I wouldn’t have talked to anybody, just the people I knew. But in the activities it was like you had to do it. So by the second class, it was okay. I did it more easily. Each time as the course went on it became easier for me. And now I think that more or less I have again the confidence to be able to speak in front of a group and say, “Well, these are my ideas, and this is what we have to do.”

8. It creates a sense of community.

By the second session participants in the PE group were starting to jump up to help post flip chart pages on the wall. By the fifth session, participants spontaneously clapped for one another when small group reporters presented their group’s work. Once again contrasting her experience in the course to her experience of more individually-focused education in public school, a participant commented, “In this [course] it was more of a group thing.”

Q4. What changes, if any, do the CHWs perceive in themselves, their families, and their communities as a result of the CHWs’ participation in training? Do these self-reported outcomes differ as a result of the type of training that is used?

Individual Level

Members of both the PE and TE groups experienced improvements in a number of individual-level variables as a result of their participation in the course. These variables included empowerment, social support, knowledge, and health behavior.

1. Empowerment

Members of both groups experienced empowerment as a result of participating in the course. However, substantial differences existed in the level and quality of empowerment between the two groups.

a. General empowerment

Members of both experimental groups expressed a general sense of increased capacity to handle the challenges life presents.

TE Participant:

. . . in the process of taking all the classes, personal things happened to us, that because of the capacitation that I had had, I focused on how to get through this. To not focus on the fear, not on feeling sad or feeling already vanquished because of what had happened to me during the course. So I felt, well, able to keep going and not be stopped by things that sometime happen in life.

Compared to participants in the TE group, popular education participants said more about their general feeling of becoming empowered, described the changes in more depth, and used more evocative language.

For me, it was like a door that they opened for me so that my life could be better, so that I could say, ‘Okay, I can do it, and if I decide I am going to do it, I am going to get through it.

I had a talk with the priest that was like two hours long and I opened up everything that I had inside me and I told him about [the course I was taking] and I told him it gave me the courage to speak of everything I had inside. So I told him everything I had had inside me since my childhood and I told him why I didn’t participate and he told me I was mistaken. Well, that mistakenness has lasted for many years. But this talk that I had with the priest, along with the course that I had, that is what has opened up my path. The person that I want to be now. Because I was really shut-down (*una persona apagada*). I have lived with a lot of sadness for many years, but now what is happening is another thing in life. But now that I have this motivation, I want to let it out. I want to bring out what I had inside.

b. Personal growth

A PE participant said:

Before, well, one went here and there, and now it makes one more responsible because of everything one has seen, and before I wasted money going here and there and now, well, I have a little more . . . responsibility.

c. Perceived control at the personal level (self-efficacy)

An increased sense of personal capability was an outcome of the course for members of both the PE and TE groups, though for the PE participants the sense of ability was multi-faceted, whereas for the TE participants it was more focused on ability to serve the community.

Several popular education participants related that the course had given them *access to skills they already possessed*:

Alejandro, a doctor in his home country, shared that before the course, almost no one in his current circle knew he was a physician, and he seldom used any of his skills, but now he feels “license” to use them. “So now, well, I am approaching more people, related to health, but because now I feel like I have more backing (*representatividad*) to be able to do it here. I take advantage of some knowledge that I have, to be able to apply it, but only now; before I didn’t approach anyone.”

Popular education participants spoke at length about how the course had helped them to *find their voice*:

Look at this . . . I'll give you an example. The other day I talked in front of the church and I felt like I was floating in the air, like nervous, but it's like I feel more courage to speak.

[When I first went to the class], I said, "I am new in this class and I am not going to talk to anyone" . . . but it was like other people told me, "No, you have to talk to other people." It made me relax; it was the first time that I could relax in a course. So I said to myself, "This course is going to help me in some way." And yes, truly it is helping me, because I have noticed I can be in a place where I don't know anyone and I can say something.

Popular education participants also expressed positive changes in their *ability and motivation to help the community*:

Blanca explained that before the course, she felt fearful of trying to help someone because she was unsure of her own abilities. "Now I feel confident to give information . . . if they need to go to a hospital or they need a referral to human resources places, I also have the awareness and all the information that we were given. Before we didn't even know this [information] ourselves, and now with pleasure, I think that if I see someone even before they ask me, I will be referring them somewhere. And I feel more confident."

Increases in self-efficacy in the TE group mostly related to *helping fellow community members*:

[The course] taught us a lot about how there's a lot of people out there who are not informed, and how they need to be informed, so they know how to take care of themselves.

Sonia spoke for several other participants when she described the course as an opportunity to be able to help others, "and to become more connected and unified (*integrarnos más*) as a community, as human beings, and do service, which is what the Lord calls us to by way of the Church."

d. Perceived control at the community level.

PE participant:

Now I know that there are more people in my parish who are trying to do the same thing, that we are trying to support our community to have a better life, better health.

e. Critical awareness of the social context

[The course] helped my way of thinking.

[It helped me] in particular to be able to see things from a different perspective.

2. Increased Social Support/Sense of Community

Before I felt . . . as the India María says, ‘Neither from here, nor from there.’ Now I feel like I am part of a group that is trying to improve something in this world, for our community -- and also truly for the world. I know that they say that little by little, one can build a city.

I feel different because I have met new people and these people, well . . . they have taken me under their wing (*me acogen*), right? And that’s why I feel different. So, by way of these courses it has helped me to become more connected as a community, and that thing that I could not do alone, well now I can.

3. Increased Participation

Two PE participants made reference to very specific increases in their participation in their church communities:

But now I have talked to the priest. I told the priest that I want to participate in whatever I can and now I am going to be in the food bank, but he said, “Not because you are a promotora but because you are just one more parishioner.” So I told him, “But [before] I never dared and now I am entering more; I am going to participate three times a week.” There I am going to start taking baby steps and I want to, then, as I am telling you, do as much as I can to serve others.

So for me the idea of becoming a volunteer, before that [it] made me think, ‘Okay, so what does that mean?’ But not anymore.

4. Increased Knowledge

Participants in the TE group reported impressive gains in knowledge of services and health knowledge. While participants in the PE group did report improvements in their health knowledge, they were far more eager to talk about new understandings of the world and new abilities to effectively share information with others.

Sonia talked about learning about services:

Another thing [about the course] that I thought was fabulous, was the quantity of services that are being offered to the community which I did not know. The community-based services that are offered by Providence and the Iris Clinic. And well, different services that I didn’t know, and that interested me because I am working with a Hispanic community also in my job and many times they require this type of service.

Juanita related that she had learned things:

- about nutrition (eating whole grains, eating a variety of foods, eating less sugar, eating fewer processed foods)
- exercise
- food safety
- reading labels

- new recipes

In some cases, the things she learned conflicted with things she had been taught since childhood.

One grows up with other ideas. I remember that . . . my mother told me, ‘when you heat up the food, let it cool down before you put it in the refrigerator.’

In other cases, what she learned in the course augmented things she already knew.

We know that we can eat vegetables, but we don’t know, but I didn’t know, for example, that I could eat up to five or more vegetables a day, right?

Two TE participants related they had learned the dangers of “prescribing” drugs:

Well, yes, really before I didn’t know and sometimes someone said to me, ‘I have a headache.’ ‘Oh no,’ [I said], ‘well go take some pills over there,’ or that is to say, I prescribed or recommended pills, right? When really one shouldn’t say, ‘No, well, go take these pills,’ or if someone has a cough, ‘Oh no, well go buy that syrup,’ right, or something like that. Now, I try to recommend that they go a little to the doctor . . .

Hilario shared that he used to have a big bottle of aspirin that he would give to his co-workers, but he no longer does this because he knows “we can’t be giving pills out, because in trying to cure someone we might poison them!”

Participants in the PE course also reported increases in health knowledge.

I worked at the [name of clinic]. I knew there were three types of diabetes. I never knew the differences between the three types. Now, after the program, I understand the three types of diabetes! I went to school but I don’t remember that they taught me. And here they explained it to us.

Popular education participants also reported learning things beyond the realm of health, such as how to empower other community members:

With this course now I feel like I learned a little bit and maybe I’ll be motivated to say to people, “Okay, what you are doing, you didn’t do something bad, but you are damaging your health.” Before I didn’t know how to say something to that person without offending them, and now in this course they taught us how to say to them, not that what you are doing is bad, but to tell them, “You can try to do this,” and give them like pathways so that they will arrive at better health.

We can be like promoters, but at the same time, like teachers, to teach them what they can do for themselves and that maybe they can help their neighbor or someone else who needs it who is going through a similar situation.

So I think [the course] has helped me a lot to tell her, “Well, you have to ask, and if there is no one who speaks Spanish, you have to tell them, “No, please, can

someone come who speaks Spanish?” so that you will feel sure of what you are asking and you can go away with information.

Family Level

1. Improvements in Exercise and Eating Habits

All the members of the TE group who participated in in-depth interviews spoke about changes their families had made in diet and/or exercise.

. . . we already knew all the damage that food can do, including oil, but when I took [the Nutrition class], among ourselves here at home, we completely changed our way of being, of eating. Everything now is very different. We hardly use oil; we try to eat a lot of vegetables and fruits. We always try to make sure we have some in the house. And we do more exercise and . . . more than anything we try not to have soda in the house, just gallons of water.

Participants also identified a substantial number of *barriers to health eating and exercise*.

Before, for example, we dedicated ourselves to working and we said, ‘Well, let’s make a quick stop, we bought some hamburgers, or we bought pizza and then we went back, it is our food and it’s fast food and then it’s back to work. And on the other hand not anymore, because now we try to take time and to arrive and eat in a healthier way, right?

“. . . the problem is that, in quotation marks, we are ‘better’; we are more advanced but towards illness.”

They identified deeply ingrained cultural values, products of historical experience, which can make it difficult to change eating and exercise habits in the Latino community.

An interesting thing is that I had always been thin and I went, during spring break, to (country of origin) and I was . . . heavier, I had gained weight. So the comment I heard was, “How good you look!” and I said, “Well, I don’t feel good.” The comment came from my sister, from my uncle, and then, erroneously, it’s like when a baby is born, he has to be fat in order to be beautiful. And when he’s fat it means he’s okay. It’s hard sometimes to change this mentality.

Trying to change family members’ eating habits can often feel like a battle.

“My husband . . . we have to influence him and help him in this way because he is a little . . . he doesn’t like certain foods. So it’s necessary to struggle with him . . .”

CHWs reported that eating habits of family members, even those who were initially resistant, have changed.

Perhaps one reason that the changes in nutrition and exercise are taking effect among CHWs' families, despite the barriers, is that many, many families had already been affected by the health problems that were discussed in the course.

Participants in the PE course also reported changes in their families' eating and exercise habits.

Speaking of the dietary changes in her multi-generational household, Lupe reported that, "in my family, the practice is on a big scale." Lupe reported that before she participated in the course, she had cooked "puras comidas" (pure main dishes). "We were really accustomed to making hamburgers. I bought the meat at Costco, or whatever store . . ." She used sugar, despite having been diagnosed with diabetes several years before, and always had to have bread in the house. But now, many things had changed. "Since I was in the study, I have not gone back to buy hamburgers at all!" She reported she was cooking more vegetables, despite her children's protests, and using less fat. She was encouraging her family to drink less soda, and had replaced sugar with Splenda. She realized that her family was not perfect and still needed to make more changes, "but we are going step by step." And beyond the health benefits of the changes they had made, Lupe could see other benefits for her family. "Look, I think I am saving a lot of money," she told me. This benefit was certainly an important one, since two adults in Lupe's household had recently been laid off, and her hours at work had been reduced.

CHWs from the PE group reported other changes at the family level, such as more ability to get out of the house, socialization of children, pride among parents over their children's participation in the course, and strengthened family relationships.

Community Level

By the end of the course, all the CHWs were involved in some health project in their community, though they were at different stages and were addressing different topics.

- CHWs from one parish initiated a walking group in which many of them were participating.
- Another group from the same parish had held their first nutrition class, which was attended by more people than could fit in the room.
- They were planning to start smaller groups that would meet in homes.
- They were coordinating the cooking classes with the walking group so people could attend both.

Seeing the high level of participation at the first nutrition class filled Sonia with enthusiasm.

"This means that people are interested . . . and I think it's important to take advantage of the moment to move some resources in the community and make them more accessible."

CHWs also shared health information and education informally within their social networks.

- Hilario and Delmi had been to visit friends, a large extended family of 10-15 people, and shared an impromptu class on nutrition and diabetes.
 - Juanita reported encouraging her friends to get preventive screening.
 - Emiliana has shared information about health care resources with people who previously knew nothing about them, and encouraged them to go for care.
- Emiliana stated:

I tell [people], “I have all, all the addresses. I have it all written down, and when you need it, share it also with your family, with your friends if you have some. Because you don’t have to just stay there, with your tooth hurting all night, and saying that you don’t have enough money to go to the doctor.”

Summary

Although it is certainly dangerous to oversimplify the extremely varied and nuanced changes which the CHWs experienced as a result of their participation in the course, two quotations – one from a PE participant and one from a TE participant – seem to sum up the difference in the changes that occurred in members of the two groups.

Hilario, a TE participant, summarized the changes he had experienced this way:

“The difference [between how I was before the course and how I am now] I would locate it in the knowledge. That’s the difference: in the knowledge that we have now.”

Lupe, a PE participant, characterized her own changes like this:

“I have learned a lot of things that have made my life more full . . . most of all, how to be able to help people, how to participate . . .”

Overwhelmingly, when I asked the TE participants what they had learned or how they had changed as a result of participating in the CHW training course, they spoke about the *facts about health* that they had learned, and how they were putting these facts – especially, facts about nutrition and exercise – to use personally and in their families. When I asked PE participants the same questions, they were much more likely to talk about changes in their own feelings of capacity, and how these feelings of increased capacity had led them to do things, such as talking to the priest, volunteering in their parish, or advocating for their rights, that they had never thought they could do. In addition, they talked about how they were passing on their newfound skills to others in their community. Whether these initial efforts will lead to long-term changes in the development of leadership or the organization of communities remains to be seen.

**Appendix I: *La Palabra es Salud* (The Word is Health)
Informed Consent for In-depth Interview**

You are invited to participate in an in-depth interview that is part of a research study being conducted by Noelle Wiggins. Noelle is working on her doctorate in Education at Portland State University and she is doing this research in order to partly fulfill the requirements of her program. Noelle is supervised by Dr. Karen Noordhoff, a Professor in the Graduate School of Education at PSU.

The purpose of this study is to learn whether different kinds of training affect Community Health Workers differently. For example, do CHWs learn more from one kind of training than from another kind of training? Various organizations are participating in this project. They include Providence Health and Services, El Programa Hispano, the Multnomah County Health Dept., and the Parish Health Promoter Program.

You were selected to participate in an in-depth interview because you recently completed the training for Community Health Workers at [name of parish].

If you decide to participate, you will be asked some questions about your experience in the training, and whether and how you feel the training has affected you. Your answers will be taped and transcribed (typed up.) It is possible that you might feel uncomfortable answering some questions, especially questions that ask you to reflect on aspects of the training that did not go very well or that you personally did not like. If you do agree to participate in the interview, you don't have to answer any questions you don't want to. You can stop at any time.

Also, we will take many steps to keep your answers confidential. The only people who will know who said what are the researcher and the person who types up the interview. The tapes and the interview transcripts will be kept in a locked file cabinet. When we report the results, we will summarize what was said by all the people who participated in interviews. Therefore, people will not be able to connect a particular person to a particular thing that was said.

During the interview, you will have an opportunity to think more about the training you participated in, which may increase your awareness and give you new ideas about how you can use what you learned. It is also possible you may not receive any direct benefit from participating in the interview, but the information we collect may help us and others to provide more effective training for Community Health Workers.

Your participation is voluntary. You do not have to participate in this interview. If you chose not to participate, it will not affect your ability to participate in your parish community or in any of the programs offered by Providence Health and Services, the Multnomah County Health Department, or El Programa Hispano.

If you have concerns or questions about your participation in this study or your rights as a research participant, you can contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 600 Unitus Building, Portland State University, (503) 725-4288. If you have any questions or concerns about this particular study or the in-depth interview, you can call Noelle Wiggins at (503) 988-6250, x26646.

Your signature means:

- You have read and understand what this forms says, or it has been read to you;
- You are willing to participate in the in-depth interview;
- You know that you do not have to participate in this interview. Even if you agree, you can change your mind and stop at any time; and
- You will get a copy of this form to keep for yourself.

Participant Signature: _____

Participant name, printed: _____

Date: _____

Appendix J: Human Subjects Research Review Proposal

I. Project Title and Prospectus

Project Title:

La Palabra es Salud (The Word is Health): A Comparative Study of the Effectiveness of Traditional Education vs. Popular Education for Increasing Empowerment and Enhancing Knowledge and Skills among Parish-Based Community Health Workers (CHWs)

Prospectus:

Popular education is a mode of teaching and learning which seeks to bring about more equitable social conditions by creating settings in which people can identify and solve their own problems. Popular education is arguably the most important educational philosophy and methodology indigenous to Latin America. However, popular education is largely unknown in the U.S. Public health offers a propitious setting in which to bring popular education to a wider U.S. audience, since popular education has been used in public health in the U.S. since the early 1980s. While the public health literature offers evidence to suggest that popular education is an effective strategy for increasing empowerment and improving health, there have been no systematic attempts to compare the outcomes of popular education to those of traditional education.

The purpose of *La Palabra es Salud* is to compare the relative effectiveness of popular education and traditional education for increasing empowerment and enhancing health knowledge and skills among a group of parish-based Community Health Workers (CHWs). Additionally, this project seeks to determine what elements of popular education may contribute to its effectiveness and what benefits and costs may accrue to a CHW-training program as a result of being involved in research. The study will employ a quasi-experimental design, mixed methods, and a community-based participatory research (CBPR) framework. It will be guided by a steering committee that will include the researcher, project staff, experienced CHWs and parish leaders.

In addition to benefits to a wide range of educators which may result from increased awareness about popular education, the outcomes of this research will allow public health educators to more effectively prepare CHWs for their work, thus increasing their effectiveness in their communities. Ultimately, this may result in better health for the marginalized communities that CHWs most often serve.

II. Exemption Claim for Waiver of Review

Not applicable

III. Participant Recruitment

Participants in this project will be members of the Spanish-speaking congregations of six Catholic parishes in the greater Portland, Oregon, metropolitan area, who are participating in training to become Community Health Workers (CHWs) in their parishes. The majority will be immigrants from Mexico and Central America, although some may be U.S. born Latinos/as and a few may be people of other ethnic groups who speak and attend services in Spanish. Past experience with this project suggests that the majority will be women. Participants will be recruited via announcements in church bulletins and flyers that will be distributed on three consecutive Sundays. On the fourth Sunday, the Project Coordinator and an experienced CHW will visit the parishes and speak during the Spanish Mass. They will invite parish members to participate in the CHW training program and will hand out applications after Mass. The Project Coordinator and Assistant Coordinator will screen applications and will contact all prospective participants, whether by phone, in person individually, or in person in a group. They will fully explain the program expectations and benefits. In addition, they will explain that CHW trainees will be participating in a research study and that they will receive more information at the first training session and be able to sign an informed consent form. Participants will be advised of the methodology that will be used at each site. All this information will also be provided in writing.

The inclusion criteria for the program are that parish members be able and willing to complete the training and undertake health promotion activities in their parish. Generally, prospective CHWs need to participate in one of the six parishes, in order to assure they will have adequate support for their work as CHWs. However, in rare cases a person who is not a member of one of the parishes may be accepted, if there is space in a training group and the interested person is a member of another group that can provide support. The six parishes will be divided into two groups and approximately 35 parish members will be accepted to participate at each site, for a total of 70.

Approximately 35 members of the Spanish-speaking congregation at a seventh Catholic parish will be recruited to act as controls. Their demographic profile will strongly resemble that of the CHW trainees. Members at this Catholic parish will not participate in training during 2008, but will be offered training in 2009. They will be recruited through bulletin announcements, flyers, and announcements at Mass.

CHW Questionnaire

For the CHW Questionnaire (quantitative assessment), the sample will consist of all CHWs who participate in training, for a total of approximately 35 in each experimental group. In addition, we will recruit approximately 35 individuals from a control parish which will not participate in the program during 2008 but will be offered training in 2009. In the case of the CHWs who will participate in training, the pre- and post-assessment questionnaire will be conducted on the first and last days of training. Prior to completing the first questionnaire, all participants will be given a

formal Statement of Consent Form (available in both Spanish and English) to read or it will be read to them, and the researcher and project staff will formally explain the form and answer any questions regarding the training program or the research project. CHWs will then complete the assessment. In the event that CHWs are unable to complete the assessment due to limited literacy, other trained project staff and the researcher will be available to administer the assessment orally in the language of their choice. In the case of the control group, the researcher and project staff will bring members of this group together on an appointed day and time to complete the survey. They will offer a food basket (containing items like rice, beans, oil, fresh vegetables and fruit) as an incentive for participation. A similar process will be followed with both experimental and control groups for the follow-up assessment, with the exception that an additional Statement of Informed Consent will not be required.

In-depth Interviews

Using purposive sampling, a total of 8 CHWs (4 from each experimental group) will be recruited to participate in qualitative in-depth interviews. CHWs will be recruited to participate who are diverse in terms of age, number of years in the U.S., region or country of origin, socio-economic status, and level of formal education. These qualitative interviews will use open-ended questions to elicit a wide range of responses and to allow the researcher to probe for better understanding. Interviews with CHWs will occur after completion of initial training. CHWs who participated in training will be contacted by phone and invited to participate. If they are willing, the researcher and the participant will agree upon a time and a location. When they come to the meeting, CHWs will be given a Statement of Consent Form for the qualitative interview to read or it will be read to them, and the researcher will verbally explain the form and answer any questions about the interview process. Once the form is signed, the interview will proceed.

IV. Informed Consent

Participants in this study will be adults 18 years of age and above. Participants will sign the consent forms indicating that they understand that they are being asked to participate in a research project, that they understand the risks involved in participating, that they can refuse to answer any question that they are not comfortable with, and that steps will be taken to protect the confidentiality of the information they provide. The informed consent forms will provide assurances that the CHWs' participation in the project will in no way affect their participation in their parish community or in future activities conducted by the Parish Health Worker Project, Providence Health and Services, El Programa Hispano, the Multnomah County Health Department, or other involved organizations. Additionally, participants will be given contact information for the researcher and her academic advisor, which they can use to ask questions or report and resolve any harm they feel they might receive from participating in the project.

First-Person Scenario

CHW Questionnaire

During the summer, the Project Coordinator for the Parish Health Worker Program came to the Spanish Mass at my parish to share information. I was interested, so I took an information sheet and an application, which I filled out and handed back to the Coordinator that same day. A few days later, she called me. She told me all about the training. She also told me it was part of a research study to learn more about what kinds of training work best for CHWs, and that I would get more information about the research study at the first training session. I said I was able and willing to complete the training and participate in the research study. She told me where and when to come for the first session.

Last Saturday, I went to the first training session. It was held at the parish where I normally attend the Spanish Mass (or at another parish that also has a Spanish Mass). When I got there, there were about 34 other Latinos from that parish and other parishes who had come to participate in the training. The Project Coordinator and Assistant Coordinator who spoke at Mass in the summer were also there, and so were some other people who I did not know. I learned later that some of the people were CHWs who had participated in the training at other parishes, a researcher, and the facilitator for that session. They all spoke Spanish but not all of them were Latinos.

After getting some coffee and food, we all sat down. We went around and introduced ourselves. The Project Coordinator explained the overall goals for the training again. Then the researcher explained about the research part of the project. She said they were trying to learn how different kinds of training affect various things about Community Health Workers, like how able we feel to do things in our community, how much we know about health, how we feel about our own health, and what we do to take care of our health. To find out this information, they asked us to fill out a questionnaire. They explained that we would fill out the questionnaire now in the first meeting and again in the last meeting. This will help the researchers figure out if and how much we change from the beginning of the training to the end.

Before we did the questionnaire, they asked us to fill out a consent form saying that we understood what we were doing and we agreed to participate. We all went over the consent form together. The researcher said the questionnaire would ask questions about all the issues she had talked about, like our own health, how able we feel to do things, and how much we know about health. She explained that some of the questions might make us feel embarrassed or uncomfortable. She said we could stop at any time or skip any question we did not want to answer. She said all the information we gave would be confidential and no one but her would be able to connect our answers to us personally. She said they when they share the results of this study, they will only share information about the whole group, not about individual people. Then she asked if anyone had any questions. One person asked whether there would be any questions that might get us into trouble. The researcher explained that the questionnaire did not have any questions that could get us into trouble. That made

me feel better. I agreed to participate and I signed the form. The researcher gave me a copy to keep in case I had any questions or wanted to contact her.

Next, I filled out the questionnaire. I was able to do it myself, but I noticed that some people had some problems so the researcher, the two coordinators and the CHWs from other parishes helped them. Everybody was able to complete the questionnaire. Afterwards, the researcher thanked us and asked if we had any more questions. She left her name and number so I could call her if I wanted to.

In-depth Interview

Last week, I completed the training series for Community Health Workers at my parish (or at a nearby parish). We had a celebration and a graduation Mass. Our families were able to join us. I felt very proud but also like now I have a big responsibility to my community. A few days ago, the researcher that came to some of the sessions called me and asked if I would be willing to participate in an interview with her about my experiences in the program. I said I would like to do that so we arranged a time when she would come to my house to interview me.

She came yesterday while the kids were still at school. I offered her some coffee and cookies, which she accepted. We sat down at my kitchen table and reviewed the information on the consent form I would need to sign to participate in the interview. The researcher explained that the questions in the interview would be different from the questions on the questionnaire I filled out at the beginning and end of the training. She explained that this time she would ask questions about the content of the training, how it was presented, whether I felt like I had changed as a result of being in the training and if so, how. She said some of the questions might make me feel embarrassed or uncomfortable. She told me I could stop at any time and skip any question I did not want to answer. She explained that she would tape record the interview, if I agreed, so that everything I said could be written down just like I said it and nothing would be missed. She said that if I wanted to turn the tape recorder off at some point in the interview that would be okay. She assured me that she would take steps to keep all the information I shared confidential and that the only people who would know who said what were her and the person who would type up the tape recording from the interview. Then she asked if I had any questions or concerns. I asked her again about whether she would ask any questions that could get me or my family in any trouble and she said she would not, so that was okay and I signed the form. The researcher gave me a copy to keep in case I had any questions or wanted to call her.

We talked for about an hour. It was a really good conversation. I enjoyed having the chance to think back on the training and everything I learned. It didn't feel too formal because I also asked the researcher some questions and she answered them. When we were done, the researcher thanked me and asked if I had any more questions or was worried about anything. I said "no" and thanked her for coming to visit me. She left her name and number so I can contact her if I have any questions or want to know more later on about how the research project is going.

V. Potential Risks and Safeguards

Overall, potential risks associated with participation in the study are unlikely and minimal.

Physical: There is little likelihood of any physical risk as a result of participation in this research project. There are no tasks associated with completing the CHW Questionnaire or participating in an in-depth interview that could result in physical harm. As part of the training, CHWs may engage in activities such as *dinámicas* (social learning games), NIA (Neuromuscular Integrative Action, a type of exercise that combines dance and yoga), and hospital visits that have a small likelihood of low physical risk.

Psychological: Participants will be asked to provide information about their self-reported health status, health behavior, psychological empowerment, sense of community, and demographic data (age, gender, income, educational level, primary language, and region or country of origin). These questions have a small likelihood of low psychological risk if participants think about their own poor health, their family's low socio-economic status, their sense of inability to impact community problems, or other issues, and are upset as a result.

Social: One experimental group in this study will be exposed to popular education. The second step in the popular education process (after increasing self-efficacy) is *concientization*, or developing increased critical awareness about how one's own problems are related to larger national and global realities. Developing greater awareness of these social issues has considerable likelihood of moderate social risk as it may cause conflicts with beliefs that have been inculcated in participants since childhood. It could cause them to interact with family members and the broader society in ways that cause conflict. We propose that this risk can be effectively managed and channeled in a positive direction by taking the third step in the popular education process, which is identifying a particular problem, developing a plan to address the problem, and implementing the plan, as a group.

Relationships among parish leaders, project staff, researchers, and experienced CHWs could become strained if information collected in the project suggests that changes need to be made in the program or the parish communities.

Additionally, CHWs may perceive that participation in the research aspect of this project may impact their relationship with their parish leaders. They may perceive it might affect services they receive from participating agencies and programs. They might perceive that their participation could affect their own and/or their families' status in the U.S. There is **no** likelihood of these social risks.

Several safeguards will be in place to minimize physical, psychological, and social risks. Participants do not have to respond to any question in either the CHW

Questionnaire or the in-depth interview that may result in psychological harm. Individual responses to the CHW Questionnaire and the in-depth interview will not be connected to identifying information, except to be able to link responses in the pre-assessment to responses in the post-assessment. Written information collected only for research purposes will not affect CHWs' future participation in the Parish Health Promoter Program. Popular education and the principles of good community-based participatory research will be used in the project steering committee to create an atmosphere of trust and equality, so that any problems that arise among members can be discussed and resolved. These precautions (as well as the one mentioned above related to the popular education process) are expected to be effective in eliminating risk associated with participation.

VI. Potential Benefits

Recently, researchers have been encouraged to think more about the potential benefits that may accrue to study participants and others as a result of being involved in research (Childress, 2006). This aspect is particularly important in a study such as this one, which is both a research project and a community intervention designed to address particular problems. There are many potential benefits associated with this study.

For CHWs, potential benefits include the study outcomes of increased health knowledge and skill, enhanced empowerment, and improved self-reported health status and health behavior. Social support and social networks may be enhanced as CHWs develop strong and supportive relationships with other project participants, project staff, researchers, training facilitators, and experienced CHWs from other parishes. Past experience suggests that participation in training is also likely to lead to paid employment opportunities for some CHWs. Among the more important benefits to the CHWs is the opportunity to contribute to their community and to feel satisfaction as a result of this contribution. Some CHWs may be interested in making conference presentations and co-authoring articles about the project; they will gain new skills as presenters and writers and gain recognition from the academic community.

Parish communities are likely to benefit in a variety of ways as result of this project. For example, parish leaders and experienced CHWs who participate on the project steering committee may develop skills as researchers, which will be able to employ later on other projects. One particular community member will be employed as an Assistant Coordinator; she will gain knowledge, new skills and enhanced job opportunities. Parish communities may develop a better understanding of their own problems and how to solve them. Over time, the general health status of community members may improve. Parish members may become more able to influence issues that affect their community. Parishes may become more closely linked and better able to work together on issues because CHWs from several parishes will participate in training together.

Benefits for the Parish Health Promoter Program may include a more well-developed curriculum, better retention and more active participation of CHWs as a

result of clearly communicating expectations, increased knowledge about which training modality is more effective in achieving project objectives, and better quality of training overall as a result of making objectives and key content items more explicit for facilitators. Additionally, the researcher will provide access to academic articles and reports which may be of interest and benefit to project staff. Participation in the study may bring the PHPP more recognition both locally and nationally. Program staff will have the opportunity to develop skills and gain recognition if they participate in making presentations and writing and publishing articles about the project.

Other CHW programs and the broader academic community are likely to increase their knowledge about whether popular education or traditional, lecture-style education is more effective for achieving a variety of aims. CHW project planners and trainers will be able to apply this knowledge to make CHW training more effective. If exposed to the results of the study, a broad range of educators will be able to apply this knowledge to make their classes more effective for their students.

In the short-term, benefits to the researcher of employing mixed methods in a well-designed and well-executed CBPR project are likely to include personal satisfaction, on-going information from all members of the team about changes that need to be made to the research strategy, information from a broad range of perspectives about how to interpret the results, and on-going access to the project staff and parish communities and their members and leaders. In the long-term, benefits may include professional respect and recognition and the opportunity to influence educational philosophy and methodology in the U.S.

VII. Records and Distribution

In order to protect participant confidentiality, each respondent to the CHW Questionnaire will be assigned a unique identifier number which will be recorded on the questionnaire form. A listing of the respondents and their unique identifiers, as well as any other information that could be used to link the CHWs with their responses, will be kept in a locked file drawer in the researcher's home office and will only be accessible to the researcher. Identifying information collected from the participants in the in-depth interviews, along with interview tapes and transcripts, will also be kept in a locked file drawer only accessible to the researcher. Before any information from the questionnaires, the in-depth interviews, or other qualitative or quantitative sources is shared with the project team for analysis, names and any other identifying information will be deleted. All forms, tapes, and transcripts will be kept on file for at least three years. These measures are expected to be completely effective in eliminating risks to confidentiality.