

Contributing to Family Health Using a Promotora Program in Guatemala

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Abstract

Pneumonia and diarrhea can be addressed with early detection and education, yet low rates of literacy and high rates of poverty impact the ability of parents in rural Guatemala to recognize and seek treatment for their children. This article describes the health promotion program implemented to address these and other common health problems in one isolated community. A promotora program utilizes informal, indigenous leaders within the community to promote health in Latino populations. Developing a health education program based on the promotora concept empowered the women of the community by giving them the knowledge and skills to improve the health of their families and their community. The lessons learned from this culturally-based health promotion model are appropriate for application in local and international communities.

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At the 2009 Biennial Convention of Sigma Theta Tau International, Dr. Karin Morin issued a call-to-action to members of the nursing honor society to contribute to global health. She linked this call to the United Nation's eight Millennium Development Goals as a way for nurses to support the improvement of health for women and children by 2015. More recently at the 2011 convention, Dr. Suzanne Prevost issued her call-to-action to engage in collaboration by bridging the gap between research and practice and responding to vulnerable populations by promoting health for mothers and children. This paper will focus on the implementation of a health promotion program designed to meet these calls-to-action voiced by Dr. Morin and Dr. Prevost. The aims of the paper are to: (1) To discuss the organizing construct of a promotora program for use with Latino populations, (2) To describe the implementation of a promotora program, and (3) To share conclusions and lessons learned from this experience conducted in a rural community in the Highlands of Guatemala.

In the Highlands of Guatemala, the indigenous Mayan women remain a highly, marginalized group. Like other women around the world, they need the skills and knowledge to empower themselves to make decisions about their own health and the health of their families. Both extreme poverty and a lack of education in a male-dominated society prevent them from having a voice or the ability to make decisions which can positively influence the health of their family and community. A research paper commissioned by the Center for Global

Development (Hallman, Peracca, Catino, & Ruiz, 2006) documented the multiple disadvantages that Mayan women face. As young girls they are the least likely to begin primary school, the latest to start primary school, and the first group to drop out of school. The major contributing factors to these rates are the household duties and the poverty that Mayan families experience in the rural regions of Guatemala. Often, parental expectations are limited in relation to the future roles their daughters will have; therefore, education may seem unnecessary for their female children. Overall, indigenous Mayans have an average of 2.5 years of schooling compared to non-indigenous groups with 5.7 years of schooling. Female Mayans remain the most marginalized group in Guatemala with only 39% of them being literate. The lack of education contributes to the high rates of poverty within the region. According to The World Bank (2012), the gross national income per capita in 2010 for Guatemala was \$2,740. In 2006, 51% of the population was at the national poverty line. The risks factors of poverty and lack of education represent major barriers to the health of the indigenous women and children of Guatemala. Education in any form, primary school or health, provides one way to reduce the health risks and limit the disadvantages these families experience in their daily lives.

Organizing Construct

A promotora de salud (Spanish for "promoter of health") is an indigenous leader within a community, who has been trained to address common health issues within the community (Elder, Ayala, Parra-Medina, & Talavera, 2009).

Normally, the promotora is a woman (Arizmendi & Ortiz, 2004). In most Latin American countries, the culture dictates that women are the care providers within the home. They are expected to care for their husband and children during periods of health and illness. Building upon this cultural norm, promotora programs have been successfully established in Mexico and areas along the borders of the United States and other U.S. areas with high Latino populations (Keller, Fleury, Perez, Belyea, & Castro, 2011; Livaudais et al., 2010; McEwen, Pasvogel, Gallegos, & Barrera, 2010; O'Brien, Halbert, Bixby, Pimentel, & Shea, 2010; Waitzkin et al., 2011). A promotora program utilizes women in the community who are recognized as leaders and trains them to educate others within their community about selected health topics; such as depression, cervical cancer, diabetes self-care, and breast cancer prevention. The promotora understands the local dialect of the indigenous language and recognizes the cultural implications which influence how sensitive health issues are discussed (Elder et al., 2009; McEwen et al., 2010). By choosing a promotora from within the community, it reduces the cultural barriers that an "outsider" might face as he or she attempts to enter the community. This concept is very similar to programs which use community health workers to address health problems in low-income countries.

A promotora program is based on the concept of empowerment (Arizmendi & Ortiz, 2004). Women in marginalized populations are provided with knowledge and the tools to improve their own health and the health of people within their community. In the low-income countries where promotoras have been utilized, the women have limited literacy or education levels coupled with high rates of poverty. Many women have not been afforded the opportunities to attend school; therefore, they have not been exposed to health education topics that many educated populations take for granted. Not only does this lack of education influence how they make health care decisions for themselves and their families, it strongly influences their self-esteem. In a study conducted in Mexico (Venguer, Pick, & Fishbein, 2007), 39,000 women were educated by promotoras and rural health assistants over a period of 3 years regarding health and life skills. The program modules focused on basic health skills, adequate nutrition, proper hygiene, and reproductive health. Each module provided content related to agency; defined as the right of each woman to make her own decisions about health, her right to a healthy diet, her right

to negotiate the work load at home, and her right to have control over her own sexual and reproductive health. Based on the study's formal and informal findings, the program positively influenced both health and social well-being of the participants. An additional study was conducted in Guatemala using a similar format and content (Leenen et al., 2008) with 400 women. Their findings indicated that women expressed positive feelings about the value of the program and lead to decreased feelings of helplessness.

The international community adopted the Declaration of Alma Ata at the International Conference of Primary Health Care (1978), which spoke to the need to educate communities regarding basic sanitation, clean water, maternal and child health care, and the prevention of local endemic diseases. The Declaration promoted self-reliance in communities and advocated the use of community health workers to respond to the needs of low-income communities. Many countries heeded the call to action, but unfortunately recent years have seen a decrease in the number of programs being established in low-income countries to address easily treatable health problems, e.g., diarrhea and pneumonia. A renewed call to action has been directed by the United Nations' Millennium Development Goals (MDGs), which were established in September of 2010 (World Bank Group, 2011). The MDGs consist of 8 goals to significantly reduce poverty worldwide by 2015. Of particular interest are goals to improve child health by reducing the under-5 mortality rates through revitalized programs to control diarrhea and pneumonia, and to reduce maternal mortality ratios through access to skilled birth care and reproductive health services. Both the Declaration of Alma Ata and the MDGs are consistent with the concepts which support the use of promotoras. Promotoras are selected from within the local community, work and live in the community, and promote the idea of self-reliance as members of the community learn how to improve their own health with local resources. Providing education about sanitation, hygiene, clean water, and methods to reduce child and maternal mortality is well within the realm of the teaching skills of properly trained promotoras.

Establishing a Promotora Program

As a volunteer of a non-profit organization, I traveled to Guatemala to provide short-term medical care in rural communities in 2005. During my first trip to the Departamento of Sololá in

Guatemala, I was introduced to the community of Pixabaj and learned how the community had minimal access to health care or education. For the first time, a school was currently being built within the caserio (village) and would give children access to an education that had not existed for their parents or grandparents. As the school was emerging and expanding to meet the educational needs of the local children, I remained cognizant of the lack of local health care. The annual medical teams meet some of the immediate needs, yet they do little or nothing for the on-going or long-term health needs of the community. The health of the children and infants, in particular, continue to be a significant concern. According to the World Health Organization (WHO) (2011), the under the age of 5 child mortality rate in 2008 for Guatemala was 34 per 1000 live births compared to the United States rate of 7.8 per 1000 live births. Of the under-5 children who die, 20% of those deaths are related to pneumonia and 19% are related to diarrhea. Both conditions are easily treated if recognized early. Prematurity constitutes 19% of the under-5 mortality rate and is strongly influenced by the fact that only 31% of births are attended by skilled health personnel (WHO, 2011). Providing health education would be one way to empower the people of Pixabaj and help them to improve their own health.

The previously mentioned research studies have shown that promotora programs are effective for health promotion in Latino populations, both in the United States and Guatemala. This type of program could begin meeting some of the health education needs of Pixabaj. Without significant funding, I drew upon local resources and the generosity of students, peers, colleagues, and U.S. health care facilities to donate supplies and equipment. In the United States, many of the supplies and equipment that seem out-dated and useless are very valuable in a low-income country, such as Guatemala.

Being a faculty member in a baccalaureate nursing program permitted me to recruit 10 students to assist with the planning and development of the promotora program. Trip preparation included gathering health statistics (birth and death rates, infant mortality rates, major disease incidence rates, etc.) and conducting interviews with other medical professionals who had worked in Guatemala. My previous experiences in Pixabaj allowed for personal insight into the problems faced by this rural community. To ensure that students had a basic understanding

of the culture, they were introduced to concepts of Guatemalan culture and the basics of Spanish language. For example, students were taught about the importance of family roles; health promotion practices; and the value of respect by health care providers. The introduction to the Spanish language included simple conversational phrases, such as greetings; introductions; directions; and questions.

Based on the health statistics and input from interviews, a plan was established to teach women within the Pixabaj community about basic hygiene, sanitation, vital signs (temperature, pulse, respirations, and blood pressure), first aid for wounds and burns, signs and symptoms of dehydration, directions for making oral rehydration solution, and how to differentiate between signs of pneumonia versus the common cold. According to the United Nations Children's Fund (UNICEF) (2010), only 64% of children under-5 with suspected pneumonia are taken to a health care provider. Earlier statistics reported by UNICEF indicated that only 22% of children under-5 with diarrhea received oral rehydration therapy (ORT) in Guatemala. Currently, no statistics are available for the use of ORT according to the 2005 -2009 time frame. This lack of statistics may be reflective of the decreased focus on ORT by the Guatemalan health system in recent years. In a rural area where many parents are illiterate, these poor statistics are not surprising.

Recognizing that in order for the promotoras to be most successful, the community needed to select the women. Our in-country host collaborated with a local lay midwife, who was well-recognized as an informal health care leader, to recruit 10 women for the initial program prior to our arrival in Guatemala. Based on input from the midwife and members of the community, a total of 11 women attended the health education classes. This initial group included a local pastor's wife, a lay midwife and her daughter, and a local school teacher; all of whom were well respected within the community.

Ten nursing students and I arrived in Guatemala on a Saturday afternoon. Since the following day would be Sunday and Monday was a national holiday (November 1, All Saints Day), we could not begin our classes until Tuesday. At the time, it seemed an inconvenience as we were anxious to maximize our teaching time with the promotoras. In reality, this was a very opportune turn of events. On Sunday, we conducted home visits and attended the local church service. During

the church service, we were formally recognized and welcomed to the community by the pastor and community members. On Monday, we made more home visits and toured a local hospital. Although this hospital was considered local, it still required a 45-minute drive by personal vehicle to get there. Very few people in Pixabaj have access to a personal vehicle. Public buses are the most common method of transportation for most people in the area. This two-day delay turned out to be very important to our success. During this time, we learned a great deal about the daily lives of people living in Pixabaj and the lack of available resources of the community. The information we learned during our home visits allowed us to adapt our teaching plans to the specific needs of the local community. For example, few families have indoor plumbing therefore it was important to teach hygiene and sanitation based on the use of latrines. The trip to the local hospital re-enforced our plans to focus on problems of diarrhea and pneumonia. We saw first-hand the geographical isolation, the poverty, and the lack of transportation which influenced decisions to seek treatment of potential health problems.

Methods of Implementation

On Tuesday, we began our first promotora classes at the local school in one of the larger classrooms. Establishing a relationship is of the utmost importance in Guatemalan culture. We introduced ourselves and shared personal information about our lives, including some details of our families. Next, we asked the women to introduce themselves and tell us about their lives. Sharing personal details of ourselves and our families is consistent with the Latino value of *personalismo*, which emphasizes the importance of establishing personal relationships with health care professionals (Organista, 2007). We also asked the women to share with us how much school they had attended. Having this knowledge helped us to gauge the literacy levels of the women, so we could adapt our teaching as appropriate. As the leader of the group, I explained to the participants that we were there to teach them and also to learn about their culture during this week. Acknowledging that they had something to teach us was one way of demonstrating cultural humility.

Teaching began with the simplest information and built to the more complex procedures. For example, the first day we focused on handwashing, basic hygiene, and counting respirations. We used simple learning activities to reinforce learning,

such as glitter to simulate germs and how they are passed from person-to-person on hands or inanimate objects. Although we came prepared to teach at low literacy levels, we were all taken by surprise that some of the women had never seen a watch. We anticipated that they would not own a watch; therefore, we had brought a watch with a second hand for each participant. How do you teach someone to count respirations if the person has never seen a watch? The nursing students were stunned momentarily, but they quickly adapted and used a large clock from the school kitchen to demonstrate how the second hand of a watch makes one complete rotation every minute. Using this demonstration, they taught the women how to count respirations for one full minute with a watch. Each subsequent day we added new information and built upon the content from the previous day. Each content area was re-enforced with demonstrations by the nursing students and return demonstrations by the participants. Certain content and procedures were modified and taught based on the ability and literacy levels of the women. For example, due to the limited literacy of certain women (women who had no formal schooling), we were not able to teach blood pressure procedures to everyone. For the women with extremely low literacy levels, we focused on the simplest procedures such as taking a temperature or counting respirations. Normal values and actions required for abnormal values were re-emphasized with games and repetition. For example, we used simple games such as Pin the Symptom of Dehydration on the Baby (a modified version of Pin the Tail on the Donkey). We used visual teaching aids to help the women recognize abnormal conditions associated with pneumonia and dehydration. Teaching with third-fourth grade level terminology seemed most appropriate for the majority of women. By the end of the third day, we were able to complete the teaching for all of our planned topics.

Reciprocity is an important component when working in a service capacity in communities. From the beginning, I expressed a desire for us to learn from the people of Pixabaj. On the last day, the local midwife brought her materials and taught us how she examined and cared for expectant mothers during the birthing process. The women of Pixabaj taught us about their local beliefs and use of folk medicine to treat common ailments. For example, intestinal parasites is a common etiology of diarrhea in Guatemala and many of the local families make a tea from a local

herb to treat for parasites. The students and I were encouraged to practice our Spanish skills. During our visit to the hospital in Sololá, we had the opportunity to visit a local market and cemetery to observe the rituals of All Saint's Day. At the hospital, we talked with Guatemalan physicians and observed the differences in health care systems between Guatemala and the United States. Every encounter during this week provided a window to a new world and the lives of the indigenous people of Guatemala. Each student will be forever influenced by the experience with the potential to make a positive impact in their future careers as registered nurses as they work with an increasingly diverse client population. In a study by Amerson (2012), students who had taken part in similar international experiences during nursing school were able to provide culturally congruent care with patients following graduation and during their subsequent practice as registered nurses.

On the last day of class, we held a graduation ceremony for the promotoras. Before leaving the United States we had collected supplies for the promotoras to use as they provide care in their local communities. As my students and I hummed the graduation song, each promotora was presented with a certificate of participation and a nursing bag with scissors, a watch, bandages, soap, and other equipment they might use to promote health and prevent illness. A picture was taken of each woman as she was presented with her bag and certificate. Afterwards, we held a celebration with cake and punch. An unanticipated benefit of the program was the boost to the promotoras' self-esteem. For the first time in their lives, they were recognized for their accomplishments outside the confines of their home. For some of these women, this was their first opportunity to ever attend school. They were empowered to learn about improving their own health and the health of the family.

In November of 2011, I returned with an additional group of nine nursing students to continue the education program. All of the initial promotoras from the first class returned, along with two additional women from the community. One woman was the wife of the local pharmacist who had heard about our program and the benefits to the women who had attended the previous year. The other woman was another lay midwife from the community. The teaching this second year re-enforced the content from the previous year and added information about potential carbon monoxide poisoning, which results from the use of temazcals (steam baths) (Thompson, Clark,

Cadman, Canúz, & Smith, 2011). Temazcals are commonly used for bathing and spiritual purposes in the Highland regions of Guatemala among the Mayan people. This topic had to be approached in a highly sensitive manner in order to acknowledge the value of this spiritual practice; while educating them about the potential dangers particularly to infants, young children, and expectant mothers. For example, rather than suggesting that they stop using the temazcal for bathing, we educated them about the signs and symptoms of prolonged exposure to carbon monoxide and to limit their time in the temazcal.

Evaluation of the Benefits

Some colleagues doubted the effectiveness that a promotora program would have in this rural region. They felt that the low literacy levels and the language barriers would prevent us from having an impact. Literacy levels and language were barriers, but we were able to overcome them. Since this was a small-scale program, no formal research method of evaluation was conducted. This is not to say that we did not have a positive impact. Our impact was just not measured in a conventional manner.

Everyday each woman attended class, even though it meant a 2-hour walk round-trip for many of the women. At least two women brought their infants strapped to their backs and cared for their infants as they attended class. Each woman listened intently to the lectures and engaged in discussions. All of the students and the promotoras laughed and talked together about the issues that women face, regardless of their geographical location. During classroom breaks, the students and the promotoras shared snacks and played volleyball. The learning process was not just focused on learning content, but also on establishing personal relationships. The smiles on the faces of the promotoras as they received their certificates and nursing bags can never be measured by a survey. The expressions on their faces spoke volumes about the joy and the self-satisfaction of accomplishing something that would help themselves and their families. One participant shared with us:

When the floods came and devastated our village, I felt so hopeless to help my neighbors. What could I do? I did not know what to do or have anything to use to help them. Now, I feel that I could help them with what I have learned this week.

Each participant personally thanked each

member of my team with words and hugs. They told us they would be waiting for us to return to Pixabaj. They were eager to learn and wanted more. Even, my nursing students were amazed at how quickly the women had learned procedures, such as taking vital signs. The nursing students felt the women had such an overwhelming desire to learn which compensated to some degree for the literacy or language barriers.

On the return trip in 2011, we begin the classes by asking participants to share how they had used the information that they learned from the previous year. Several women spoke of how they shared the information with their neighbors. For example, one woman had recognized that her neighbor's infant was exhibiting the signs of pneumonia and encouraged the family to seek medical treatment. As we reviewed the previous year's content, we consistently observed behaviors that we had taught the previous year; such the correct procedure for handwashing. Handwashing seems such a low level skill; but in a country where many infants and children die from diarrhea and dehydration, it cannot be stressed enough. We also observed that the women with higher literacy skills were taking notes of the content that we covered. At least 2 of the women from the previous year had kept notebooks with the previous year's information and were now adding to it. The school teacher requested our education materials (posters and handouts) at the end of the week, so that she could share it with students in her classroom.

Establishing and maintaining a relationship was a major emphasis for the program. It was clear that we had done this, but again it was not measured in a conventional manner. The first day of our return trip, we were greeted by the women with hugs and smiles. The women spoke excitedly about how happy they were that we had returned and were already talking about a return for the next year. On the second day of the classes, each woman brought in her traditional clothing and as a group they dressed my students and me in the traditional style. For the women to dress the students and me in the traditional clothing was a sign of respect and gratitude for our teaching. This also allowed us to share a part of their traditional Mayan culture. On the last day of the class, each woman stood and expressed her sincere gratitude for what we had brought to their community. They were disturbed that they had nothing to give us since we had given them so much. We assured them that their kind words and willingness to come to our classes were the only reward that we needed. No,

we did not use t-tests, surveys, personal interviews, or focus groups to measure the results; but it was clear that we had made a positive impact. Recently, one of the students who had taken part in teaching the promotora classes emailed me. She was now working in labor and delivery and had recently cared for a newly immigrated Guatemalan woman. The student shared that her experiences in Guatemala had helped her to be more prepared to communicate with this patient. As the student wrote in her email, "I believe this was the most connected that I've been with a patient."

Lessons Learned

The lessons learned from this international experience can be applied to both local and international settings. Gathering available health statistics about the community provides evidence of prevalent diseases and health conditions to be addressed through education. Both the World Health Organization and the Central Intelligence Agency provide health statistics by country which may prove useful in the planning phase. Health educators need to take time to observe the local conditions by visiting homes. Outsiders coming into a new community may believe that they understand the health needs of a community, but may fail to understand the cultural context and living conditions which influence healthcare decisions unless they visit the homes of community members. Interviewing and seeking the input of local health leaders, both formal and informal, allows them to become involved participants in the decision-making process. Obtaining the "blessing" (permission) of the community prior to entry into the community will help to promote a successful community program. In many collectivistic cultures, developing a personal relationship is a pre-requisite to task completion. A promotora program utilizes those personal relationships within the local community as a vehicle to promote health education. In our case, the in-country host was an accepted leader in the community and acted as a community liaison to facilitate communication between the health educator team and the community members. Each of these steps can be utilized when working in communities, regardless of the setting.

Conclusion and Implications

According to Domínguez and Arford (2010), social capital requires linking of marginalized people with ties to resources outside their community. While the relationship is usually vertical due to

the inequality on a socioeconomic scale, it has the potential to be very positive by bringing in new information to the local community. My students and I brought information to a local community who could benefit from our knowledge, but we also learned elements of their culture which would benefit us as we care for Latino cultures in the United States. The promotora program encourages bonding of social capital by utilizing the women of the community in their natural “caregiving” roles for their families, friends, and neighbors. In order to continue bridging social capital, we hope to begin working with a local Guatemalan school of nursing and local health practitioners.

Earlier research has demonstrated that promotora programs are effective in promoting emotional and physical health in Latino communities. This paper has focused on how these research findings have been translated into practice and used to address the health needs of a vulnerable population per the calls-to-action by Dr. Morin and Dr. Prevost. Nurses working in local communities within the United States need to consider establishing small promotora programs to address specific health needs of their Latino clients. The information shared here provides a roadmap for other nurses who desire to develop a culturally-based health promotion program. Nurse educators who recruit students for international experiences should consider developing on-going educational programs to address health problems in low-income countries.

From a research perspective, nurses should consider adapting the cultural aspects of a promotora program to meet the health needs of other immigrant populations within the United States. In order to accomplish this, the researcher will need to determine the cultural expectations of the target group. Using the health promoter concept with a different culture and adapting the educational intervention to take into account the unique expectations of the cultural group will provide rich insights into how different populations respond to health promotion interventions. Additional research is still needed to understand how promotoras function mostly effectively in working with clients who are experiencing chronic health conditions (Keller, Borges, Hoke, & Radasa, 2011). In the near future, we plan to conduct a more formal community evaluation to determine the effectiveness of the program in Guatemala. The use of promotora programs to educate the public has many relevant implications for both clinical practice and research.

On the last day of class, we asked for input about issues that the women wanted to learn in the upcoming year. Based on their health concerns and learning desires, the program will focus on the unique health problems of women and expectant mothers. This trip to Guatemala was not just a destination for my students and me. It is a journey that we will continue as we return in future years. Each return trip will build a stronger relationship and we will continue to improve family health as we educate the women of Pixabaj.

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