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Community Health Workers-Promotores de Salud in Mexico

History and Potential for Building Effective Community Actions

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Abstract: This article takes a historical perspective combining 3 illustrative examples of the origins of the community health worker (CHW) model in Mexico, as a community-based participatory strategy. Three examples were identified from the sparse literature about CHWs in Mexico emphasizing their key roles and functions in various community settings. The CHW models illustrate what is known of training-development and planning, implementation, and evaluation of the CHWs model in different settings addressing cardiovascular disease and risk factors. The potential exists for integrating CHW projects to expand the health promotion model with new emphasis on municipality and regional participation. **Key words:** *community health workers, promotores de salud, Mexico*

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PROMOTORES de Salud/community health workers (PS-CHWs) have been involved in several important roles in Mexico's health care system for more than 25 years, yet there is a paucity of empirical data and published field experiences about the role definition, educational requirements, training, and program outcome results of PS-CHWs. The current state of information and experiences about CHWs has resulted in lack of clarity about PS-CHWs' potential for facilitating community action for health.

In this article, we briefly review the history of PS-CHWs in Mexico. This article does its best to trace the history of CHWs in Mexico, while acknowledging that some of that history is poorly documented. Therefore, the goal of this article was to begin a documentation process of what is known about PS-CHWs in Mexico. Contributing to that documentation process, we introduce 3 initiatives that collected empirical evidence about CHWs' roles and outcomes, including efforts guided by

PS-CHWs to prevent and reduce chronic disease, particularly cardiovascular disease and its major risk factors, which are highly prevalent in Mexico.

BACKGROUND

Historical perspective of PS-CHWs in Mexico

Reports in the public health literature since 1993 provide accounts of the utilization of PS-CHWs as part of community mobilization strategies within the Mexican government to improve health of participants receiving Mexican Social Security Institute (IMSS) services. A pilot study conducted in the State of Jalisco is 1 good example (Rasmussen-Cruz et al., 1993). With support of the leadership of 1 municipality and with the formation of a Community Health Board (Comité Comunitario de Salud), PS-CHWs played various roles and functions, starting with diagnosis of community needs. Promotores de Salud/community health workers received various trainings and served in the capacity of volunteers who were called "incidental promotores" given their volunteer status. The majority were youth who participated sporadically in tasks such as cleaning campaigns, vaccinations, organization of sport events, and cultural or ecological events within the municipality, all guided by the Community Health Board. Other promotores were called "periódicos" (for a period of time) who worked as volunteers mostly on weekends or once a month. Yet a small percentage consisted of a third type, the "permanente" (permanent) promotoras who were mostly adult women who worked from home. In addition to the promotores (as) who worked in schools or neighborhoods, there were others (coaches, trainers, and athletes) who organized sports activities.

Rural Mexico has provided for the last 20 to 25 years examples of programs of mostly female PS-CHWs who utilize popular education (PE) to support child nutrition. In a program described by Arenas-Monreal et al. (1999), PS-CHWs were trained on various community nutrition actions, including nutrition assessments, establishment of cooperatives to produce basic and healthy nutrition products, construction of ovens for cooking, and housing improvements. Noteworthy are the accounts of "promotoras indígenas" (indigenous PS-CHWs) from the "Programa de Organización Productiva de Mujeres Indígenas" who have been working in rural Mexico offering various services to empower their own communities (Consejo Nacional Para El Desarrollo de los Pueblos Indígenas, 2010). The early work of Ysunza and Salas (1996) and collaborators in Oaxaca for building capacity of rural promotores within a context of comprehensive rural development is pioneering. Unfortunately, little empirical evidence has been reported on these efforts (Wiggins, 2012).

Since 2001, under the auspices of the Director's Office for Health Promotion of the Ministry of Health (Dirección General de Promoción de la Salud) PS-CHWs were described in association with health promotion services under the categories of institutional promotores, volunteer promotores (from their own communities), and other institutional personnel (Secretaría de Salud, 2005, 2007). Institutional promotores under this health promotion umbrella are hired directly by Secretaría de Salud (SSA) or IMSS, depending on the type of community health center that offers services at the local level. Unfortunately, no empirical evidence exists that describes the success of institutional promotores.

The Health Promotion Operational Model developed in 2006 under the Ministry of Health (Santos-Burgoa et al., 2009) provides a platform from which the PS-CHW model can be best examined within the context of contemporary Mexico. With the Health Promotion Operational Model for Mexico 2007 to 2012, the concept of prevention became part of the health agenda with activities that included improving maternal and child health as well as combating chronic disease (including cardiovascular disease) and health conditions such as diabetes, obesity, and breast cancer. Unfortunately, health promotion activities have not been at the

forefront of systematic health actions envisioned for PS-CHWs. In fact, SSA recognized that the PS-CHWs' profile in the catalog of health professions published in 2006 has not been updated to provide a better match to the functions of PS-CHWs within the new model of prevention and health services needed for the country (Secretaría de Salud, 2007). Furthermore, SSA reported a deficit of personnel associated with health promotion activities in the primary care health units for the country. Finally, the personnel code of "promotor" included functions such as secretaries or drivers, which are problematic for establishing PS-CHW key roles and functions (Secretaría de Salud, 2007).

Levels of education, roles, and functions of PS-CHWs in Mexico

In 2005, SSA reported a total of 2905 PS-CHWs representing the 32 federal entities of the country, primarily representing the states of Veracruz, Estado de México, and San Luis Potosí (Secretaría de Salud, 2007). Information gathered by the Director's Office for Health Promotion of the Ministry of Health (Dirección General de Promoción de la Salud, Secretaria de Salud) in 2007 showed that the level of education of PS-CHWs varied from elementary school to bachelor's or graduate degrees and that the category included personnel from disciplines such as medicine, communication, agronomy, social work, nursing, among others. Thus, varied functions and actors referred to as PS-CHWs have been inserted within a health promotion agenda in the country, thus compromising the potentially unique and well-defined roles PS-CHWs can play within and outside health services of Mexico. In addition, the various levels of education reported for PS-CHWs make it difficult to discern to what extent the level of formal education of PS-CHWs has changed over time and to what extent formal education is required or common among PS-CHWs. SSA recognizes the need for making PS-CHWs a profession, which would signify that this workforce requires efforts to recruit, train, and update their roles and functions unique to their profession.

The PS-CHW profession has also been identified as a technical profession. For instance, in 2006, the bachelor's degree in health promotion was developed by the Universidad autónoma of Mexico City (Universidad Autonoma de la Ciudad de México, 2006) to provide a mechanism for promotores de salud working in the area of health promotion to be recognized as having technical skills. Different actors or agents of health promotion within the SSA included personnel from the local health entities with representation of PS-CHWs as members of health promotion teams, working in conjunction with other local institutions to understand and establish community actions to address the health needs of the community. Yet, there is paucity of data documenting the PS-CHWs' roles and functions within these local jurisdictions.

A more recent example of PS-CHWs in Mexico is provided by the Opportunities Program (OP, now called Prospera Program) from the federal government (Avila & Gabarrot, 2009). Most of the PS-CHWs in the OP were females and were selected from their own community as health, nutrition, or education promotores. Their function was to communicate to their peers OP actions or activities. Opportunities Program provided support to women through the provision of monthly cash incentives under the premise of community co-responsibility. The women assisted with conducting monthly nutrition monitoring within the health center primarily focusing on mothers and children, participated in monthly talks about health promotion and assured children's attendance at school. These PS-CHWs did not receive any monetary remuneration but received occasional trainings from OP (on topics such as health, food and nutrition, and education) to maintain their interest and participation in the community.

Currently, PS-CHWs in Mexico within SSA are defined as health professionals who have completed a university degree in medicine, nursing, psychology, nutrition, or social work, whereas in the past PS-CHWs were community members from indigenous communities

who usually did not have such training (Secretaría de Salud, 2005, 2007; Ysunza & Salas, 1996). The principal roles or functions of PS-CHWs are to communicate 35 basic themes of prevention that are required to be implemented in health centers. In terms of hierarchy, the PS-CHW reports to the director of the health center, in addition to the coordinator of social participation (*participación social*), or someone in that capacity who serves as a coordinator of health promotion programs.

The model of PS-CHWs for Mexico promotes the professionalization of health promotion functions within an institutional arrangement and through the ongoing provision of trainings to the personnel involved in health promotion activities. However, trainings have not been done frequently. The health personnel who are devoted to health promotion activities report that these trainings have been insufficient given the many programs they have to cover from the federal and local governments (Secretaría de Salud, 2005, 2007).

EXAMPLES OF PS-CHW PROGRAMS IN MEXICO

A literature search that included Spanish and English databases was performed. Search terms included the following words: promotores de salud, trabajadores de salud comunitaria, and programas en Mexico. Unfortunately, only 15 references were identified that included some type of information related to health promotion and PS-CHWs in Mexico. From these reference works (cited in this article) only 3 examples provided the kind of evidence required for inclusion in this overview of PS-CHWs in Mexico. This evidence was related to examination of 3 components that were used as the inclusionary criteria—overall information about the PS-CHW model, their roles, and health/and or process outcome information. Thus, for each of the 3 examples described in this article these 3 components were identified—overview, PS-CHW roles and outcomes including health outcomes (for the first 2 examples), and process outcomes (last example).

Example 1: The US-Mexico Border Center of Excellence PS-CHW program to counter chronic disease

Overview

The US-Mexico Border Center of Excellence, a collaborative between the University of Arizona Mel and Enid Zuckerman School of Public Health and the Colegio de Sonora (Hermosillo, Sonora, Mexico), has been leading efforts within the border region to provide a knowledge base and research and translation work regarding PS-CHWs (Cornejo et al., 2011). Several key areas are summarized next regarding the PS-CHW model within the US-Mexico border context.

Roles of PS-CHWs

Within a border environment, the roles and functions of PS-CHWs have been defined in the context of community health centers or outside these centers, with PS-CHWs serving underserved urban and rural communities (Cornejo et al., 2011). These roles and functions are intertwined with activities conducted by other health professionals such as nurses and social workers, making it difficult to recognize and evaluate the unique functions of PS-CHWs. However, several activities at the community level have been carried out by promotores or *auxiliaries de salud* (auxiliary health workers) with support of the public health system including SSA. For example, the results of a survey of 121 promotores from Tijuana conducted by Alfaro-Trujillo et al. (2012) illustrate several characteristics and roles-functions of PS-CHWs that shed light about utilization of this workforce for improving health and well-being within a border context. Table 1 presents a summary of the different areas that were covered by the survey regarding the work associated with PS-CHWs within the state of Baja California, Mexico. More detailed information about specific results of this survey has been published by the authors elsewhere (Alfaro-Trujillo et al., 2012).

Table 1. Self-Reported Survey Results of 121 PS-CHWs From Tijuana, Baja Califonia, Mexico

Sociodemographics	97% females, 68% married, 89% with 9 years of education or less, 79% born in states other than Baja California
	50% had salaried job, 1/3 as PS-CHWs plus other jobs: commerce, beauty salon, domestic worker, factory job, waitress
Training	61% received training as PS-CHWs received as total or partially by the Programa de Educación y Formación para Promotoras Comunitarias
	70% also received workshops once or twice a month
	12% received training once every 6 month or less
Recruitment	35% were recruited by other PS-CHWs, 33% hearing it from the organization, 14% recommended by friends
Time working as PS-CHWs	61% work between 1 and 5 hours/week, 14% between 6 and 10 hours/week, 7% between 11 and 20 hours/week,
	30% worked less than 2 years, 14% from 3-5 years, 14% from 6-10 years
Supervision and accompanied	50% always, 16% often, 22% sometimes, 7% rarely
Compensation/remuneration	44% always, 8% often, 23% sometimes, 7% rarely
	40% had a form of monetary compensation, close to 40% received in-kind compensation (ie, food, food coupons)
Priority areas of work/service	Tuberculosis, sexual and reproductive health, blindness prevention, basic health and diabetes detection, nutrition, environmental health, dental health
Specific activities performed	Participating in public health campaigns and distributed materials, 1-on-1 counseling, patient referral and accompaniment, taking vital signs, support sick people, detection
Common health issues identified	Nutrition, family planning, family violence, high blood pressure, diabetes, environmental health, cervical cancer, STDs, HIV, breast cancer, eyesight, tuberculosis

Abbreviations: PS-CHWs, community health workers/promotores de salud; STD, sexually transmitted disease.

Health outcomes

The outcomes of the Border Center of Excellence work with PS-CHWs have been measured through Meta Salud (Health Goal), a PS-CHW–facilitated pretest-posttest quasi-experimental 13-week intervention aimed at improving lifestyle behaviors and clinical outcomes associated with heart health, physical activity, nutrition, diabetes, healthy weight, and emotional well-being (Denman et al., 2014). Meta Salud consisted of a combination of 2-hour weekly group educational sessions and group physical activity sessions guided by PS-CHWs. A total of 9 PS-CHWs from community health clinics administered by SSA delivered the Meta Salud program. The Meta Salud is an adaptation for northern Mexico based on 2 successful heart healthy programs, Pasos Adelante (Steps Forward) and Su Corazón Su Vida (Your Heart Your Life), that have been shown to be successful on the US side of the border region and within and outside border states for reducing risk factors for cardiovascular disease in Hispanics-Latinos (predominantly of Mexican origin) (Balcazar et al., 2005, 2009, 2010, 2011; Staten et al., 2005). Meta Salud was able to successfully replicate positive results in clinical biomarkers (low-density lipoprotein and high-density lipoprotein cholesterol, triglycerides, and glucose) and anthropometric measures (body mass index, weight, weight circumference, and hip circumference) shown by Pasos Adelante. The authors concluded that Meta Salud is a

scalable intervention that can be replicated in many other regions of Mexico in addition to the Mexican side of the border region.

Example 2: The Universidad Iberoamericana, Department of Health, and the University of Texas School of Public Health Promotora de Salud Projects

Overview

A bi-national university partnership (the Universidad Iberoamericana-Department of Health [UIA-DH] in Mexico and the University of Texas School of Public Health [UTSPH] in the United States) has implemented the model of PS-CHWs utilizing the "Su Corazón Su Vida" curriculum of the United States in several Mexican urban communities (Balcazar et al., 2005, 2006, 2009, 2010). This curriculum has been validated and adapted to address cardiovascular health in the urban-poor community of Santa Fe in Mexico City (Perez-Lizaur et al., 2012) and in the municipality of Chimalhuacan, State of Mexico.

Roles of PS-CHWs

For the last 6 years and utilizing community-based participatory elements of the program Salud Para Su Corazón, UIA-DH validated the Su Corazón Su Vida manual and identified the role of PS-CHWs as providers of culturally appropriate health education based on the educational models of Su Corazón Su Vida. These models were part of a feasibility study to test the PS-CHW model for cardiovascular health promotion and disease prevention in Santa Fe, Mexico City (Perez-Lizaur et al., 2012). Within that feasibility study the roles of PS-CHWs were linked to building individual capacity through the delivery of health education. A lead PS-CHW from El Paso, Texas, trained 28 PS-CHWs with the new curriculum and the roles these PS-CHWs played as health educators. Part of the Su Corazón Su Vida education modules includes pedagogic and practical tips as opportunities to facilitate individual capacity to participants associated with the promotion of participants' cardiovascular health and well-being. A total of 28 PS-CHWs participated in the 40-hour training. The feasibility study consisted of a community-based, baseline (pretest) to 12-week follow-up (posttest) design behavioral intervention without a control group for 452 adult participants who completed the program. Promotores de Salud/community health workers delivered the Su Corazón Su Vida sessions in 6 different geographic areas. Sessions were delivered once per week for approximately 2 hours at each site, for a total of 12 weeks in a group format. As a result of the PS-CHW experience, the UIA-DH has become a PS-CHW Training Center for the Su Corazón Su Vida program in Mexico. A total of 7 trainings have been completed with 311 PS-CHWs trained and with 70 PS-CHWs who have received follow-up continuing education trainings to reinforce Su Corazón Su Vida concepts.

The municipality of Chimalhuacan recently went through strategic planning to develop a health promotion plan to combat obesity and associated risk factors for Chimalhuacan. Through UTSPH-UIA-DH collaboration, the roles of CHWs were identified as part of a comprehensive municipality strategy whereby PS-CHWs served in their roles as key agents of change by providing culturally appropriate education utilizing Su Corazón Su Vida manual. The municipality-wide strategy was launched with the support of the mayor (municipal president) and trained PS-CHWs from Chimalhuacan with the program Su Corazón Su Vida (Balcazar et al., 2011; Perez-Lizaur et al., 2012). A total of 120 PS-CHWs were trained to serve as health educators by a team of PS-CHWs nutritionists supervised by UIA-DH and a lead PS-CHW from the El Paso, Texas, network of PS-CHWs. A conceptual framework was developed for establishing key roles of PS-CHWs through a municipality-wide model that the new health promotion plan of Chimalhuacan is launching. The model includes 4 main components as key elements of infrastructure—(1) the Family Development Agency called "Desarrollo Integral de la Familia" functioning as the key agency from which to launch the PS-CHW initiative; (2) the Center for Capacity Building and Training of PS-CHWs, housed in Desarrollo Integral

de la Familia, where the PS-CHWs are organized, trained, and launched to serve as health educators within 12 Community Development Centers located throughout the municipality; (3) a social marketing body from the municipality called "Dirección de Comunicación Social" that will serve to spread the news about the activities of the health promotion model with PS-CHWs; and (4) the Center of Social Epidemiology and Informatics to collect information about changes in health status and social determinants of health. Following the HEART Phase 2 model published by Balcazar et al. (2012), the "Núcleos de Servicio de Salud y Bienestar" (Centers for Health and Wellbeing) are places in the community that will provide additional programmatic opportunities for health promotion in places like parks, schools, churches, supermarkets, and recreation facilities. Within these "Núcleos de Servicio de Salud y Bienestar," PS-CHWs will serve as health educators to accompany community participants to engage in health promotion activities. Finally, in the future, the model envisions engaging the health system infrastructure with new roles for PS-CHWs. This model is being replicated in Tecate, Baja California, Mexico.

Health outcomes

Positive results from the Salud Para Su Corazón program in Santa Fe, Mexico City, were observed in behaviors such as taking action to modify lifestyle, which increased among adults 60 years of age or younger from 31.5% to 63.0% ($P < .001$) and among adults aged older than 60 years from 30.0% to 45.0% ($P < .05$). Positive responses were also observed for cholesterol and fat consumption reduction. The mean blood glucose concentration among adults aged older than 60 years decreased postintervention ($P < .05$). The authors concluded that there were significant improvements in some heart-healthy habits among adult participants and that the PS-CHW model has potential to improve heart-healthy habits and facilitate behavioral change among high-risk adults living in similar poor urban areas of Mexico City (Balcazar et al., 2015).

Example 3: The National Institute of Public Health (INSP) PS-CHW projects with women in Xoxocotla, Morelos

Overview

The town of Xoxocotla is located in the municipality of Puente de Ixtla in the state of Morelos in the south of the country. It has its roots in the Nahuatl culture and is well known for its social movements (Arnaut, 2010). In terms of public health, it presents problems related to family violence, addictions, pollution, and chronic diseases.

From 2005 through 2007, women of Xoxocotla actively participated in a participatory action research (PAR) initiative, by the National Institute of Public Health (INSP) and Emory University, to establish a series of dialogues to create an agenda of community actions that served later as the basis for the PS-CHW health plan.

Roles of PS-CHWs

A series of PS-CHW workshops about self-esteem and empowerment were developed utilizing PE (Freire, 2002) and PAR (Minkler & Wallerstein, 2003). From these workshops the group identified topics related to healthy living and health problems such as overweight and obesity. Female PS-CHWs involved in the collaborative initiated a project based on PE and PAR to address risk factors from cardiovascular disease including overweight and obesity. A total of 30 women participated in a series of nutrition workshops. The reflection-action process of the PS-CHW enabled them to actively participate in the content development and facilitation of the curricula of the workshops. The participatory evaluation of the workshops facilitated recognition of PS-CHW roles—(1) the importance of creating hands-on sessions about healthy recipes and physical activity; (2) the need to be trained on home gardening to increase vegetable consumption; (3) the importance of understanding social, cultural, economic, and environmental barriers that deter from healthy eating and active living; and (4) the PS-CHW role as change agents for building community actions to maintain activities of healthy eating

and active living involving different community stakeholders. The community health center staff expressed their interest in including health topics such as diabetes and high blood pressure.

Process outcomes

The content of participatory evaluation and experience of previous projects led INSP to start a new project in collaboration with the men and women of Xoxocotla. After 4 years of different actions based on PE and PAR (Freire, 2002; Jara, 2013; Nuñez Hurtado, 1998; Shediac-Rizkallah & Lee, 1998) a Community Working Group was formed and has been involved with the development of a strategic plan, called *Michme*. The purpose of *Michme* is that the People of Xoxocotla adopt health as a human right and participate in improving their quality of life through the integration of habits, knowledge and cultural needs for the prevention of obesity, diabetes and hypertension, and adherence to treatment of these conditions.

Capacity building of the Community Working Group and PS-CHW is the core of *Michme* sustainability, through (1) workshops covering different health themes necessary for the design of the *Michme* and its underlying concepts; (2) interchange with similar projects including participating with UIA-DH in trainings such as Su Corazón Su Vida and Project HEART from UTSPH; (3) honoring Xoxocotla's history, present, and future; and (4) active participation in the design and realization of planned activities and its evaluation. As they are not remunerated for their participation, and they have to commit time that could be devoted to an economically productive activity, the permanence of PS-CHW in the group is at risk.

DISCUSSION

The review of the origins of PS-CHWs in Mexico suggests that their roots date back 20 to 25 years in rural Mexico with the presence of indigenous promotores (mostly women) who played a role in their communities using PE. More recent history dating back 15 to 20 years showed that PS-CHWs initiated informal advocacy in communities by playing roles associated with community diagnosis of health-related issues (Rasmussen-Cruz et al., 1993; Secretaría de Salud, 2005, 2007). From community diagnosis, PS-CHW roles and functions became more diverse, with PS-CHWs performing various activities from vaccinations to community health and environmental campaigns. More defined roles and functions of PS-CHWs within the Mexican health system (through SSA and IMSS) accompanied the development of functions of health promotion enacted around 2001, where PS-CHWs were seen as agents (either volunteer or institutionalized) of health promotion.

Unfortunately, by SSA's own accounts the function and roles of PS-CHWs have not been well defined and monitored (Secretaría de Salud, 2005, 2007). A deficit of PS-CHWs personnel has been acknowledged by SSA since 2006. Given the mixed level of education and professional background that PS-CHWs have had within SSA as health promotion agents, there is limited understanding in Mexico of the advocacy role of PS-CHWs who serve their own communities. Furthermore, the development of the bachelor's degree in health promotion by the Universidad Autónoma of Mexico City has confused the definition and level of professionalism and credentialing required of PS-CHWs serving as agents of community health promotion within SSA. It can be said that PS-CHWs in Mexico lack a true identity and relevance within the systems of care that serve the population of Mexico, including vulnerable rural and urban communities.

The development of professional networks of PS-CHWs has been a challenge given the problems of lack of identity, lack of regular employment, instability of financial support for the development of the PS-CHW workforce, the lack of credentialing, and limited empirical work to support the development of evaluation parameters and metrics to judge performance. Within this context of uncertainty about the legitimacy of the PS-CHW as a viable workforce in Mexico, the policy work that is required to promote the profession of PS-CHWs within Mexico remains

elusive. Contrary to popular belief among some CHW advocates in the United States, the federally funded network of PS-CHWs in Mexico is fragmented and has been weakened by a lack of clear role development.

From what is known about PS-CHWs and the limited empirical evidence about their roles and functions, it can be said that PS-CHWs work (as volunteers and at times receiving a stipend) in the periphery and within systems of health care in Mexico. However, the accountability of their roles and functions is limited given the paucity of empirical evidence about their work as agents of health promotion in the communities they serve.

The 3 examples described in this article begin to showcase some empirical evidence of the work (including roles and functions of PS-CHWs) primarily within the context of chronic diseases such as obesity, diabetes, hypertension, and cardiovascular disease. The INSP example provides some anecdotal evidence of an empowerment model that is being tested. The Chimalhuacan PS-CHW model is an example of the potential conceptual framework that can be utilized to test the development of an infrastructure of PS-CHWs that can be inserted within and outside the government with support of municipality infrastructure. However, this model is just being implemented at this point and no data are available. Very promising models for scaling and implementation in Mexico are those from the Meta Salud program in Northern Mexico and the Su Corazón Su Vida program in Mexico City.

CONCLUSIONS

The PS-CHW model in Mexico could be considered as a viable community health promotion strategy to reach vulnerable and underserved Mexicans. Within the strategic approaches put forward by the Mexican Health Promotion Operational Model (Santos-Burgoa et al., 2009), the PS-CHW model continues to be an untapped and yet fertile resource for improving community health and well-being. A potential exists to utilize the 4 pillars of Rosenthal et al.'s (2010) framework for moving forward the PS-CHW workforce in the United States (development of the workforce, occupational regulation, financing, and research and evaluation) to fully examine the feasibility and desirability of PS-CHWs as an intricate and functional part of the Mexican health care systems and other systems of well-being. Building PS-CHW legitimacy and resource investment to develop the workforce has the potential to contribute to the development of an ecological approach to address health needs and begin to tackle in a more cost-effective manner the burden of chronic diseases highly prevalent in Mexico (Acosta-Cazares & Escobedo-de la Peña, 2010).

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Promotores As Advocates for Community Improvement: Experiences of the Western States REACH Su Comunidad Consortium: Erratum

In the October-December 2015 issue of *The Journal of Ambulatory Care Management*, the article by Kutcher et al,[1] "*Promotores* As Advocates for Community Improvement: Experiences of the Western States REACH Su Comunidad Consortium," should have appeared as Open Access in print and online. The article has been corrected online and appears as Open Access on the journal's web site.

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