Changes in Empowerment: Effects of Participation in a Lay Health Promotion Program

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The Camp Health Aide Program is a lay health promotion program for migrant and seasonal farmworkers. The program increases access to health care while facilitating leadership development and empowerment of individual farmworkers through training and experience as lay health promoters (camp health aides [CHAs]). This article describes a study which documents impacts on the CHAs of working as lay health promoters in terms of changes in personal empowerment. The authors developed a working definition of personal empowerment and interviewed 27 CHAs at three program sites (Arizona, New Jersey, and Florida) at three different times. CHAs are grouped in five descriptive categories reflecting varying degrees of change in empowerment over this period. Of the total group of 27 CHAs, 24 exhibited some increase in personal empowerment during the study period. These changes are described in detail, and implications are discussed.

INTRODUCTION

The Camp Health Aide Program (CHAP) is a lay health promotion program for migrant farmworkers which has been developed and implemented by the Midwest Migrant Health Information Office (MMHIO) since 1985. To date, more than 250 migrant farmworkers have been trained as camp health aides (CHAs) to provide health education, basic first aid, referrals for health and social services, and translation services for their friends, neighbors, and coworkers. CHAs are recruited from migrant labor camps and farmworker communities. Training emphasizes a participatory approach drawing on the experiences of the farmworkers themselves. CHAs begin the program with 20 hours of

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intensive work covering a broad range of health issues. After this initial training, they are expected to devote approximately 20 hours per week to their new role. Training continues at a less intensive level while CHAs carry out their roles as health promoters. As compensation, they receive a modest educational training stipend during the period they participate.

The CHAP model has since been established in nine states nationwide. Program evaluation over this time documented positive impacts in the areas of health behavior of camp residents and advocacy for healthier conditions in camps and work sites. Anecdotal evidence accumulated which underscored the positive effect program participation had on CHAs themselves. Many spoke of feeling more confident in their ability to learn new information and help other people and of improved relationships with family members and peers. Some noted that they were better able to advocate for health and social services because of their experience as CHAs.

The CHAP increases farmworker access to primary health care while facilitating leadership development and empowerment of individual farmworkers through training and experience as lay health promoters. An implicit assumption is that empowered lay health promoters are more effective in their roles as educators and advocates. Beginning with the premise that CHAs do experience changes in their lives as a result of the program, we wanted to explore more systematically and in greater detail how the program affected individual feelings of empowerment.

In 1992, MMHIO received a grant from the W. K. Kellogg Foundation to adapt and implement the CHAP model in three states outside of the midwest region. Federally funded migrant health centers in Arizona, Florida, and New Jersey collaborated to implement programs in their service areas. An evaluation was designed to examine different aspects of the program model. This article focuses on a program implementation component of this evaluation that has received less attention in the general literature on lay health programs than others: how participation in the program affects the lay health promoters themselves.

BACKGROUND

Much of the recent literature on lay health advisor/educator/promoter programs has been concerned with strengthening program evaluation. A review by Fennell of evaluations of peer education programs noted an absence of research on the effectiveness of peer educators and, in particular, evaluations which provided outcome data on target populations.[1] Subsequently, an evaluation of lay health advisors (LHAs) with migrant farmworkers in North Carolina examined the effectiveness of LHAs in their interactions with the target population in terms of changes in health knowledge and use of clinical services.[2] In their 1992 review of LHA programs, Eng and Young develop conceptual and planning models which (a) link possible intervention effects of LHAs with changes in individuals in the target population, collaborating social service organizations, and broader community networks and (b) describe critical decision points in planning LHA programs.[3]

We found relatively little discussion in the literature which focuses on changes within lay health promoters as part of participation in a program. Several studies document increased employment opportunities and increased self-esteem and status within their communities.[4-7] One report conjectured that such changes may result in increased social distancing between health promoters and their communities, rendering them less effective

in the long term.[8] Warrick, Wood, Meister, and de Zapien note that no long-term studies of peer health workers exist, but their short-term observations suggested that, on the contrary, increased self-esteem and community recognition of their teaching roles augmented the health promoters' commitment to the community.[9]

Harlan, Young, Eng, and Watkins describe a continuum of helping relationships ranging from a health care professional in a clinic setting on one extreme to an LHA or someone who naturally and spontaneously provides advice and support to neighbors, friends, and coworkers on the other extreme.[10] Members of self-help groups and community members who are paraprofessionals in health care organizations represent other types of relationships that fall along the continuum. The role of CHAs contains a combination of elements from different lay health models, which place them near the LHA end of the continuum. CHAs are members of the migrant and seasonal farmworker community. They are connected to a migrant health center, but they are not staff of the health center. Much of their work is natural, arising from health and medical needs of neighbors and coworkers, although there are clear expectations that CHAs look for and create opportunities to provide health education within their migrant camps or communities and workplaces.

The CHAP was not created with an explicit goal of increasing the self-esteem of participants. Rather, its original goals concerned increasing access to health care and knowledge of health issues for migrant farmworkers. In response to anecdotal reports from the field, a pilot study by Stewart documented differences in empowerment among women who were CHAs and migrant women who had never been CHAs.[11] This evidence complemented that in other literature which explored the role of empowerment in health.[12,13]

Stewart's definition of empowerment described two levels: personal and collective. Personal empowerment refers to intrapersonal processes which involve both cognition and action on the part of the individual. Collective empowerment refers to the process by which individuals begin to relate to the society in which they live.[11] We have used this definition as a basis for operationalizing a model for the present study.

METHODS

Conceptual Model

We have focused on changes in the individual lay health promoter as our primary level of analysis. At the same time, we wanted to build a model which recognized the interdependence of the individual and her/his social environment. Our objective was to describe changes in CHAs which concerned self-efficacy, a positive social identity, knowledge of social and political structures which were connected to carrying out their roles, and the ability to transfer skills from one life domain to another. As such, we defined the following four factors:

1. the degree to which the CHA was able to describe future life goals in specific terms (life goals),
2. the extent of cognitive information the CHA had about health problems of migrant farmworkers and about ways to improve their health status (cognitive information),

3. a sense of perspective about health problems of migrant farmworkers in relation to other workers (perspective), and
4. the degree to which the CHA saw her/his role as one part of a community of farmworkers (role).

Factor 1 addresses aspects of self-efficacy and a sense of coherence in life. Factor 2 examines the CHA's self-efficacy as well as the ability to look critically and more broadly at the community of farmworkers. Factor 3 addresses the development of a critical worldview of health issues and workers. Factor 4 looks at the ability to identify with others and to see problems in common with the larger farmworker community. Information was collected from individual CHAs on each of these four factors.

Research Design

In-depth interviews were conducted with a cohort of CHAs at three project sites at three points in time: (a) shortly after they entered the program but before training commenced; (b) 4 to 8 months later, after training was complete and the harvesting season had ended; and, (c) at the end of the second harvest season, approximately 16 months after the program began.* Participants were the initial CHAs trained at the Arizona, New Jersey, and Florida project sites. A total of 33 CHAs were interviewed shortly before beginning training. Six dropped out of the program before the end of the first harvest season. Multiple interviews were completed for the remaining 27 CHAs who comprised the study population.†

A questionnaire was developed based on information from the pilot study on empowerment previously conducted with CHAs in Michigan farmworker camps.[11] Questions were open-ended and asked participants about life experiences, experiences as a farmworker, likes and dislikes of farmwork, future goals and how to achieve them, health-related problems for farmworkers and how these problems differed from those of other groups of people, actions one would take in case of an accident or illness, what people could do to stay healthy and the likelihood of carrying out these behaviors, and expectations about being a CHA. The wording of questions was modified to reflect the passage of time when the questionnaire was used for the second and third interviews.

Interviews were conducted during the period March 1993 to April 1995. They were administered by a member of the research staff in Spanish or English, depending on the preference of the CHA. A total of 17 CHAs were interviewed in Spanish; 10, in English. Interviews were conducted in the CHA's home whenever possible or at the field site office or clinic and lasted from 20 minutes to 1 hour. Each interview was tape-recorded, subsequently transcribed, translated to English if necessary, and summarized. Interview summaries were structured around the following topical areas: personal background, life as a farmworker, health problems affecting workers, actions as a CHA, and expectations/experiences of being a CHA. Transcriptions, translations, and summaries were developed by the staff member who conducted the interviews.

*The Arizona site was a year-round program. CHAs were permanent residents of the area. New Jersey and Florida sites had periods of no harvesting activity, and some CHAs migrated during these periods.

†Six CHAs (two at the New Jersey site and four at the Florida site) completed interviews at program initiation only. Two left the program because of language barriers, two left because of violence in the area, one left for health and family reasons, and one was asked to leave because of noncompliance with program expectations.

Organization of Information

Interview summaries for each of the 27 CHAs were reviewed to assess changes in empowerment over time and to develop groupings of CHAs with similar degrees of change. Three of the research staff independently read each series of summaries, examining them on the four factors: life goals, cognitive information, perspective, and role. Each reader brought a different perspective to the grouping process. One was the interviewer and had developed the interview summaries. A second was the project evaluation consultant who was privy to a large amount of background and anecdotal information on the CHAs and the CHAP. The third reader was a doctoral student in anthropology and social work who had no contact with any of the CHAs. Through a collaborative effort, five categories of CHAs were created:

1. relatively low empowerment initially and throughout the interview period,
2. relatively low empowerment initially with small increases over time,
3. relatively low empowerment initially with relatively large increases over time,
4. relatively high empowerment initially with little change, and
5. relatively high empowerment initially with some increase.

Our intent was to make the categories as independent of each other as possible. During the process of assigning a CHA to a particular category, it became evident that the dynamic nature of each factor made some overlap between categories inevitable. That is, a CHA could have changed a lot on one factor but very little on the other three, while another could have changed a relatively small amount on all four, and the two CHAs would be classified in the same category. We left the degree of change in each factor to be an implicit judgment for each of the three research staff involved in classifying. Staff arrived at identical classification assignments for 16 of 27 CHAs. Consensus was reached on classifying the remaining 11 CHAs.

RESULTS

Nine CHAs were assigned to Category 2. Eight were assigned to Category 3. Three were assigned to Category 4, and seven were assigned to Category 5. No CHAs were assigned to Category 1, although six CHAs dropped out of the program before at least two interviews were completed.

CHAs in Categories 2 and 3 are distinguished from those in Categories 4 and 5 by an initial sense of vagueness about life goals, a lack of comprehensiveness when describing health problems faced by migrant farmworkers, and little sense of being part of a larger community. We refer to this set of descriptors as *low empowerment*. In contrast, the CHAs in Categories 4 and 5 initially could describe life goals in specific terms, had a perspective on the health problems of migrant farmworkers as compared with other workers, could talk with some specificity about those health problems, and shared a view of the role of a CHA as a part of the broader community of migrant farmworkers. We refer to this set as *high empowerment*. Within these two aggregate groupings, we distinguish the degree to which change occurred. We describe the empowerment changes for CHAs in each category in what follows.

Category 2: Relatively Low Empowerment Initially With Small Increases Over Time

CHAs in this category initially identified personal goals such as "study and prepare myself to give my kids a better life," "get my GED [general equivalency diploma]," "I'm tired, I want to get out of farmwork," and "I want to see my kids studying and going to college." "Studying" represented the way to achieve these goals, but most were unable to elaborate on how they would do this. Many stated their ambitions for the future in terms of providing a better life for their children, a future which would include jobs other than farmwork. By the last interview, these ambitions were expressed in somewhat more specific terms, such as, "I want to start a business for myself, have my own house . . . and provide my children with a good education." Several identified nursing as a career goal. Studying remained the chief mechanism to achieve goals. For several, it seemed evident that despite studying, there remained roadblocks to achieving any changes in their lives. One person identified herself as the reason for limits on changing her life. She had found a job working for the local school district while continuing to participate in the CHAP during the harvest season and "that's been good for me," but she downplays her accomplishment: "[I want to] aim a little bit higher, but with the head I've got I don't think so."

Most described the new knowledge they acquired through the training program and their experiences applying it as very positive benefits of CHAP participation: "With this program . . . everyone knows me . . . and I feel better. [People in the camp] are sad and we talk with them . . . they relieve themselves of their problems . . . and we feel good." For many, successfully completing the formal training program represented fulfilling (at least partially) their goals of "studying" to change directions in their lives. Women in particular said they experienced increased status within their families.

Many CHAs were able to talk in more comprehensive terms about health problems facing farmworkers by the second or third interview. From "not eating a hot meal" and "not seeing health problems of migrant workers as different from other workers" to describing pesticide poisoning and lack of access to medical services, CHAs were able to articulate a much broader view of important health issues. Nevertheless, many also described problems in a blame-the-victim manner. This attitude is illustrated by the following comments:

> People should wash hands before eating when working in pesticides . . . [but] they get lazy . . . and they're not near water.
>
> People don't follow [a healthy lifestyle] because they're stubborn.

Interviews revealed that few saw themselves as part of a community of workers sharing many similar health problems. Despite the fact that many CHAs were critical of working conditions, most could provide no ideas on how they would change them other than leaving and finding other kinds of work. One person focused on people's ignorance as being the chief roadblock to better health.

Category 3: Relatively Low Empowerment Initially With Relatively Large Increases Over Time

CHAs in this category were more likely than those in Category 2 to articulate life goals in more definitive terms at the initial interview as well as during subsequent interviews.

Careers in health care were specifically mentioned, and in several cases, the jobs CHAs identified increased in status and educational requirements as time passed. Studying was mentioned but almost always in the context of studying to achieve a specific career goal. At the first interview, one CHA stated, "I've always wanted to be a nurse, and I said, 'Well, maybe if I start low I can reach higher.' " At the second interview, she said that although she had always been interested in nursing, "I never got the urge, of stepping that big step . . . until I came here [CHAP]." By the third interview, she was going to school part-time and had gotten a job in a nursing home.

Many in this category talked about "liking to help people." One person said at the first interview that she battles depression by feeling useful, and helping people makes her feel useful. By the second interview, she said, "It was like I was feeling low and depressed and this [CHAP] was like a lift up to a new future. I'm seeing forward to keep on studying." By the third interview, she said she wanted to become a social worker.

Cognitive information increased considerably for CHAs in this category. By the third interview, the majority could talk comprehensively and at length of medical problems affecting farmworkers, of gaining access to medical services, and of making the health system more accepting of farmworkers. These descriptions were, for the most part, different than the tendency to blame the victim given by CHAs in Category 2. For example, a CHA in Category 3 described frequent colds and illnesses due to the weather as the most serious problems for farmworkers at the first interview. At the second interview, he talked at length about pesticides and about gaining access to medical care:

> If you don't speak English you automatically come to a dead end . . . it is like we are on the outside. Like we are not people. Like they humiliate us . . . and [it] is worse for those people who work in the fields because they arrive a bit soiled to the clinic.

There was no mention of blame for workers who remained ill because they were not motivated enough to wash their hands.

There was a greater sense of being part of a larger community of workers who shared health problems because of their work and because cultural and economic differences with others isolated them. After working one season as a CHA, one person said, "Sometimes, I see some of the people who see me [as a CHA]. It's like I'm no different from them. I'm equal. I work in the fields. I think they like that . . . it's not like I'm a nurse or I'm a doctor." By the third interview, she said,

> I've been happy and I remember saying why I wanted to be a CHA and I remember saying, "Family, family, family," but it's not just family now.
>
> It's like I've made a lot of new friends . . . and people come looking for me now and that makes me feel really good, really special. . . . I've gotten more involved. . . . I feel the difference.

There is more frequent use of *we* and *us* rather than *I* and *them* in describing health problems and how to deal with them by the time the third interview was conducted. As one CHA put it, "now I know my job is to have more communication with people . . . because farmworkers always need many things . . . we go to work and many of us are in poor health." She also felt needs could be better met if people were united. This was difficult, she said, "because people are so busy just providing for themselves." Another confronted the grower at her workplace to get pay allocated more fairly among workers and succeeded.

In general, there appeared to be a greater sense of personal control over life circumstances among this category of CHAs by Interview 3 as compared with those in Category 2, enough so that they could reach out beyond themselves and beyond their families to help the larger group of which they were a part.

Category 4: Relatively High Empowerment Initially With Little Change

The three CHAs in this category clearly stated career goals at their initial interviews. Two identified getting GEDs and then pursuing professional courses in nursing and business administration. A third was very committed to raising her three preschool-age children and studying English. All had experience in work unrelated to farmwork (plumbing, electronics, and cleaning houses) and preferred it to work in the fields. Future plans were described with some detail:

> We [CHA and spouse] want to buy a house and a couple of decent vehicles and open a restaurant and make back the money we spent on the house and vehicles. But my main goal is to try to get my GED.

Individuals in this category stated they felt confident they would be effective in the CHA role and that their training would provide benefits for their families and for camp residents. All expressed considerable interest in being able to help people and were realistic in their expectations of what this would mean in practice. One said,

> I think at first it will be a little difficult, but as time passes, I can help them as much as they will be able to help me. . . . If I am taught to give first aid or something, the next time they can try to help their own family or a friend.

Another CHA felt he already filled the role and that the program would give him more training and allow him to spend more time helping people.

> They can call me and not have to worry about me saying something like, "Well, I don't have time right now," 'cause I'd make time . . . because I know it isn't just a feeling I feel inside [about helping people]; this is something that's right.

At the first interview, CHAs spoke at some length and in some detail about health problems specific to farmwork. Their comments reflected their direct experience on the job. One spoke of job-related trauma and his efforts to help injured coworkers:

> As a plumber you could get hurt but [you are] being paid by the hour and moving as slow as you can. . . . Farmworkers have to move as fast as they can. You're around chemicals, tractors . . . plumbers have insurance . . . we go to clinics which are often packed . . . we have no insurance.

The others, speaking about pesticides, said,

> It's different, I think, because they don't have the necessary protective clothing . . . and they should have clothing.

> Many bosses only care about the work. They don't care about the health of the workers.

CHAs spoke of problems related to the kinds of work farmworkers did and the relatively dangerous environments in which they worked. There was a notable absence of comments about individual behavior and motivation in relation to health problems.

The general tone of comments and observations recorded in the initial interviews was upbeat, positive, and realistic. In contrast, comments made during subsequent interviews were less optimistic. At the second interview, one CHA stated he felt improving health depended more on changing individual behavior: "They [farmworkers] need discipline and motivation I guess." A second CHA had worked hard to make the local clinic more accessible to residents. She commented,

> A lot of farmworkers didn't go to the doctor, and since we began working . . . we began to motivate them to get checkups. . . . They used to always say, "Oh, why go if the same people are always there and they leave us until the end?" And now, no. . . . I try to tell them, "Go. I'll give you the card, yes, they'll attend to you. . . . Don't give up." Before, it was rare that they would go, and now a lot of people have gone.

But by the third interview, she blames farmworkers, in part, for their health problems,

> because they get sick and don't go [to the clinic]. They keep working instead of taking care of their health. . . . I don't think they have problems getting to the doctor. If they don't go, it's because they don't want to, but the services are there.

Despite obvious frustrations, one CHA wanted to continue working: "Many [residents] trust me and talk to me about their problems." A second said she was not sure she wanted to continue with the CHAP. Despite the fact that she likes the program and talking to people and that there is still work to do, she does not like being required to attend conferences or feeling pressured into being a political advocate for farmworkers. The third CHA did not return to the program the second season.

Category 5: Relatively High Empowerment Initially With Some Increase

CHAs in this category were able to define goals for the future in concrete terms, focusing on careers which were, for most, human services oriented, such as social work and the ministry. Those with families wanted to be able to provide an education for their children which would offer choices other than farmwork. Five of the seven people in this category had direct experience working in the fields, although two of the five had worked only briefly. As one put it, "I think that farmwork is very badly paid work. That's why I left the field. Because the pay is very bad, it kills the workers." Although all aspired to hold jobs which were safer and which provided greater financial security, their comments about farmwork reflected a strong sense of pride and dignity. During her first interview, one CHA said,

> It's hard work in the fields, but . . . it's honorable work . . . and I tell my son, . . . "Never forget that you're studying because I made sure that school was the most important thing because I didn't want you doing what I do. Now one day, if you become someone important and in front of you is someone dirty . . . because he comes from the field,

> remember that that's where your mother came from. . . . Never disrespect those people because they are honorable people who are suffering to bring you the food on the table."

A majority of CHAs stated that they had been doing "this kind of work" (helping people) most of their adult lives. One had traveled around the country speaking on peasant rights and social justice. Another had been working as a fix-it person in the camps and was responsible for orienting and helping new workers. A third said, "I've been doing this all my life . . . my husband says I'm a social worker without pay." Almost all were able to comment at some length about medical and health problems of workers as a result of their experiences as helpers.

Despite their past experiences as informal helpers, there were numerous comments about new things they had learned. By the second and third interviews, people in this category expressed very positive feelings about what they had learned and how they felt they were helping fellow farmworkers:

> I feel happier for myself, and it reaffirms my Christian vision. There is a spiritual reinforcement in knowing that I'm doing more than I could before [CHAP] to help the people.

> These are lovely experiences of feeling useful, of knowing that one is helpful to people . . . it's something that stays inside of you. . . . Knowledge is something that one keeps forever in one's mind, that no one can take away. . . . This [CHAP] has had a good effect on me because I've learned. I feel useful . . . I feel like I'm someone beneficial to my community.

For many in this category, training formalized their roles as helpers in addition to increasing cognitive knowledge about health. This allowed them to carry out the helper role to greater personal satisfaction.

In contrast to CHAs in Category 4, the comments regarding the potential to change circumstances for the better remained realistic but upbeat. As one put it, "I'd like to change many things but I can't. Yes you can, but it's very hard." While one CHA in Category 4 was inclined to shift the blame for seeing little change in many serious health problems to negative behaviors of workers, CHAs in this category remained focused on broader circumstances that impeded change. At the third interview, these feelings were expressed:

> Many people don't go to the doctor because they don't want to miss work. For them it's much better to come to the clinic when something hurts and they can't stand it, than to come for a simple checkup.

> One gets to know people, apart from illness, the problems of people, the void there is when one is isolated like we are here. . . . Before [CHAP], I was just working, and now I look for a way to rise above this.

One CHA lost his job because he attempted to get care for a worker: "They [the grower] told me to not get involved in that. . . . That's how the problems began and . . . they took my job away." The company transferred this CHA to another division in which he had less contact with farmworkers. "I don't regret what I'm doing [being a CHA], but I have less time to be with the people . . . I have to struggle a bit more to find them."

In summary, 24 of the total category of 27 CHAs exhibited some increase in personal empowerment during the study period. All of the 17 CHAs classified as having low empowerment at the program outset (Categories 2 and 3) showed some increase in

empowerment; eight showed relatively large increases. Of the 10 CHAs classified as having high empowerment at the program outset (Categories 4 and 5), 7 showed additional increases in empowerment, while 3 showed little or no change.

DISCUSSION

The intent of this study was to document, in a systematic format, how CHAs are personally affected by participation in the CHAP. Our findings are consistent with a decade of experience with the CHAP and anecdotal stories and remarks made during this period by participants. A large majority of participants have found the experience an empowering one.

These findings held in three separate field sites representing differences in the context of program implementation. Although the core of the CHAP remained uniform across the three field sites (use of teaching and training materials and technical assistance), recruitment strategies differed. In Arizona, CHAs were geographically dispersed over a large area. They did not migrate and lived in small, rural communities. The length of the Arizona program (year round) allowed the program coordinator to spend a longer period of time recruiting participants than her counterparts in New Jersey and Florida. As a result, she was able to carefully and methodically select participants. In New Jersey, CHAs resided in small or mid-sized labor camps or in enclaves of farmworkers in nearby urban areas. The program was seasonal (four to five months long), and the program coordinator was under greater time constraints, relying heavily on clinic and community recommendations for participants. Consequently, some of the CHAs were already considered to have leadership qualities. Most of the Florida CHAs lived in a single labor camp with more than 5,000 residents. The community was literally at their doorstep. Information about the program was distributed in the community, with the understanding that interested individuals would come to the program coordinator's office for an informational interview, although the program coordinator also recruited participants door to door. Most people displaying interest in the program were given the opportunity to participate, making this approach less selective than those in Arizona and New Jersey.

Limitations to our research design—in particular, the lack of a comparison group—preclude drawing the conclusion that participation in the CHAP was the sole reason for the changes we documented. Each individual's life and set of experiences over the period of time that interviews were conducted are complex. There is certainly interaction between the skills and confidence gained through participation in the program and one's relationships with family members, professionals in the community, and supervisors. Life changes are not simple to describe or linear in pattern. The CHAP encompasses an important set of experiences for the participants who showed increased personal empowerment while they participated in the program, but it is not the only influence on participants' lives during this time. Differences in feelings of empowerment may also be explained, in part, by the nature of each participant. That is, those who referred to themselves, in one way or another, as natural helpers could be considered to be more empowered than those who saw their work as a CHA as merely a task to be completed.

We did find that age, gender, and formal education of the CHAs in each classification category were consistent with our descriptions of each category. That is, the CHAs in Categories 4 and 5 had more formal education and had a higher percentage of males than did CHAs in Categories 2 and 3, characteristics which often describe more empowered

individuals (mean age = 32.5 vs. 31.2 years; mean years education = 10.6 vs. 7.8; percentage males = 67% vs. 33%, respectively). We did not find that high levels of empowerment, either before or after participation in the program, translated into greater numbers of contacts with the community. The activity level of CHAs was confounded by constraints in geography and the availability of farmworker residents, which varied across field sites as well as within field sites in Arizona and New Jersey.

IMPLICATIONS

This study indicates that there may be additional benefits to lay health promotion programs beyond increasing access to health care and providing culturally appropriate health education to underserved communities. Changes in personal empowerment that occur within participants, while difficult to measure precisely, are important program benefits. They should not be overlooked when assessing and promoting the value of lay health programs.

Evaluating personal changes in lay health promotors can have important implications for ongoing program administration. We noted that recruiting people who already feel empowered is not necessary for the success of the CHAP. However, the quality of feeling capable of helping others is critical to being able to assist others to make decisions about their health. Being aware of personal experiences and needs of CHAs, as well as of environmental conditions affecting their lives, allowed the program coordinators to offer individualized attention, training, and support when needed. This enhanced the experiences of the CHAs and their effect.

Recognizing the personal changes and increased feelings of power that occur while individuals participate in the CHAP validates the potential for such programs to change the face of the health care system and the dynamics of poor, isolated communities.

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