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Executive Summary

Lead poisoning is one of the greatest health risks facing young children in Rhode Island. Although an extended network exists to deal with the crisis, many families continue to lack basic information about lead poisoning prevention. This information gap is particularly a problem for recent immigrants, of which Latinos comprise the majority in the state.

In this thesis, I examined the reasons for the information gap and focused on a new program in Rhode Island that attempts to address the issue. The program is sponsored by the Center for Hispanic Policy and Advocacy (CHisPA). It promotes both health and leadership in the Latino community by training health *promotoras* to conduct educational outreaches in their communities on a variety of topics--including lead poisoning. Over the course of two semesters, I used the qualitative research methods of participant observation, formal and informal interviews and document analysis.

From my research I found that the informal and diverse nature of the outreaches make them an effective means by which to communicate important information about lead poisoning to Latinos in Rhode Island. The program has the potential to increase awareness about prevention techniques, and it serves as a model for future educational outreach efforts on urban environmental issues. Finally, the promotoras program works to develop a stronger and healthier Latino community overall.

Prologue

I followed a rather round--about path to the promotora's program. In the fall of 1995 I began working as an intern with Childhood Lead Action Project (CLAP), which is based in the Juanita Sanchez Center in Providence, RI. Through my work with CLAP, I became interested in the concept of how to effectively communicate information about lead poisoning prevention to parents. While working at the Center, I met the program coordinator for the promotoras and began to learn about the program from our informal conversations. As the semester wore on, I became interested in comparing the CLAP and the promotora programs in order to understand how they might work together, and in what ways their goals and strategies differed.

Unfortunately, due to funding constraints, CLAP was forced to take a temporary hiatus at the end of November. As a result, I refocused my attention on the work of the promotoras. Over the past 6 months they have given home presentations in apartments at Elmwood, Cranston, and Olneyville. All of the outreaches have been hosted by Latina mothers with children living at home below the age of nineteen years of age. The hosts are generally friends or family of the promotoras, or an individual connected in some way with the Juanita Sanchez Center. Through my work with the program I have learned not only about lead poisoning prevention, but about the Latino community in Rhode Island, the challenges and successes of community organizing and education, and the ethical considerations for university students who conduct participatory community research.

1 Introduction: Lead Poisoning and The Need For Prevention

INTRODUCTION

The time has come to reallocate the nation's resources towards preventative health promotion and education. Based on a review of recent journal articles, most public health specialists would agree with this vague, yet noble statement. Yet despite the fact that prevention has become the “buzzword” of the 1990's, the majority of preventative intervention studies have not included the groups most in need: minorities, women and immigrants--often a combination of all three. Ramirez, MacKellar, and Gallion (1988) have noted the paucity of published accounts of public health intervention programming aimed at minorities:

Most of the large community health demonstrations of the last decade have occurred primarily but not exclusively with White North American and European populations. *Some groups most in need of reducing health risks may be minimally influenced by programs aimed at the dominant culture. This is especially true among recent immigrant and refugee populations, with their varying cultural, dietary, and folk medicine practices* (Blum, 1990, p.253). (emphasis added)

How can we know if the populations most at risk are receiving the information they need if they are not included in such studies? Health promotion entails more than a flood of educational materials into the pamphlet display of the local clinic. How best to conduct

preventative intervention, particularly in high risk populations, is one of the most difficult challenges facing specialists in the public health and environmental fields.¹

Latinos as a group in the U.S. are statistically considered at risk, particularly recent immigrants. Approximately 20.8 million Americans identify themselves as of Hispanic origin, which is roughly 8.4 % of the US population (1990 Census). Of these families, 23% have incomes below the poverty level, as compared with only 9% of white non-Hispanic families (Ibid.).

Comment [HW1]: Page: 4
shouldn't you use RI data? Should be available from the SSDC

In this paper I will focus on Latino² populations in Rhode Island, but the reader should keep in mind that a number of the issues that this group faces are relevant to Latinos elsewhere, as well as to other recent immigrant groups. In Rhode Island, Latinos make up the majority of the immigrant population and often live in some of the poorest and oldest areas of the city. Almost 90% of Latinos in Providence earn less than \$20,000 a year (US Census of Population and Housing, 1990). Nearly half of Latino children in Providence live in house-holds that are below the poverty line, whereas less than a fifth of Anglo children live in such conditions (1990 Census). Latinos comprise the largest group of immigrants in the state. In the past ten years the Latino population in Providence increased 133%. (Healthy People 2000, p.3), and in 1993, the majority of legal immigrants stating their intent to move to Rhode Island were Latinos (Statistical Abstracts of the U.S.). Latinos also comprise the largest linguistically isolated group in

¹ Risk level based on mortality rates, incidence of reportable diseases, maternal and child health, EPA air quality standards and socio-economic statistics (Healthy People 2000, 1995, p.3).

²The term Latino is used throughout this paper to refer to individuals with origins in Latin America, the Spanish Caribbean, and Puerto Rico. The majority of Latinos in Providence are Dominican, although sizeable Guatemalan, Puerto Rican, Columbian and Salvadoranean communities also exist.

Rhode Island, which means that within a household, no one over age 14 speaks English “Very Well”³ (Census, 1990).

Latino populations in Rhode Island are at high risk for many illnesses and diseases. In Rhode Island’s 1990 Health Interview Survey, 41% of Latinos reported being in fair or poor health. The incidence rate of Tuberculosis in Latinos is seven times that of whites, and 21% of Latinas desiring live births didn’t receive prenatal care in their first trimester (Reynes, 1995, pp34-38).

Lead poisoning is one of the greatest health risks for young Latino children in the state. One out of six children in Elmwood (a predominantly Latino neighborhood in Providence) will be lead poisoned, as opposed to one out of ten Anglo children (Promotora fact sheet, 1996). The problem is that while a number of resources exist to treat those suffering from lead’s affects, few resources have been channeled into prevenative intervention, especially intervention targeted at Latinos.

THE THREAT OF LEAD

WHAT IS IT, AND WERE DOES IT COME FROM?

Once identified as “The Free State”, Rhode Island now has the dubious distinction of being known as “The Lead State”, possessing one of the highest percentages of childhood lead poisoning in the country (RIDOH grant, 1994). Lead poisoning can cause significant brain dysfunction in children, resulting in symptoms ranging from headaches and loss of appetite to aggressive behavior and developmental

³ Very Well is one of five options which non-native English speakers can choose from on the U.S. Census.

retardation (McCann and Husband, 1995). Its effects impact not only the family of the poisoned child but reverberate throughout the Rhode Island population. According to a public health briefing produced by the Rhode Island Department of Health (RIDOH), the dysfunction that lead poisoning can produce “costs Rhode Island millions of dollars in avoidable special education costs annually (Simon et. al., 1995 p.120).”

In the summer of 1995, approximately five percent of children who had their Blood Lead Levels (BLL) tested in Rhode Island were legally defined as poisoned, which means that their BLL was 25 micrograms per decileters (*ug/dl*) or more. Although the children may have encountered the lead in a number of ways, the most common source is in house paint. Since 68 percent of the homes in RI were built before 1950 (Plant, 1988, p.2), and house paint contained lead until 1972, most children become poisoned in or around their homes, where they ingest paint chips, or dust and soil containing pulverized lead paint. Other sources include: lead soldering in the jewelry industry; glaze used on pottery from countries such as Mexico or China; and the soldering used in food containers produced outside the U.S. (although customs no longer permits food containers that use lead to be sold in this country). While the natural lead content of surface water and groundwater is negligible in Rhode Island, (McCann and Husband) lead can leach into tap water from household plumbing. The greatest risk, however, is in the windows of the home.

IT'S NOT THE WEALTHY WHO WORRY

As with many health issues, education and socio-economic status influences the likelihood that a child will be lead poisoned. According to the 1996 Rhode Island KIDS

COUNT Factbook, the number of lead poisoned cases increased 12% in 1995 in the five poorest sections of the state, which is more than double the number of cases in the rest of Rhode Island. A 1995 RIDOH study showed that in wealthier areas of state, such as Barrington, the number of cases of lead poisoning was insignificant whereas in poorer and older areas, such as Providence, the proportion of all children identified as poisoned was close to 15 percent (RIDOH: "Health by Numbers", 120). In 1995, 35.3 percent of Providence children with BLL's above 15 *ug/dl* were Latino children, even though Latinos comprise only 25% of the city's population (RIDOH Blood Lead Summary Report). There is little doubt that lead poses a serious threat to the Latino community in Rhode Island, particularly in low-income, urban areas of Providence, Central Falls, Cranston and Pawtucket.

ABATEMENT VERSUS EDUCATION

Since the most common source of lead poisoning in Rhode Island is house paint, the most effective method to avoid poisoning a child is to abate the lead found in the house (EPA, 1995 p.xi). Unfortunately, this process is long and costly. Moreover, if the abatement is not carried out properly, and if the child is not removed from the house during and immediately after the process, according to an EPA review of studies addressing lead abatement, the child's BLL may actually increase as a result of the construction (*ibid.*). Often families most at risk can't afford to abate the lead in their homes. Frequently they are tenants and must rely on their landlords to remove the lead paint or cover it with new paint. Two thirds of Latino residents in Rhode Island rent their homes, and in Providence the number is close to 80 percent (U.S. Census, 1990). Thus

many Latino remain at the mercy of their landlords, who are slow to respond to abatement (or other requests) because of negligible profit factor, as well as the relatively empty threat of legal action.⁴

Families who are unable to abate are not helpless, however. **Simple safety precautions performed in the home, such as placing furniture against windows, improving the child's nutrition, and wet-mopping floors and window sills with detergents that contain phosphates can reduce BLL up to 50 percent, with an average decrease of 22 percent (EPA, 1995).** While these measures alone cannot eradicate the threat of lead, they can significantly reduce the risk that children face.

CHALLENGES TO REACHING LATINO FAMILIES

LIVING OUTSIDE THE HEALTH CARE SYSTEM

In recognition of the barriers to abatement, RIDOH, clinics and non-profits have initiated efforts to increase education in Rhode Island, but progress has been slow. Although it has been shown that learning about protective measures reduces the risk of lead poisoning, many Latino immigrants do not receive this information. Either they do not come into contact with health-care practitioners who explain the necessary methods, or if they do receive the information, it is not conveyed in an effective manner.

1992, the RI Kids Count Data Book reported that 11.8 percent of the 225,690 children in RI have no form of health insurance, and according to the 1990 RI Health

⁴ This subject is complex enough to warrant its own thesis, which now exists. For further information, see unpublished thesis by Pat Boulay.

Interview Survey, 15 percent of RI residents have no regular source of primary medical care (RIDOH grant application 1994). For Latinos the statistics are as high as 17.8 Percent (Reynes, 1995, p. 22). One coordinator at the Providence Head Start program sometimes spends an entire year tracking parents down to make sure that all of their children's medical forms are up to date.

These numbers do not even include residents living in Rhode Island without documentation, one of the groups most likely to be without regular health care. For obvious reasons, it is difficult to gather accurate data on undocumented residents living in Rhode Island, but by all accounts (from Latino Community Leaders, to the Planning Office of the State House) the numbers are at least in the hundreds, and the majority of these residents are Latinos. For families without documentation, "the fear of mistreatment by immigration officials, drug investigators, and other types of authorities is always present."(Cesareo Amezca et al., 1990, p.255). According to one outreach worker at RIDOH, even though their children register for school, many undocumented immigrants manage to avoid contact with doctors or representatives of RIDOH, whom they perceive might be connected even remotely to Immigration Services. As a result they often remain outside of both federal and state health care assistance programs.

Comment [HW2]: Page: 3
I don't think this is the right term - immigrants have little to fear from Immigration - don't you mean undocumented aliens?

Comment [HW3]: Page: 3
you need to make clearer that kids also are supposed to be tested when they "hit the system" i.e. before they start school or day care - are you saying that this doesn't work or that some kids are just kept out of the system?

LANGUAGE AND CULTURAL BARRIERS

Often it is difficult for Latinos to receive the necessary information even if they do see a health care professional regularly. Many immigrants, unaccustomed to the U.S. health care system, are loathe to challenge their doctor, or are unable to do so in English. Therefore, it is often more difficult for them to obtain the follow up tests and to receive

language--appropriate information about lead poisoning. A false assumption exists that translating materials into Spanish makes them fully accessible to Spanish speaking families. Even when information is translated, it may be at a literacy level well above that of the parents. According to one community organizer, many Latino families are not accustomed to reading the pamphlets they receive. Finally, while lead poisoning is a serious threat to children, many families must contend with more basic issues such as food and clothing. The amount of time and energy remaining to deal with lead poisoning is minimal. Understanding these challenges to communicating lead prevention strategies among Latinos is important in order to develop effective intervention programs.

2 Study Design and Methods

INTRODUCTION

For my study, I wanted to find out in what ways the promotoras program could enhance the present system of medical, legal and social services with regard to lead poisoning. In order to do so, I used a combination of methodologies, including participant observation, formal and informal interviews and document analysis. To respect the privacy of those individuals with whom I spoke, I have not included their names in this document (Kimmel, 91). In some cases the professional title will enable those familiar with a program to identify the speaker, but I believe that the title is necessary in these instances to give validity to the speaker's perspective on the subject. I have not used the promotoras' names nor any other information I thought might identify them in this document, except for their areas of expertise when necessary, as well as general demographic information about the group as a whole.

While a study of whether Blood Lead Levels (BLL's) decreased in the months following the outreaches, or an investigation as to whether parents altered their behaviors after the presentations would have been most useful in studying the efficacy of the program. I came across a number of obstacles to obtaining this type of data, however, and in any case, this information alone would not have been sufficient. If a program is

successful, it is necessary to know why it works, so that it can be replicated. Thus more than BLL or even behavior changes was needed.

One of the main problems with studying BLL or behavior directly is that this type of research would have required prior knowledge of BLL or parental habits within the home. Since many of the participants were unknown before they attended the outreaches, it would have been difficult to gauge accurately how much their behaviors changed. It would have been possible to obtain BLL records, but because the promotoras have been active for such a short period of time, it was not possible to take a large sampling of participants, nor evaluate changes over an extended period of time.

In order to find out the promotoras' role in lead poisoning prevention, I used the following questions as a framework for my investigation.

1. What kind of information has the targeted population already received, and what haven't they received?
2. What differentiates the promotora presentations from the other outreach efforts?
3. How well prepared are the promotoras to respond to the needs of the targeted population?
4. What aspects of the promotora presentations were most appreciated by the participants
5. How sustainable is the program?

METHODS

To answer the above questions required the use of several different methodologies. Questions (1) and (2) necessitated, in particular, that I read the literature of the various organizations addressing lead poisoning in Rhode Island and, conduct informal and formal interviews with their staff and with outreach participants. I used primarily participant observational techniques to answer Questions (3) and (4). For Question (5) I based my conclusions primarily on the afore-mentioned methods but also compared my observations to information gleaned from phone interviews with other program coordinators around the country and from similar case studies found in journal articles. The use of multiple sources of evidence enhanced my research, because it enabled me to “address a broader range of historical, attitudinal, and observational issues” (Yin, 1988 p.97). Often interviews conflicted with my own observations, and thus I used triangulation methods in the form of background research and further interviews. The multiple-technique approach was essential because no one method enabled me to view the entire picture.

PARTICIPANT OBSERVATION

“Participant observation combines participation in the lives of the people under study with maintenance of a professional distance that allows adequate observation and recording of data” (Fetterman, p. 45). Most of the observation of the promotoras took place during evening presentations and the Saturday morning planning meetings from October 1995 to March 1996. A total of fifty people were observed, five of whom (the promotoras) were formally interviewed. I interviewed half of the participants informally.

Comment [HW4]: Page: 12

This seems like a rather random list of non-parallel items. You'll need to explain the logic of their choice, and why other questions - e.g. "How much is awareness changed by participation in a Promotras' session"? are not included.

I attended five outreaches, each of which lasted between two and a half to three hours. These outreaches took place in a participant's home. Generally they consisted of an initial half hour for socializing and set-up; four twenty minute presentations followed by question and answer periods on AIDS, breast cancer, domestic abuse and lead poisoning; a twenty-minute "wrap-up" segment, which included games used to reinforce the information; and a twenty-minute clean-up at the end. I also attended seven Saturday morning meetings, which lasted between two and three hours. While working at CLAP I participated in four outreaches, each of which lasted roughly an hour, and one RIDOH home visit, which also lasted roughly an hour.

My role as a participant differed depending on the situation. I always acknowledged my status as a student but sometimes emphasized my experience with lead and other times discussed my thesis research. At the promotora outreaches I assisted with set-up and clean-up and occasionally took pictures. Like the other promotoras, I sometimes asked questions of the presenters but did so infrequently. I tried to be encouraging during the presentations but found that I had to break eye contact frequently so that the promotoras would not address their talk to me.

During these presentations, I looked for the following indicators as a means to gauge the interaction between the promotoras and attendees:

- Do the parents appropriate the language of the educators?
- Who asks questions?
- To whom do they address these questions? the educators only? one another?
- Who does not ask questions?
- Do the parents tend to tune out during certain sections?
- How do the educators incorporate visual aids into the presentation?
- What motivates parents to attend the presentations?
- What information are parents most interested in?

Comment [HW5]: Page: 15
tell me more about this one

Comment [HW6]: Page: 15
not clear to me what you do with the answer to this one, or to the second one below.

Comment [HW7]: Page: 16
Again, this seems almost like a random set of questions - I don't see a logical track here. Let's discuss these.

I used these indicators because I was not authorized by the coordinator to hand-out formal surveys or do formal interviews with those in attendance. The coordinator was concerned that in the initial stages of the projects, that such evaluation would have a negative impact on the program because participants would consider the follow-up contact intrusive. As a result, I needed to rely on my own observations in order to ascertain the satisfaction of the participants. I was able to ask informal questions during the breaks such as “what have you heard about lead before this talk?” but obviously did not have time to speak with all of the participants in this fashion. While I did not generally take notes during the meetings and outreaches, I did take “quick notes” of important actions or statements, and wrote up field notes immediately after each observation, often as I sat outside in my car.

FORMAL AND INFORMAL INTERVIEWS

I began my research by reviewing the existing programs working to reduce the incidence of lead poisoning in Rhode Island. Between November 1995 and February 1996 I conducted informal interviews, which lasted roughly an hour, with the following individuals at their respective organizations and institutions:

Outreach Worker and Lab Analyst	I Department of Health (RIDOH)
Director and Outreach Worker	Childhood Lead Action Project (CLAP)
Outreach Coordinator	Visiting Nurses Association (VNA)
Nurse	St. Joseph's Lead Clinic
Nurse	Hasbro Lead Clinic
Nurse Practitioners	Blackstone Valley Health Centers
Community Outreach Coordinator	Elmwood Neighborhood Housing Services.
Health Outreach Coordinator	Social & Ethnic Development Center for Southeast Asians (SEDC)

As I have worked with several of these individuals, I considered them to be Key informants (Yin, p.89). These interviews helped me to elucidate the similarities and differences between the educators' expectations and the expectations of parents, and they enabled educators to point out areas where they believed the various groups might work more closely with one another. While I was not able to interview doctors, I was able to speak with practitioners at both Blackstone Valley Health Centers in Pawtucket and Central Falls. These clinics serve a large percentage of the Latino population in Rhode Island. These interviews assisted me to outline the role which doctors play in the educational process.

In addition, I interviewed five of the eight promotoras individually in Spanish, using a standard protocol that combined both formal and informal interview techniques (Fetterman, p.49). These interviews lasted approximately an hour each. Because I spoke

Comment [HW8]: Page: 17
I don't follow here.

to the promotoras almost exclusively in Spanish, and I am not a native speaker, I taped these interviews in order to ensure accuracy. While I found these interviews useful and enlightening, I received as much information, if not more, from listening to comments and observing actions during meetings and presentations, and from talking informally with promotoras during breaks. For example, I asked several women about the difficulties of working with women from other countries, to which most responded that it was an asset and not a problem. One promotora explained, “It helps that there’s a mix of nationalities...even though it’s Spanish, each group has their own vocabulary. So if someone is giving a presentation to people who are not from their country, they will know what words they can and can’t use”. At the same time, all of the Central American promotoras dropped out of the program. While there are additional possible explanations for this occurrence, a discrepancy existed between the perfectly harmonious picture which the promotoras desired to paint, and the reality of the occasional friction between personalities.

In order to avoid false assumptions, I used triangulation to verify the information I received in the interviews. Triangulation involves “testing one source of information against another to strip away alternative explanations and prove a hypothesis” (Fetterman, 89). I found this technique extremely useful in understanding what motivated the women to participate in the group. Often their explanations about the camaraderie sounded pat and slightly rehearsed, but watching the way they relied on one another during the outreaches, and joked around after the meetings, their words took on a deeper meaning.

DATA ANALYSIS

In order to understand the different theoretical frameworks of the various groups,

I compared their mission statements, visual aids, pamphlets etc. with journal articles. I looked for how culturally appropriate the materials appeared to be for the targeted community, as well as the assumed literacy level of the materials. I also looked for differences in the underlying goals of the organizations. For example, whether they articulated an awareness of lead in the broader context of health and urban environmental justice issues. I tried as much as possible to evaluate the extent to which the actions of the organizations conformed to their statements of purpose. This task was difficult, however, because I was only able to observe the work of the promotoras, CLAP and RIDOH.

Comment [HW9]: Page: 17
the missing piece here seems to be interviews with those who attend the sessions. Aren't these the most important folks with whom to speak?

GAINING ACCESS

Certain pitfalls exist with the use of participant observation because the researcher can “assume positions or advocacy roles,” which may affect her observations (Yin, p.92). In addition, “the participant-observer is likely to follow a commonly known phenomenon and become a supporter of the group or organization being studied, if such support did not already exist,”(ibid., p.93). While these issues must be acknowledged, I would not have been allowed access to these groups as a mere observer. Participation in the outreaches permitted me (to a limited extent) to perceive the situation from the viewpoint of those involved in my study (ibid.).

Obtaining access through the *gatekeeper*--the program coordinator--was crucial to my study (Yin, p.52). A number of individuals approached the coordinator during the time I worked with the group, requesting permission to observe the program and interview the women. I was the only researcher whom she allowed to sit-in on the program. She expressed her concern about the women’s discomfort with outside observers, as well the sense that the researcher would “use” the promotoras without contributing to the program. Initially, when I sat in on some of the Promotora meetings and attended the outreaches, I went on the pretext of being a friend of the coordinator. Soon, however, I began to feel uncomfortable, because I was representing myself falsely to those individual’s whose work I was observing (Kimmel, p.71). I then attended a Saturday meeting and explained my research, asking permission to attend their outreaches. While the promotoras may have felt pressure to permit me to accompany them, by setting my interests out initially, I was able to gain their trust. I was able to speak honestly about my own work, just as they did about theirs.

In exchange for access, I also offered my “services” to the women in a number of different ways. I was able to do review training sessions on lead poisoning; assist with office duties; give rides after the parties; and generally be supportive during the presentations and give constructive feedback afterwards. In addition, some of the promotoras saw my work as a means towards greater state-wide recognition and funding. In a sense, my contributions to the program gave me the right to participate as an “honorary” promotora

3 The Existing Service Web

INTRODUCTION

A complex network of medical, legal and social forces working to reduce the incidence of lead poisoning in Rhode Island already exists. At the center of this web is RIDOH, which receives funding from the state, the federal government and the Center for Disease Control (CDC). The RIDOH helps to fund the lead treatment clinics, the Visiting Nurses Association Inc. (VNA) outreach programs, and other non-profit outreaches. Yet while all of these programs play important roles in the war on lead, few of the programs specifically dedicate their efforts towards prevention.

THE HUB: THE RHODE ISLAND DEPARTMENT OF HEALTH

PROGRAM OVERVIEW

The RIDOH lead program is composed of three separate divisions: the Laboratory, Family Health, and Risk Assessment. Since the mandatory testing law was passed in 1991, health care practitioners are required to test the child twice a year during the first four years and once a year until the child is six. Blood samples are sent to the RIDOH lab, where they are analyzed⁵. In this manner, the state is able to keep track of

⁵ Samples from RI Hospital and St. Joseph's Hospital are analyzed on site, but the results are sent to RIDOH.

the number of lead poisoned children in Rhode Island and monitor whether doctors are testing for elevated BLL's (RIDOH guidelines).

If a child's BLL is above 20 *ug/dl*, the Family Health Section of RIDOH sends a letter to the child's home, informing the parents that they are eligible to receive an educational outreach visit from the Visiting Nurses Association (VNA). If the child has a blood lead level of 25 *ug/dl*, in addition to receiving a home visit, RIDOH then contacts the parents to inform them that the department is legally required to offer a home inspection, during which time inspectors make recommendations to the home owner as to how she or he can make the dwelling lead safe⁶. The home owner is then given a certain amount of time to comply with the recommendations before action is taken against him or her.

RIDOH focuses most of its resources on lead testing and treatment of lead poisoned children. It does do limited outreach through its Door-to-Door screening program, conducted in selected low-income neighborhoods during the summer when lead levels tend to be highest. But because of the skepticism with which many high-risk populations view government agencies, RIDOH has turned over all of its lead outreach programs to various local agencies.

PROGRAM LIMITATIONS

⁶ Lead safe is a term used to describe areas that follow the CDC's regulations. Lead safe should not be confused with Lead Free. In some states, such as Massachussettes, landlords and home owners are required to ensure that their dwellings are Lead Free. There are pros and cons to the latter. Although the child less at risk, the cost of ensuring that a house is Lead Free has caused some landlords to refuse to rent to families with children below the ages of six years.

Despite the fact that a BLL above 10 *ug/dl* can cause behavioral symptoms and at 15 *ug/dl* serious “cognitive, behavioral, and neurodevelopmental” can occur (RIDOH Screening Guidelines, 1995) no mechanism exists to ensure that children with these BLL receive intervention. RIDOH guidelines stipulate that “when consecutive tests obtained 3-4 months apart are 15-19 *ug/dl*, environmental inspection and abatement should be conducted if resources permit” (ibid.) Generally, however, resources do not permit. With the tremendous amount of data it receives, RIDOH simply lacks the time and resources to contact every family whose child’s BLL is between 15 *ug/dl* and 19. Since 80 percent of children with elevated BLL fall into this category, this means that the majority of children may not receive intervention.

Even those children who test above 25 *ug/dl* may not receive the intervention they require because of the sheer volume of cases. According to one official at Risk Assessment, families must often wait up to two to three months to receive a lead inspection visit, and at least several weeks for a home education visit. Thus the number of families it must respond to severely limits the RIDOH’s ability to ensure that families understand the sources of lead and ways to prevent their children from becoming poisoned.

THE LEAD TREATMENT CLINICS

Presently only two lead treatment clinics exist in Rhode Island, one at St. Joseph’s Hospital and the other at Hasbro. Patients are referred to these clinics for

confirmation tests when initial test results show elevated BLL, as well as for treatment such as nutritional counseling, iron supplements, and chelation therapy. While both programs do educational intervention, neither is equipped to work on prevention.

PROGRAM OVERVIEW

St. Joseph's Hospital, located in the Elmwood neighborhood, serves all Rhode Island residents and accepts all forms of health insurance including Medicaid and RItCare. The small waiting room of the lead clinic, run Mondays and Wednesdays from 7:00 a.m. until 11:00 a.m. is almost always filled with parents and children, many of whom speak little English. As they wait to find out their children's' test results, the cramped yellow, walls, the blaring television and the brusque nurses, only heighten the parents' anxiety. Yet if the nurses and doctors, two of whom are bilingual, are impatient, it is most likely because they serve between twenty and fifty families a day.

Entering the Hasbro Building of Rhode Island Hospital means entering another world from that of St. Joseph's. One is immediately struck by the Candyland-like atmosphere that pervades the airy space. Bright painted fish cover the hallways leading to the lead clinic. In the center of the clinic's waiting room, a play house the size of a garage stands, painted in cheery pastels--with lead free paint of course.

Unlike St. Jo's, however, the Hasbro lead clinic serves only those families whose children have tested above 20 *dl/ug* and are referred by a RI Hospital doctor (or those who tested above 25 *dl/ug* if they were referred by a Harvard Community Health Plan doctor. It is open only one day a week for three hours and is serviced by a trilingual doctor (fluent in both Portuguese and Spanish) and one nurse. During the clinic's hours,

they meet with an average of 15 families. If the doctor cannot be present, then the nurse must find someone in the department who can translate for her, which increases the time allotted to each, explained a nurse. She estimated that 25 percent of the parents who attend the clinic are non-English speaking; the majority are Latino. Although there is an effort to coordinate the presentations so that the nurse can meet with several families at once, she admitted that this technique was unsuccessful because of the number of children who needed supervision during this time.

The practitioner's job in the clinic is to explain to the parents the effects of lead on a child's development and to help the family identify possible sources for lead poisoning. The practitioner also explains possible treatments and methods for prevention. Depending on the risk factors, the families may be recommended for the Family Outreach Program--lead education sector run by VNA of Rhode Island. In some instances this process occurs simultaneously with the Department of Health inspections, but as mentioned earlier, often families must wait several weeks, if not months, for an inspection, especially if their child's blood lead levels are below *25 ug/dl.*

PROGRAM LIMITATIONS

Although families do receive preventative information from the clinics, for most, this visit marks the first time that parents are told about their child's condition. With the information about medical treatments and procedures, the situation is stressful enough. It is not necessarily the most conducive time for discussion of home prevention measures. This problem is especially true at St. Joseph's, which treats the majority of lead poisoned children in Rhode Island.

The Hasbro Clinic, while far more attractive than the cramped room of St. Joseph's, is limited in the scope of the services it can provide, since it only services patients of RI Hospital doctors and the Harvard Community Health Plan. Most patients on RItCare are unable to use these doctors, and as a result, do not have access to this Candy-land. In addition, although the doctor on call is trilingual, the nurse is not and must explain her information through an intermediary, which further impedes communication with parents.

Both clinics direct their efforts to children who are already poisoned, since parents must be *referred* to the clinic, and this generally happens only once an extremely high level has been found. Therefore, parents whose children's levels are between 15 *ug/dl* and 19*ug/dl* do not receive the information they need from RIDOH or the lead clinics. As noted earlier, often the information given to parents, while translated into Spanish, remains at a literacy level which is above that of the parents.

THE VISITING NURSES ASSOCIATION

PROGRAM OVERVIEW

The Visiting Nurses Association Inc. links RIDOH and the clinics more closely with individual families through its home education visits, which are designed to reinforce and expand on that which parents learn from the health care practitioners. VNA provides lead education on several levels within the Providence area. All newborn infants in Rhode Island are screened for their potential risk level, developmental delays and other health factors. Based on this screening process, families identified in the high risk group are referred to VNA for home education visits. According to one VNA coordinator, of the 280-350 referrals per month that VNA receives, between 60% and 70% of the families accept a home visit. Throughout the first six months of the child's life, the nurse may return for subsequent visits in order to provide more detailed information and assistance with issues such as nutrition and lead poisoning prevention (Dana Hansen, 1993 p.34).

After this six month period, the nurse administers a diagnostic test to the child. If from the nurse determines that the child is at risk of lead poisoning, she then recommends that the family receive a lead education visit. This outreach program, now in its second of a three year term, is funded by a grant from the RIDOH. VNA provides two home visits to the families, reinforcing what the family has learned at the clinic, including methods for blocking off window sills, the importance of using detergents with phosphates when cleaning and of maintaining a balanced diet (for more information see

appendix ?). Health care practitioners can also recommend families to the VNA, including those affiliated with Hasbro Hospital and St. Joseph's. Families may also be referred to VNA by RIDOH and the clinics.

Since an estimated 70% of VNA's clientele are non-English speaking, (the majority are Spanish speakers) they have tried to address the issue of language barriers by staffing the program with people who are both bi-cultural and bilingual. The lead outreach worker is a bicultural/bilingual Dominican woman, and along with two nursing assistants, the program includes three Latino interpreters. VNA also utilizes para-professionals, with high school diplomas and training in relevant areas (translating and social work) to perform lead education outreaches.

As mentioned earlier, VNA also coordinates the educational outreach program for children who have been identified as having lead levels above 25 ug/dl. VNA receives referrals for home visits from RIDOH and from the lead clinics. Nurses perform an average of 30 visits a month and have a 50% no-find rate. This rate is not surprising since the families are often referred to VNA because they are considered non-compliant (have not responded) to previous RIDOH overtures.

PROGRAM LIMITATIONS

One of the most difficult aspects of the VNA work is tracking down parents in order to arrange and conduct the home visits. Only about 40% of the families first referred from the Family Outreach Program to the follow-up lead education session actually receive a visit from an outreach worker. Often those families recommended by

RIDOH are even more difficult to contact. “I can see why they stopped [conducting home visits]. They only have to pay us when we find the families. We spend half our day running around trying to find people, so we spend half our day unpaid,” explained the coordinator of the Maternal and Child Health coordinator. Part of the difficulty in reaching parents of lead poisoned children stems from the broad spectrum of problems with which these families must contend. Frequently parents of lead poisoned children end up in “some of the most deplorable housing conditions,” because of other problems and thus require multiple interventions. Thus the process of performing individual home visits is often inefficient because it is difficult to reach these families.

THE CHILDHOOD LEAD ACTION PROJECT

PROGRAM OVERVIEW

The Childhood Lead Action Project (CLAP) evolved “out of the successful grassroots effort toward the passage of the 1991 Rhode Island Lead Poisoning Prevention Law (CLAP grant proposal, 1995). Originally CLAP sought to provide a full-time prevention effort against lead poisoning, facilitating Parent Action Groups (PAG) that enabled primarily low-income, non-English-speaking parents to address the “conditions that cause lead poisoning by sharing information, education each other, and recruiting new members” (Ibid.). Last year, CLAP received a grant in conjunction with Brown University to perform lead home education and soil testing visits. Until budget constraints required that the program take a temporary hiatus this winter, the outreach

coordinator continued to do educational presentations at local community centers but was unable to do home visits.

PROJECT LIMITATIONS

Unfortunately, after the initial success following the passage of the 1991 law, it became difficult to sustain interest in the (PAG). The outreach coordinator at the time, a Guatemalan community organizer, found it nearly impossible to recruit and maintain families. The home visits proved problematic for many of the same difficulties that VNA faces, but were even more difficult because CLAP is such a small organization, with two full-time and one part-time employee. Further discussion of the limitations on this type of organization can be found in chapter six.

THE HEART OF ELMWOOD LEAD PROGRAM

EDUCATION AND OUTREACH COMPONENT OVERVIEW

The Heart of Elmwood Lead Project (H.E.L.P.), run by Elmwood Neighborhood Housing Services (ENHS), now in its second year, received a grant of 3 million dollars from the CDC for a pilot lead abatement and prevention program in a limited area. H.E.L.P. planned to identify leaders in the area and recruit them as block captains in order to educate and organize the 10 square block area. The proposal also included PAG similar to those created by CLAP. In the fall of 1995, H.E.L.P. contracted with the new Promotora program to facilitate outreach in the area.

PROGRAM LIMITATIONS

Despite ENHS's long history of activity in the area, H.E.L.P. has found it difficult to gain access to the community, which may be related to the changing demographics of the area, with the influx of the Latino residents. Until last year, the organization had only one part-time Spanish-speaker. Moreover, although ENHS considers itself a community based organization, it did not consult the community in which the grant was to be implemented before proposing or beginning the project. As a result, the neighborhood's ownership and investment in the project has been relatively low. H.E.L.P. has found it difficult to sustain the involvement of paid volunteers, whose responsibilities included going door-to-door to talk to residents about the program. It has also had difficulty identifying block captains, but as the program has become better known in the area, these obstacles seem to be decreasing. The contract with the Promotoras was initiated in recognition of the reluctance of community participation in the program.

HEAD START

Providence Head Start has been one of the leading organizations to encourage lead testing, mandating that all children entering its program provide test results upon registration. Head Start is presently in the process of developing lead poisoning outreaches to parents, but the presentations have not yet begun. Since of the 1052 children enrolled in the Providence Head Start program, 50% are of Hispanic origin and

35% come from families that do not speak English well, efforts have been made to translate materials into Spanish. Yet even with such progressive efforts, the concept of prevention remains vague. One program director spoke positively about Head Start's ability to distribute information about lead poisoning: "With lead we're lucky because information comes in flyers. We know the info is getting out there, (Ibid.)." Whether families receive these flyers and whether they read and understand them, however, are two very different questions.

THE BLACKSTONE CLINICS

At both of the Blackstone Valley Health Clinics, one bilingual nurse at each clinic specializes in lead poisoning prevention education. At the clinics there appeared to be a high level of concern about lead poisoning, and according to the nurses, the practitioners discussed the risks of lead with the parent during check-ups. It was not possible to ascertain the number of doctors in Rhode Island who discuss with patients the risks of lead poisoning, but as noted in Chapter 1, often the patient/doctor relationship does not facilitate effective communication practices.

4 Current Promotora Programs And Their Historical Basis

INTRODUCTION

The promotora program, sponsored by CHisPA has the potential to supplement the previously mentioned programs and improve the connection between Latino families and health resources in Rhode Island. As noted in Chapter 1, the stated objectives of the Promotora program differ from the above in both philosophy and practice. The project aims to address health holistically, including a number of different topics simultaneously. In addition, it draws upon existing cultural traditions in the dominant Latino populations in Providence. While the concept of lay-health educators is not new, the Rhode Island program is the first of its kind in New England. One of the most unique aspects of the program is its focus on lead poisoning prevention, as well as its strong emphasis on leadership training. In order to appreciate the structure of the program, some background on the development of the health promoter will be helpful.

Comment [HW10]: Page: 6
presumably, in the preceding study, you will have shown that these programs aren't adequate

THE HISTORY OF THE PROMOTORA PROGRAM

LATIN AMERICAN ORIGINS

The notion of a lay health advisor, as these promotoras are generically called, is certainly not unique to Latino cultures (Baum, 1993), but this type of health promotion has worked quite successfully in Latin America. In Spanish, the word *promotore*⁷ means promoter. Promotores literally promote health education; they also promote empowerment by recommending and modeling positive behaviors for their communities (Blum, 1981 p.254). A number of promotoras active in the U.S. first trained in their homelands of Mexico and Central America before they immigrated to this country (interview with Juanita Gonzalez, 2-29-96).

No agreement exists as to where the concept originated, nor does there exist one umbrella organization or promotora program design. Yet women who identify as promotoras are active throughout Latin America from Argentina to Mexico (Promotora Conference Highlights, 1995). According to Elia Rivera, one of the first promotoras in El Salvador, one of the consequences of the country's civil war was the creation of a gap in the work-force, that required rural women to take on responsibilities outside of their traditional roles as mothers and homemakers. As a result, "many women found themselves shadowing doctors and nurses because the need [for such services] was so great" (ibid.) and medical resources were scarce. Juanita Gonzalez, who now coordinates a promotoras program in Chicago, was trained in Mexico during the 1960's and 1970's,

learned to give injections and even performed stitches (interview with Gonzalez 2-29-96). Although in the U.S. she no longer provides such services, she continues to educate families, acting as a resource for individuals on subjects such as mammograms and vaccines; she also trains new women to become promotoras (ibid.).

RECOGNITION FROM THE WORLD HEALTH ORGANIZATION

The diffusion of the promotora concept internationally and nationally owes its success in part to the World Health Organization (WHO). “Since 1984, the World Health Organization has been defining health promotion as “the process of enabling people to increase control over and to improve their health,” (Eisen, 1994). At its 1988 conference, WHO reaffirmed its commitment to “the future health of humans and their environment in the present and future because it pays attention to both healthy outcomes and healthy processes.” (Blum, H.L., 31, 1981). With encouragement from WHO, large, international organizations have begun to sponsor promotora programs. Planned Parenthood, for example, trained Mexican women in remote villages and towns about reproductive health issues so that they could serve as liaisons to the health care practitioners in the cities, and as resources within their communities (ibid.).

WHO’s conclusions are not new. They draw on theories developed in response to other social change pressures of the past two or so decades, including the women’s movement, social justice, ecology and community development movements” (ibid.). its

⁷Promotore is the general term for both men and women. Since most of the programs are comprised by women, the feminine conjugation of the word (promotora) is used throughout this paper.

statement formally recognized the importance of such measures and brought international attention and prestige to efforts already underway.

HISTORICAL OVERVIEW OF DEVELOPMENTS IN THE U.S.

Neither health outreach nor environmental community outreach are new to the U.S. At the turn of the century, “the work of charity societies and settlement houses....included health and environmental protection efforts” (Thompson et al., 1993). For example, African-American churches, among other organizations, long active in the area of health promotion, have only recently begun to work with government agencies and universities to provide outreach programs to their constituents (Bracht ed., 1990). Throughout the latter half of the century the role of lay-health-advisors, has evolved concurrently with the needs and politics of the day (Eng and Young, 1992).

During the late 1960’s and early 1970’s, a number of changes increased public awareness of the need for more community health programs. With the impetus of the civil rights struggle, many immigrant and minority groups, particularly Chicano and Puerto Rican, began to agitate for more aid and better access to health care in their communities (Oboler, 1994, p.46). Simultaneously, these groups turned inward and began to focus on grass-roots efforts to combat these problems (Ibid.). During this time, “numerous community organization efforts in the United States were undertaken....as a result of a plethora of federal comprehensive projects (model cities, neighborhood community health centers, etc)” (Thompson et al., 1993).

In recent years, the concept of the rural health promotora filtered over the border from Mexico into states such as Arizona and Texas, merging with civil rights and urban

redevelopment struggles to create a new breed of promotoras in the U.S. This new breed continues to focus on underserved and disenfranchised populations. Yet the populations with whom they work now live in the inner cities-- still isolated from medical and social services despite their geographic proximity.

CASE STUDY OF A "HEALTHY CITY"

The Healthy Cities Programs was one of the first initiatives to sponsor the use of Spanish speaking, lay-health-promoters. In 1971, concerned about the stress that many poor migrant communities placed on small, ill-equipped health centers in border towns, the Laredo-Webb Country Health Department in Texas began to use health assistants, previously consigned to providing in-office support, to assist with educational outreaches to young, Spanish-speaking mothers (Gonzalez and Woodward, 1974, p.146). Soon the program developed into two main components: community health education and an information and referral system, supervised by a social worker" (ibid., 145). While the program began with prenatal care, over a period of three years it expanded to incorporate immunization and environmental health issues including lead and carbon monoxide poisoning prevention education. Although this program encouraged feedback from its "promotoras" about the program, ultimately DOH officials decided on the program design and agenda. As will be discussed further in this chapter and in chapter 6, control over these decisions is one of the key elements that distinguishes the new promotora programs from more traditional lay-health worker programs.

OVERVIEW OF CURRENT PROMOTORA PROGRAMS

In the US, Promotores programs exist in Arizona, California, Chicago, Massachusetts, Oregon, and Texas. Each of these groups differ somewhat with regard to ideology and methods of implementation. Such variation is natural and desirable since part of the concept of the promotoras is to reflect the specific needs and desires of the community which they serve. Moreover, until the first promotora conference in Chicago, most groups have operated alone, often unaware of each other's work. Most of the programs do share a few basic goals:

- to make use of existing connections in Latino communities;
- to expand the knowledge, skills and awareness of the community about relevant health issues through outreach programs in homes, schools, and community centers;
- and ultimately to empower people to make changes in their own lifestyles and in their communities.

The use of existing connections is extremely important. According the Department of Health and Human Services, "Regardless of Latino's ability to pay for services," many programs attempting to assist Latinos, "misunderstand the importance and role of family and social supports in promoting health and preventing disease within the...culture and fail to integrate these supports," (DOH&HS Public Reports, 1993). Since almost all of the promotoras are mothers and wives, the program makes use of these family ties. In the CHisPA review of the Chicago Conference:

Promotoras expressed a natural sense of belonging to the community and to their families. Conversely, they perceived their families and their communities as naturally belonging to them...For those in the community who have been impacted by the Promotoras, they agree that the Promotoras are effective mainly because their presence inspires an assumed sense of trust, confidentiality and understanding (1).

Thus one of their most successful aspects is that the programs includes traditional values of recent Latino immigrants⁸ into its design. The programs are able to incorporate these components because the promotoras are encouraged to provide input, and in some cases direct control over the program focus and approach. While the programs differ in terms of the subjects they address, most focus on women's health and prenatal care, issues that are considered urgent by health practitioners and the promotoras. Most of the successful programs are funded by either the State Department of Health, a university, or some combination thereof, but many of them began without such secure financial backing. The Promotoras Voluntarias (Volunteer Promoters) in Arizona receive money from the Arizona Department of Rural Health to:

disseminate information and create an ongoing resource of knowledge about reproductive health care, sexuality and family life education within the community.... and identify women in need of reproductive health care and provide them with a combination of education, support, advocacy and referral services (Ibid.).

Since the Arizona program's inception, more than 300 promoters have been trained, including the first all-male group of Promotores who graduated in 1995 (Ibid., 5).

Promotores agree to remain active for one year, but many extend their service commitment beyond the year. Even when the Promotores no longer continue with the

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⁸ These values are of course not unique to Latino populations.

program, they leave with the knowledge and the skills to improve their own health and may continue to act as a promotore on an informal level.

Comment [HW11]: Page: 11
I'm still left wondering who organizes these efforts, and who funds them.

Although most of the programs exist independently, a coalition of promotore programs now exists in Chicago. The coalition was founded in the late 1980's after the head of the Illinois DOH visited the Planned Parenthood Promotora project in Mexico. She was so impressed with the program that upon her return to the U.S., she contacted fledgling promotora groups in Chicago and offered her support. The coalition now receives funding and training from the Illinois Department of Health and the University of Illinois Nursing School (conversation with Olivia Hernandez, University of Illinois Latino Research, 2-28-96).

Over the years, some of the Chicago programs have expanded the notion of health from its traditionally narrow definition to include more issues relevant to the individual communities. Thus the promotores have run a Safety Seat Project in addition to other health education projects. This program is perhaps the most similar to a lead education program because although it is not an issue traditionally addressed by health care practitioners, it is an issue that is extremely important to the health of the community. In the last decade, urban promotora projects such as these have cropped up more and more frequently across the country.

OVERVIEW OF THE CHisPA PROMOTORA PROGRAM

THE CENTER FOR HISPANIC POLICY AND ADVOCACY

Comment [HW12]: Page: 12
I think the history section needs more detail - e.g. how well has it worked elsewhere? Have Safety Seats actually been used? (I assume you mean car seats for kids?) who organizes, etc.

Comment [HW13]: Page: 8
Need to explain who is funding this program.

Founded in 1991 out of a “comprehensive needs assessment of the Latino community conducted by the Hispanic Social Services Association of Rhode Island (HSSA), CHisPA’s goal is to “lead and influence change that improves the quality of life for Latinos in Rhode Island” (CHisPA mission statement). Among the services it offers are:

- Information and Referral Services
- Policy Analysis, Research and Advocacy
- Community Education on Prevailing Issues
- Leadership Development Training Programs
- Technical Assistance to Emerging Local Groups
- Leadership in the areas of Health Access and Education

Located in the Juanita Sánchez Multiservice Center, CHisPA works side by side with several other local non-profit service agencies with the goal of providing “comprehensive services to low-income disadvantaged individuals,” and to serve “as a locus for activities of grassroots community groups”(Ibid.). The proximity of CHisPA to other local groups enables the organization to contact many sectors of the population and to publicize information about upcoming initiatives, as well as draw volunteers from a wide array of Latinos in Rhode Island.

THE HISTORY AND CREATION OF THE PROMOTORAS PROGRAM

In 1994, CHisPA received a grant from the National Council of La Raza to create a leadership training program for Latinos in Rhode Island. The director of the promotoras program explained that her initial desire to create the leadership program stemmed from CHisPA’s awareness of the dearth of skilled, informed, Latino advocates in Rhode

Island. “About the same ten people were called to be on every board when they needed a Latino.”(interview with program director, 11-1-95). Since this small group of people could not fill every position of leadership in Rhode Island, CHisPA sought to increase the number of people with the skills to assume such responsibilities.

The next step was to decide whom CHisPA would target for the program. Eventually, the program was divided into two parts: entitled Pasos y Puentes (Steps and Bridges). Puentes, the more advanced leadership course involved local Latino professionals, college students and community workers to help build networks between various social service agencies and other organizations. The program created an environment where individuals could discuss issues they faced at work and improve organizational and fundraising skills, and community development strategies.

Pasos, which CHisPA designed to attract disenfranchised women in the Latina community, focused on more basic leadership skills and building self-esteem. The Pasos training sought to build on the skills that the women already possessed “Women have their own networks...That’s leadership [because] real leaders provide information to the community...Without realizing it, many of these women have been doing that for 20 years,” the director explained (interview, 11-7-95).

The three--month long training, which began in June of 1995 focused on empowerment and self-esteem, including recognition of the ways in which the women had already been acting as leaders for their families and communities. The Promotoras also learned about other agencies in the community and which ones employed bi-cultural and or bilingual workers.

The main requirement for both Pasos and Puentes was that participants attend the sessions, and that they do a community service project related to their training. The original 16 Pasos participants decided to focus their project on health, choosing four topics that they believed to be relevant to the community: lead poisoning, cervical cancer, sexually transmitted disease and domestic violence. They then divided into groups, each gathering materials to create “information folders” on their subjects to be left in the office for general use. The folders were to present a variety of information in Spanish in the most user friendly manner possible, including health-related facts and statistics relevant to the Latino community, and the names of organizations providing services with bicultural and bilingual individuals on staff.

At the end of the three--month training, the women decided that they want to make more use of the information they had learned and considered several options, including a health fair. The program coordinator, who was familiar with concept of the promotoras, suggested the idea to the women who agreed at once. They then continued to meet each Saturday and receive trainings on the selected topics, with the intent that they would eventually be certified to do informational outreaches on these subjects, as well as continue to develop their general leadership skills. In addition to specific training on their chosen themes, the women became certified in CPR and First Aid, participated in resume and interview workshops, and attended presentations on the RI legal system and government.

FUNDING

The promotora program presently operates on a very small budget, roughly \$25,000 a year. This amount supports one full-time program coordinator, outreach and meeting costs. Both the outreaches and meetings require education, transportation and child-care. In addition, the outreaches require gifts and educational materials. Many trainings are offered without charge, but some cost money, as do some educational materials. Thus funds are also needed to ensure that the promotoras remain up to date with the most current information about their issues.

The National Council of La Raza (NCLRA) paid for the Paso program, and renewed its support for one year. The program has also received funding from the Rhode Island Foundation and the Haymarket Foundation. The ENHS contract also helps to support the program. The women contribute from their own pocket to a fund for coffee etc., but this is not a reliable source as the women have limited resources. Presently funding is one of the key issues upon which the success of the Promotoras depends, as will be discussed in Chapter 7.

PROMOTORA DEMOGRAPHICS

The promotoras reflect the demographics of the communities in which they live, such as Elmwood, where 60% of Latinos are Dominican, and 28% are Puerto Rican (CHisPA statistics, Healthy People 2000, 1995). They are predominantly of Puerto Rican or Dominican background, of low-income financial status. Most of the women have

more than two children above the ages of two years old. They are all between thirty and fifty years of age, the majority are in their mid-thirties.

What distinguished their counter-parts was their level of education. In Rhode Island, the average level of educational attainment for Latinos is high school. Many of the promotoras had taken university level classes in their countries of origin in subjects such as accounting and computers. Two of them are enrolled at the Community College of Rhode Island in courses in English and administration.

5 Observations, Findings and Analysis of The Promotora Outreaches

INTRODUCTION

In a 1994 comprehensive study of community development projects across the U.S., by Arlene Eisen, only those projects that involved the community initially and throughout the effort in the major decision-making processes could show long term improvements in the communities(p.231). My findings show that the promotora program attempts to involve the community on many different levels. First, the program develops Latina leaders in Rhode Island. It also encourages these leaders to work on preventative education about issues that they feel are important and introduces the leaders to new issues without limiting them to outside agendas. Finally, it facilitates communication and greater health and environmental awareness within the community. Using Eisen's study as an indicator, the promotora program has the potential to affect long-term change in the health of Latino populations in Rhode Island.

The limitations of this project fall in to two, somewhat overlapping, categories: specific issues regarding implementation and more fundamental structural constraints. The first group relates to more technical and practical questions. The second set of issues, while also practical, touch at more conceptual questions about the goals of the program and its future sustainability. This chapter contains findings that speak to the first group of limitations. I will discuss the more conceptual limitations, as well as long-term recommendations, in Chapter 6.

POPULATION SERVED

The participants range in age from early twenties to sixties, although most seem to be late twenties to early forties. Generally the number of adult participants, excluding the promotoras themselves, is between seven and ten. Children of the invitees also participate on occasion, but I did not interview them. Most of the people who attend the outreaches are neighbors and friends of the hosts and live within walking distance, if not in the same building as the host. Four of the outreaches took place in Elmwood in one floor apartments, none of which were owned by the occupants. As expected, slightly older women seem to be more concerned with cancer detection. Everyone expressed interest in the AIDS prevention presentation and the domestic violence prevention. Because many older women act as caretakers while parents work, participants of all ages expressed interest in lead poisoning.

THE IMPACT OF THE PRESENCE OF MEN

Men were in the minority, if present at all. If the host's husband was home, sometimes he would stay in a separate room. In other instances he would join the party, as would other spouses or sons. The male presence changed the tone of the meeting somewhat, but the impact also seemed to depend on the persons involved. At one meeting, during a discussion of domestic abuse, the husband began to discuss female-
instigated violence against men. Afterwards, several of the promotoras expressed frustration that he had steered the discussion away from their main focus. In another instance, where men were not present, the participants acknowledged that their absence

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enabled them to speak more freely than they would have otherwise. At another party, however, the women reacted favorably to the male involvement. Explained one promotora, “I think men should be there. It’s not just us women. Men need to learn also [about how to prevent domestic violence].” In this case, the women viewed the male presence as a demonstration of concern for the well-being of the women, and of the desire to improve dynamics between men and women.

I did not note a significant impact on the female participants response to the lead poisoning presentation with the presence of male participants. They continued to ask questions and remain engaged. The negligible affect of the male presence in this case may result from two important factors: First, the outreach in general was directed towards women, focusing on issues of concern to them. Thus an underlying assumption existed that the promotoras were directing their information to the women present. Perhaps more importantly, lead poisoning is an issue which concerns parents, and since parenting responsibilities remain to a great extent within the sphere of the woman, she would feel comfortable demonstrating her authority in this area. The men’s interest in lead poisoning may reflect changing social patterns in which men play a greater role in child rearing and are thus more concerned with related health issues (Oboler, 1995, p. 56, Rhode Island Community Organizer).

A TYPICAL PARTY

Through the course of my observations I noticed that the Promotoras refined their talks, tailoring them to the audience present, adding personal stories and including more time for feedback and review. While each group of participants created a unique atmosphere, the parties all shared the same general structure. The invitees arrived early and chatted with one another while the promotoras and the host set up their posters⁹, coffee and donuts. They signed an attendance sheet and checked off whether they would be interested in hosting a party. Aware that the participants often bring young children with them (as do some of the promotoras) several promotoras set up a play area, with crayons, paper and other art to occupy the children during the presentations. The Promotoras took turns supervising the children during each other's presentations.

After a brief time for the women to look at the posters, eat, meet or catch up with one another, one promotora opened the presentation by introducing the group and their purpose. This position rotated at each outreach. She then asked the women to go around and say their names and their countries/cities of origin. Often the promotoras turned this process into a game, in which the women were asked to repeat the names of the others in the circle. Children and teenagers who attended the outreach were included in this and all other parts of the presentation (unless their parents requested them to leave, as was the case in a few instances when domestic violence and AIDS were discussed). The Promotoras responded to the children's questions with the same respect with which they addressed the adults. Often the youngsters were as knowledgeable, if not more, than their parents, having learned about the subject at school. They seemed to enjoy demonstrating this information for their parents.

⁹ The posters contained information about the presentation subjects with colorful pictures and large

GENERAL CONTENT OF THE SESSIONS

Each information session generally lasted about twenty minutes, including the time allotted for questions. Sometimes they began with the lead presentation, followed by women's health/cancer detection, domestic abuse, ending with STD's. The group chose this order because the women felt that it progressed from the least intimate to most taboo. Lead poisoning, while upsetting to parents whose children suffer, is the subject with the least social discomfort ascribed to it and therefore considered to be the easiest to discuss. For example, parents never sent their children out of the room during lead poisoning. "It's good that people are learning about these subjects," said one participant, referring to AIDS prevention. "But sometimes they still feel that they shouldn't know about them, or at least shouldn't talk about them." The promotoras also decided that it would be easier to open discussion about female genitalia in connection to cancer detection, than to STD's, which lead to more controversial issues of fidelity and premarital sex. The promotoras chose to discuss domestic violence also before STD's because they felt that women needed to have a awareness of their general rights as individuals before they would be comfortable with the notion of rights in a sexual relationship (e.g. the right to use a contraceptive that prevents the transmission of AIDS or not to engage in sexual acts).

Both presentation designs had pros and cons. When they began with lead, the participants seemed to gain confidence in asking questions, which carried over into the more emotional issues of abuse and STD's. I observed another advantage to this order

lettering.

which became evident after attending several parties. With four different presentations, the outreaches can last up to two-and-one half hours, making it difficult for even the most enthusiastic participant to remain focused. Moreover, when the lead presentation came last, the growing restlessness of the audience was visible. Leaving the most salient and “sexy” issues to the end, the promotoras were able to maintain a high level of interest and participation on the part of the group. On the other hand, beginning with AIDS prevention piqued the participants attention immediately, whereas it took the women longer to engage with the issue of lead.

THE USE OF PERSONAL EXPERIENCES

Many of the promotoras spoke from personal experience, relating their own histories to the participants. For example, one woman, who spoke about domestic abuse, began her talk by explaining, “I left my country to leave my husband who was abusive. And when I left I didn’t know to take my children’s birth certificates.” In the process of sharing her story, the Promotora was able to highlight a significant problem for women who attempt to leave their abusers without creating a plan beforehand. Because she spoke about her own experience, other women immediately responded with examples of similar situations with which they were acquainted. While they did not usually describe their own relationships, they often mentioned friends or asked general questions.¹⁰

¹⁰ Domestic violence was an extremely salient issue, along with lead, it would seem to merit an entire outreach.

LANGUAGE OF INCLUSION

Sometimes the promotoras presenting turned to their colleagues in the audience to assist them in responding to a question. This technique had the unintended benefit of physically making the conversation more inclusive because it interrupted the monologue. Moreover, it demonstrated the camaraderie within the group which seemed to impress the participants.

When opening her discussion about AIDS, one of the promotoras often began with the statement, “we can speak safely and honestly here, because we are like family” or “we are among family.” This reference to family indicated both the value placed on such a role, as well as the special dynamic created in the home party. At the end of their talks, the promotoras also stressed to the participants the importance of passing on the information they had learned to others, explaining that “if a friend has a problem, you can tell them what resources are out there,” which could be of service to them. They emphasized that the invitees now held the same responsibility, and were in effect, promotoras themselves.

AWARENESS OF LEAD

During the lead presentations, the most common questions from participants were:

- what are its physical affects?
- can lead be irradiated from the human system?
- can adults be poisoned?
- how can it be treated?

Few parents were aware that lead levels below 25 were dangerous. Many parents were aware that lead can be found in paint, but were not clear on how they could protect their children within the home. Most of the parents with children under six had had them tested for lead, but two women said that they took their children to be tested as a direct result of the presentation. Another woman, who did not attend the outreaches called the promotoras after her child was diagnosed in order to discuss what she should do with them.

MATERIAL REVIEW

Before each Promotora began her talk, she reviewed important facts highlighted by the previous speaker, asking the audience questions. Often the promotoras not speaking, who were seated among the other guests, also asked questions at the end of a presentation, in order to break the ice and encourage the other women to do so as well. According to Cesareo Amezcua, “mediated communications can model new behaviors so that they are learned (acquired) on a cognitive level (i.e. the person knows how to perform the behavior) (1990). But cueing and feedback--direct social reinforcement--are usually needed for behavioral learning, that is, for actually performing the new behavior. Not only did the promotoras recommend that individuals take a more control of their health, but they modeled such behavior themselves, as part of a “direct social reinforcement.” As soon as other women began to raise their hands, the promotoras then ceded the floor. Their initial activity avoided the awkward situation in which no one dared to be the first to ask a question.

Assessing the level of absorption of the material was difficult for the promotoras. A written survey was problematic because some individuals could not read or write well enough to fill out such a form (in Spanish or English), and because after the lengthy presentations the guests were ready to leave. Therefore, the promotoras devised a game, Family Feud style, where the teams would have to answer questions about the issues presented in order to win prizes such as Clinique cosmetics, or cologne. This five minute exercise drew a strong positive response from the participants, who were quite competitive, often yelling and laughing at one another. At the end of the party, the promotoras gave an especially large gift of make-up to the host of the party, as much as an incentive for other women to host parties, as a thank you for her hospitality. While most of the hosts had a strong relationship with one or more of the promotoras, and therefore may have felt obligated to “help” their friends out by hosting a party, several of the hosts with whom I spoke voiced a sense of moral obligation to the community to host such parties. “We need more of these gatherings. If I didn’t have one, I didn’t know anyone who would,” said one host. They also expressed interest in hosting future parties in their homes, although so far the Promotoras have not attended an outreach in the same home twice. Over half of the hosts, as well as guests expressed interest in becoming a promotora.

After each party, the promotoras gathered outside for a few minutes to discuss the presentations and congratulate one another. Longer analysis took place during the bi-monthly Saturday meetings. While they seemed frustrated occasionally during the Saturday morning meetings, with the pace of the program, the lack of participation on the

part of some promotoras etc., they left the parties buoyed by their sense of accomplishment and purpose.

PREVENTATIVE FOCUS

FINDINGS

Early on, it became clear from my review of documents and from my interviews with representatives of local organizations that the promotoras are needed to supply the preventative education that neither RIDOH nor the two hospitals offer. They are also needed to reinforce and supplement information provided by local doctors and clinics. The supplementary education is necessary because as mentioned in Chapter 1, even parents who realize that lead is dangerous are often unaware of how their children can ingest it. As one promotora explained, “All they know is that lead’s bad, but they don’t know how its contracted or how they can prevent it.”

In addition to its focus on prevention, one of the most significant aspects of the promotora program directly regarding lead is that it addresses elevated lead levels below 25 *ug/dl* but above 15 *ug/dl*. While some practitioners and VNA tell parents about the health risks to their children at these levels, many of the party participants as well as parents who attended CLAP outreaches were unaware that their children might be at risk.

The need for more intervention and outreach is not due simply to the language barrier. All of the clinics I visited employed a bilingual staff, yet one of the promotoras’ main concerns was the reticence of many Latino parents to question the health practitioner. “Our culture encourages us to have much confidence in our doctors, and since we have confidence in what he [the doctor] says, if he says ‘it’s okay, then we think it’s okay,” said another promotora.

INTERPETATIONS

The Promotora program encourages the participation of families, and because of its non-medical atmosphere, it can attract parents who do not visit the doctor on a regular basis, as well as those who do not feel comfortable discussing their concerns with health care professionals. Thus Promotoras help reach the population that falls between the cracks of the current program by explaining the risks of these levels, reviewing them at the end of the party, and encouraging parents to ask for the results of the screening, even if the doctor tells them that they their not at risk.

The concept of reinforcing information from the health care practitioner, is of course, predicated on the assumption that parents take their children for yearly or more check-ups at the doctors. Since statistics show that 17.5 % of Latinos in Rhode Island do not have a regular source of primary care, however, the promotoras must often do more than simply reinforce previous knowledge (Reynes, 1995, pp34-38). Often, they must ensure that parents receive the knowledge for the first time.

THE HOLISTIC APPROACH

FINDINGS

Another important part of the program is its holistic approach. The promotoras attempt to address various health issues, rather than assuming that families are concerned with only one issue (Strawn, 1994, p.161). VNA often sees the highest levels of social problems in families with lead poisoning: “abuse, transience, deplorable housing conditions. They require multiple interventions,” said one outreach worker.

While they cannot tackle every issue facing families, the promotoras do attempt to address a number health issues simultaneously, understanding that they all contribute to a child's general health risk and exposure to lead. Although participants may attend the party to hear about a particular issue, they come away with more knowledge about a host of subjects.

INTERPRETATIONS

By including lead among more salient topics such as AIDS and domestic abuse, promotoras are able to draw a larger crowd than might otherwise gather to hear lead poisoning. The holistic approach may be a solution to some of the problems other groups interested in fighting lead poisoning have encountered. Readiness of the minority community to work on a particular health issue may depend on the organizer's ability to integrate other community issues (e.g., crime prevention) (Brach, 1990, p.255) For example, the difficulty ENHS has had in bringing parents together for lead outreaches may reflect the fact that parents have more pressing priorities than lead--priorities which might be altered-- but which cannot not be ignored.

ENHS, recognizing the value of the promotoras program has contracted with it to do lead outreaches, using the promotoras as a means by which to gain access to the community. While this connection is a positive step in recognizing existing community links, by funding only lead--specific outreaches, ENHS misses the opportunity to gather the names of interested families who would attend a general promotora outreach. Furthermore, lead--only presentations, as initial outreaches and not follow-up presentations, work contrary to the holistic concept, which has been well-received.

BUILDING COMMUNITY/REDUCING ISOLATION

FINDINGS

VNA and CLAP outreach presentations, offered only on an individual, case by case level, while helpful in the short term to the families receiving the intervention, are an inefficient use of resources. As noted by VNA and CLAP coordinators, finding families is extremely time consuming since nurses are required to go to each home, often with unsuccessful results. The promotoras offer an alternative because they are able to reach families who were hesitant to allow a health professional into their home, but who would be comfortable inviting a few friends over, or attending a party at a neighbors house. They are also able to reach a number of families at the same time.

Moreover, rather than reinforces parents' isolation from one another, the promotoras encourage communication among individuals, which provides a social reinforcement for what they learn at the parties, as well as an awareness that their problems are not "individual obstacles [but] are more accurately described as social problems," (Strawn, 1994). The promotoras provide a safe place for parents to discuss their experiences with one another.

This "space", both physical and psychological, that the promotoras create is a significant aspect of the program. They use simple language, as compared to some of the informational sheets given out by groups such as RI Hospital. One of the promotoras who conducts the lead component of the program begins her discussion by comparing the danger of lead to the danger of puncturing oneself with a needle. While she then distinguishes the differences, the simile is a simple way to help parents visualize a risk that they cannot see. Thus the promotoras avoid intimidating individuals with complicated medical terms.

Participants responded positively to this acknowledgment of cultural identity and to the way in which the promotoras tailored their presentations to the community. They tended to adopt the promotoras' use of inclusive speech such as "we", "we Latinos," or "we women". The use of personal anecdotes also created a familiar and comfortable atmosphere. The positive cultural identification coupled with the health promotion also serve to counter frequent assumptions that "inner city problems stem from the cultural or social deficits" of Latino or other minority communities (Eisen, 1994).

The literal space of the home also helped to set an informal and intimate setting. Parents were encouraged to bring their children if they did not have daycare. One woman, for example, got up and began to heat formula during a presentation, rejoining the group after a few minutes. Although the child's cries necessitated a response, in many other situations the woman would have been made to feel uncomfortable for tending to such needs. One of the most common reasons that the promotoras cited for the lack of

attendance on their part and that of the party participants was child-care responsibilities. By creating an atmosphere favorable for children, the promotoras were able to reduce this barrier to education.

Finally, the inclusion of individuals of all ages allows for inter-generational communication. It has the immediate effect of ensuring that all those who are involved in child-care (teens who baby-sit, fathers, grandfathers etc.) learn how to prevent lead poisoning and are able to reinforce with one another what they have learned. Moreover, as mentioned previously, often the children know more about some of the issues than their parents. At one party, a participant joked to her neighbor, “look at your son. How does he know all this? Maybe he should join the promotoras!” Thus the outreaches enable parents to give positive feedback to their children.

INTERPRETATIONS

In addition to imparting information on specific issues the promotora program structure strengthens ties among its participants. The opportunity for children to share their knowledge about specific issues with their parents and to be taken seriously by adults reinforces the bonds between people of different ages. The inclusive voice verbalizes the commonality of the outreach participants, and the comfortable setting encourages individuals to attend. Thus the promotoras link reduction in the incidence of lead poisoning to the development of a sense of community in the population that they serve. Rather than attempt to develop a promotora component similar to that of the VNA, it may be more useful to investigate the possibilities of developing a VNA outreach that mirrors the promotora style.

COMMUNITY LINKS: MODELING AND SELF ESTEEM

FINDINGS

Because the Promotoras are women, they create a comfortable and familiar space for the other women in attendance. Although the female participants might be equally comfortable talking about lead with a male outreach worker, the format of the presentations was more reflective of traditional female interactions, such as “Tupperware parties”. Both the promoters and a community organizer claimed that the age of the women and their status as mothers was not important, yet many of the promotoras use their positions as mothers or wives in order to speak with authority about the issues.

The promotoras view themselves as role models. After one woman became an U.S. citizen she told the group, “people ask me why I did this. I tell them that they should become citizens so that they can vote. I pay taxes, why shouldn’t I vote?” Moreover many participants demonstrated their desire to emulate the promotoras by signing a sheet stating their desire to join the program in the future. Thus while in some ways the promotoras reaffirm the traditional female sphere of caretaker, they also serve as positive role models for both men and women.

INTERPRETATIONS

As a result of the respect and trust that the promotoras have, they are able to act as links to social services. They frequently cited this component as one of the most valuable parts of the program. One woman said that the program enables “you to help people [because you] know key people in the community,” and that as a result, “you know where to go to help people.” Several promotoras expressed the view that they were able to influence people because of their personal connections. As noted, two attendees had their children tested for lead as a direct response to the outreaches. Another man approached one of the promotoras after an outreach and requested the number for

RIDOH anonymous AIDS testing. One promotora explained that a friend, “called me because she knew me, and she knew that I had been studying about AIDS,” said one promotora. While it is too soon to make any quantitative judgment as to whether individuals increase their use of services as a result of the program, this area deserves further study.

The fact that women who attend the parties want to join the group is also important because this way the program can continue to draw in new members, and it will have a greater chance of sustainability and replicability. New promotoras are especially needed as the original promotoras expand their work or move onto different projects, or are forced to leave the program for personal or professional reasons.

INCREASED AGENCY AMONG THE PROMOTORAS

FINDINGS

Up till now, most of the discussion has focused on the impact of the promotoras on the broader community. Some of the greatest and most immediate impacts of the program are on the promotoras themselves. The development of self-esteem, that is, faith in one’s own abilities and the confidence to try new projects, was one of the most significant results of the program.

One of the strategies of program is to include the promotoras in as much of the decision making as possible, encouraging them to take a leadership role in the direction of the project itself. Since the current director has resigned, the women will be interviewing the candidates for position of the director. Moreover, during a Saturday meeting, it was the promotoras who came up with the criteria upon which candidates should be judged.

The change in self-esteem could be seen in a number of different areas. Over the course of the training, the women became more comfortable with their sexuality, more able to discuss issues related to the body. “When I first asked them to draw human genitalia, the women were able to recreate the external male organs quite well, but had no idea what went on inside,” said the coordinator. “The reverse was true when they drew the female body.” She explained that this discrepancy was common because frequently Latina women view male sexuality in terms of the physical act of intercourse, whereas they are taught to see female sexuality in terms of reproductive capability.

The women also began to be able to articulate their rights during the trainings. The right not to be economically abused, is one such example; the right to be spoken to with respect is another. In each of the interviews, the women stressed that they had not previously considered such rights in the context of their own home. “I just didn’t think about it with my husband, you know. Outside, yes, but not in my house. Now I think about it. I know [domestic abuse] is not just physical, but psychological and economic,” said one promotora. The women’s understanding of their relationship with their doctors also seemed to change along with the broader understanding of rights. Specifically with regard to lead test results above 15 *ug/dl*, one promotora explained that the women would be more comfortable asking their doctors questions now, “because they know what questions to ask. They don’t feel ignorant.”

Other areas of change included more confidence in organizing and in their abilities to complete tasks alone. After the leadership training ended, as the year progressed, the promotoras began to take more initiative as far as organizing parties and training sessions. In addition, many of the women continued to do research on their topics outside of the program. While some may have had the research skills, even before coming to the States, the opportunity and the incentive to use these skills and refine them did not previously exist for most of the promotoras. One woman, a former professional,

now on disability leave from her job at a factory, researched the herbal medicines and brought in recent articles connecting lead poisoning to aggression.

Another example of the increased autonomy occurred at the International Promotora Conference in Chicago, which half of the CHisPA promotoras attended. For many of the women, it was the first time that they had traveled without their families. A few of the women even ended up traveling to the conference on their own, which they recounted a number of times with pride during the Saturday meetings.

Not only did their perception of their own abilities change, but the promotoras came to demonstrate more confidence in each other's capabilities, identifying as a group and providing a support network for one another. The support for one another could be seen in the agreement by women who could pay for some of their travel costs to assist those who were in less of a position to afford the trips. Many of the women cited the "la unión" as one of the things that initially drew them to the group. The women demonstrated the respect they have for one another when I asked to whom they would turn if they had questions about one of the selected themes. All said that they would first turn to the other promotoras working on the subject. "I would ask Maritza¹¹ or someone else in the lead group," offered one woman, adding that if they did not know the answer, she would then turn to a professional lead outreach worker.

INTREPRETATIONS

As promotoras learn to take more initiative, and have more confidence in their abilities, their experiences in the program have the potential to affect other areas of their lives, both personal, and professional. The program also offers the women a valuable support network to discuss relevant issues in their lives. As the women came to rely on

¹¹ The name has been changed.

one another for work-related and personal advice, the trust they developed demonstrated the success of the program's community building goal.

PROVIDING PROFESSIONAL ADVANCEMENT

FINDINGS

While so far none of the women have found new jobs as a direct result of the program, they have received assistance with their résumés and with the job search. Through CHisPA they find out about job openings, as well as about agencies that might be willing to hire them. Along with an increased awareness about opportunities has come an appreciation for the limited professional opportunities for those who are not bilingual, or at least proficient in spoken English. The women are keenly aware that their program would appear more marketable if they could do outreaches in both English and Spanish, but presently only one woman, for whom Spanish is a second language, feels sufficiently comfortable to give outreaches in English.

When I spoke to the promotoras, many expressed frustration with their level of English and with the lack of opportunity to improve it. Roughly half of the Promotoras have already taken ESL classes, but only two are presently enrolled. There does seem to be a more enhanced realization that in order to improve their employment situations, they will have to improve their English. "I have it in my head that I can't speak English," said one promotora, who acknowledged that she can in fact read, write and communicate orally in English. Most of the women felt that they would be able to give their presentations in English, but were concerned about their abilities to respond to the participants' questions.

INTERPRETATIONS

In contrast to the common perception that if bilingual services are offered, individuals will not learn English, most of the promotoras did in fact speak some English and expressed the desire to improve. What they lacked most was confidence in their own abilities. The questions remains whether this frustration will provide sufficient impetus for registration or continued participation in ESL classes until the women are proficient

The desire to improve their English is in part based on the realization that job opportunities for Spanish speakers are limited. Yet the women claimed that professional advancement was not one of the driving motivations for joining the group. Nonetheless, the fact that they often had the coordinator review their résumés and act as a reference, shows that potential job opportunities are one recognized benefit of the program. The women may have hesitated to admit this factor because they felt that they would appear less committed to the program.

HOW LONG CAN PEOPLE SIT FOR?

FINDINGS

One of the main implementational problems is that presently the outreaches last roughly two-hours, with another half an hour for set up and cleanup. Two hours is a long time to do anything, especially listen to people talk, no matter how engaging the speaker or subject matter. The problem arises because in order to include the most important aspects of each subject and have a question and answer period following the talk, an allotment of at least twenty minutes is necessary per speaker. Even with this amount of time, a great deal of significant information must be omitted. Thus the promotoras must

decide how to balance the amount of information they wish to convey with the participant attention span.

INTERPRETATIONS

This dilemma will become more complicated as the group expands its area of expertise. It may eventually make more sense to choose only three topics, mixing the more salient with the less “sexy” and provide a rotation. While individuals would miss some information at each talk, they might be more likely to retain what information they did learn, and, equally important, they might be more likely to recommend the party to their friends. One way to evaluate the participants’ response to the outreaches is to encourage the presence of one non-presenting promotora at every party. Her job would be to conduct peer evaluations. This solution would maintain the program’s autonomy and strengthen the women’s reliance on one another, as well as the quality of their presentations. Some outside evaluation will be necessary from time to time but would not be required at every outreach.

SHOULD THE PROGRAM REMAIN SPANISH ONLY?

FINDINGS

As mentioned earlier the language barrier is an obstacle for further expansion of this program. While on the one hand, the promotoras address a specific group of people who are not targeted by many health promotion programs, Spanish speakers are clearly not the only group that could benefit from information in this area. The inability to speak English well enough to lead an outreach limits the women’s effectiveness in strengthening a broader community in Providence. Moreover, it limits their capability to

provide links to existing services or to act as advocates because they themselves are unable to voice their concerns.

The women seemed to have mixed feelings about expanding their audience. On the one hand, both during their Saturday meetings and at the parties, they spoke very much in cultural terms, using phrases such as “we Latinos need to...” which demonstrated the value to them of working within the Latino community. At the same time, when asked specifically whether they thought limiting the focus of the program to the Spanish speaking Latino population was sufficient, all of the promotoras interviewed responded, negatively, using broad, inclusive terms. “We are open to anyone not just Hispanas. After all we are all humans, no?” stated one promotora. This response was no doubt affected by the fact that their interviewer was an Anglo woman. Although the women frequently attempted to recruit me to be an English speaking promotora, they were clear that one of the most important criteria in choosing a new coordinator was that the person be a Latino, preferably a woman.

INTERPRETATIONS

There is a difference, between the promotoras’ ability to communicate in English and the expansion of the program to non-Spanish speaking people. Nevertheless, whether the promotoras continue to focus on Spanish speakers or branch out to include a wider group, they will be more effective as community links and advocates if they are bilingual. If the promotoras do decide to limit their involvement to the Spanish community, they can increase their visibility through the media. The promotoras may be able to use such outlets as Spanish radio stations and newspapers to recruit promotoras and to publicize important issues (Pancer, 1989-90, p. 109). In this way they would be able to reinforce word-of-mouth support with a more formal and recognized form of advertisement.

While the program may serve as a model for other immigrants, a community outreach worker at The Social and Ethnic Development Center for South East Asians (SEDC) explained that he did not think that South East Asian immigrants in Rhode Island would attend such parties. He explained that the women are too busy and that their husbands would not approve. This argument may be valid, but it could also be used to describe the situation of many of the most dedicated promotoras. It would be worthwhile to investigate how different South East Asian populations respond to the parties.

6 Long-term Recommendations and Conclusions

CHALLENGES TO A SUSTAINABLE PROGRAM

Ensuring ongoing training, maintaining and developing program leadership and securing financial viability are the three most crucial challenges facing the promotora program. While each of these issues and some immediate solutions can be discussed separately, they all relate to the structure of the program, and thus a broad solution that addresses each one is most useful. For this reason, I have placed an analysis of the problems first, followed by suggestions for possible project redesign to improve the chances of sustainability.

KEEPING ABREAST OF THE LATEST RESEARCH

Presently no mechanism exists to ensure that the Promotoras receive the most recent information. Without continual refresher courses and updates, the Promotoras will not be able to provide reliable information, and thus will not be able to sustain the community's confidence and could even run the risk of circulating misinformation to parents. Because the program is presently based in CHisPA, which is a policy oriented organization, it lacks a formal relationship with health care and environmental professionals who would be able to ensure that the promotoras used the most recently revised information.

THE ROLE OF THE COORDINATOR

One of the greatest obstacles facing the current program is that presently it lacks any sort of sponsor, as the present coordinator was forced to resign this spring due to prior commitments. With no one currently running a new leadership training course, the promotora program is not on a course for sustainability nor expansion. Clearly the answer is to hire a new coordinator, but the immediate loss to the women is a personal one and has temporarily impacted the morale of the group.

Without the coordinator's involvement, both the organization and the women's commitment have declined. When I asked one of the promotoras if she thought the group would continue without the coordinator, she responded, "really I can't say." Since they do not receive financial compensation, the risk of losing promotoras is high. Already in one year close to half of the women no longer actively participate in the outreaches. Many of the promotoras stressed that the program took time away from their families, or that they were unable to make meetings because of work. It is imperative that a new program coordinator be found as soon as possible who can continue to foster the sense of unity that has drawn the women together.

Making the role of the coordinator into a rotated position held by the promotoras is one option. Although it is in line with the goals of the program, two challenges to this scenario exist, which should be considered. First, although the women are more competent and confident than when they began the program, they still need the coordinator primarily for administrative organization. Aspects of the project, such as grant writing and training, require a full-time or part-time staff member with some experience and connections within the existing system of sponsor organizations. The second problem is that not all of the promotoras have the time, experience, or personal qualities necessary to effectively coordinate the group. There may be some tension as to

how the coordinator would be chosen, and the length of time each woman would occupy this role.

These problems, notwithstanding, having the promotoras coordinate their own program, with technical support from interns, would be the ideal scenario, and it would be in keeping with the program's goals. In addition, because of their personal investment in the program, if the promotoras become the coordinators, they will be more likely to commit to the program for several years than someone hired from the outside. Since the position will be rotated, a structure will be established such that the program does not depend upon the leadership capabilities of one individual.

THE QUEST FOR FUNDING

Since the La Raza grant will end in one year, the promotora program needs to look elsewhere for funding. Unless a sustained financial relationship is developed, the problem of inadequate funding will continue to limit the effectiveness of the group. Although the budget is relatively low, money is necessary for publicity, training and party supplies (coffee, donuts, raffle gifts etc.).

One solution would be for the women to arrive at complete financial solvency themselves, writing grants and creating a craft business as Promotoras in the De Madres a Madres (From Mothers to Mothers) Program in Texas (McFarlane and Fehir, 1994 p.386). Presently the CHisPA promotoras are planning several bazaars and are selling coupon books with the goal of raising \$300 each: the cost of attending a promotora conference in Arizona, but these endeavors cannot support the entire program. The promotoras cannot afford to spend the amount of time required to maintain the project's finances.

Another more realistic option to ensure financial sustainability is to seek grants from groups working on specific issues, but this solution is also problematic. The

promotoras' contract with ENHS to provide twenty Lead Education Parties in the Heart of Elmwood enables the women to continue their work but as mentioned previously, the single issue focus is not ideal. Many of the women expressed frustration that other topics, which they considered as, if not more, important to the health of the community than lead were not included.

A related problem arose because CHisPA agreed to the contract without consulting the promotoras, and thus the women felt that the contract undermined their authority to define their own program. Because the grant was based on the geographic neighborhood, the connection between the promotoras and the hosts or participants was lost in some instances. While the promotoras may still be effective without the personal link, especially as they become better known in the neighborhood, they had intended to establish themselves first among friends and acquaintances. Their level of comfort decreased when they did not have this connection. Specific grants can enhance the scope of the promotoras' work, but it is extremely important that the promotoras understand and agree to the terms of their relationship with any outside funding organizations, and that these organizations support the broader goals and approach of the promotora program.

RECOMMENDATIONS FOR LONG-TERM SUSTAINABILITY

PARTNERSHIP WITH THE UNIVERSITY

As mentioned in Chapter 4, a number of current promotora programs have aligned themselves with Universities and/or local Departments of Health. The most promising solution for funding sources for the CHisPA promotoras would be to create a similar

partnership with a local university. Ideally the RIDOH would be part of this program, but presently it does not appear to have the resources to enter into such a project. The partnership between the promotoras and a larger institution would solve some of the issues of training, leadership and funding, as well as facilitate the integration of individual versus institutional initiatives.

At Brown, several examples of community/university partnerships exist. The Center for Environmental Studies plays this role in its ES 192 class, in which students work for a semester with active community projects. The School of Medicine and the Center for Public Policy are involved in more long term projects such as the Providence Plan. Because Brown does not run a nursing program and does not generally serve the Latino population in Rhode Island, it may be more practical for the promotoras to work with other institutions, but a partnership with Brown should not be ruled out. The Community College of Rhode Island (CCRI), the University of Rhode Island (URI) or Providence College may be suitable partners because these schools already serve the Rhode Island Latino population with continuing education and ESL courses.

Such a relationship would be productive for both the university and the promotoras. The promotoras program would benefit foremost from the university's vast expertise in the area of medical and social research. Nursing students could be employed to train the promotoras about relevant issues. Environmental studies concentrators could also do outreaches. Thus the promotoras would receive the most up-to-date training without charge. The arrangement would also reduce the stress on the coordinator because she would be able to draw upon the school's broad network of resources.

The university could offer financial assistance to the program and could help the promotoras obtain grants from other sources, including the RIDOH. In this way the promotoras could continue to address holistically the social and physical environmental factors that affect the community's health.

A partnership with the university would also enable the promotoras to become knowledgeable about a variety of urban environmental issues, such as garbage, recycling, air and water quality. If the promotoras develop an advocacy component, these might be some of the areas into which they could expand. The increased training would ensure that women did not get bored of their topics, and it might lead to more professional opportunities.

The university would also benefit from the symbiotic relationship. Training of the promotoras could become a practice for the students, and the university would have access to grants aimed at community based groups. In addition, as the program expands, the promotoras would also be able to assist the university with a long-range study of certain issues affecting the community. One mechanism for this partnership would be through the Health and Education Leadership for Providence (HELP) program, which seeks to involve universities and hospitals in the "advancement of the health, educational and social welfare of Providence neighborhoods and residents" (HELP newsletter). While the program itself does not fund projects, it has been successful at fostering the relationships between large institutions and local community groups.

CASE STUDY OF A PARTNERHSIP

One example of this type of relationship exists in Texas. *Madres a Madres* is a promotoras program sponsored by Texas Woman's University, College of Nursing in a Houston, inner-city, predominantly Mexican, community. (McFarlane, Fehir 381). The program is funded with a grant from the Houston March of Dimes and the W.K. Kellogg Foundation, (McFarlane, Fehir 381). The theoretical goals of the program are based on both feminist and empowerment educational models, focusing on both the volunteers involved and the community in which they served.

Although to a certain extent one and the same, this explicit duality of intent, similar to that of the Providence promotoras, differs from traditional projects where the outreach workers are seen as tools rather than as a goal in and of themselves. "The program aimed for women to achieve greater personal strength and ability to cope and work within the system for better community health. The process by which the purpose was obtained was caring, a value held in high esteem by the women" (382). Thus even with ties to the university, empowerment remained a goal and increased health care is considered both a mean and an end. Although the risk of university involvement is that it may indirectly reaffirm traditional dependent relationships which the promotoras are trying to alter through their very initiative, the university/community partnership remains the best option available.

OTHER FUTURE AREAS OF STUDY

In previous promotora programs around the country, the issue of job training surfaced after the first year of the program. The women wanted to continue to develop

their skills and increase their marketability, and they became disenchanted with the program when it did not serve as a stepping stone to other professional opportunities (Warrick, 1992, p.24) Strategies for offering job opportunities should be investigated. Ideally the promotoras would be paid for their services. Realistically, they might also be employed as nursing assistants who conduct outreaches and offer home care through programs such as the VNA. At the very least, they should be paid for training new promotoras.

Program planners should keep in mind that as promotoras develop job skills and become employed in related fields, they may be less available to the program. This factor need not be a problem as long as such an expectation is incorporated into program planning. Studies should also be conducted as to why certain women are able to continue with the project, despite financial and family constraints, while others are forced to drop out of the program.

Another related area of concern is the relationship between the promotoras and other health professionals. In the past this interaction has occasionally been marred by tensions on both sides (Joel S. Meister et al). Some professionals viewed the promotoras as a threat to their own jobs. Moreover, many of the nurses and practitioners did not feel the promotoras to be qualified for further professional advancement, despite their knowledge, because they had not enrolled in a graduate degree program in the field. Some promotoras, angered by this attitude, cited the resentment they faced as the reason why they left the program. If the promotoras expand their involvement, it will be important to ensure that their relationship with the health care professionals is one of trust and mutual respect, since each fills a necessary and separate niche.

THE INDIVIDUAL VERSUS THE COLLECTIVE

In recent years political debates over individual versus institutional change have filtered into public health discussions about disease prevention, as well as environmental activism. In some ways the promotoras foster more collective action. They rely upon one another, they encourage community interaction, and they discuss universal rights.

Nevertheless, their efforts focus on education, not advocacy, that is to say that they operate under the assumption that, “information is power and if women are provided with culturally relevant information about services...they will use the information,”(McFarlane and Fehir, 1990, p.274). Yet often, even when individuals have the information, they are unable to change the situation because of external factors. For example, even when parents are aware that their landlord is responsible for lead abatement, they may not be able to effect change simply because of the convoluted and overloaded legal system in Rhode Island (Pat Boulay, 1996 p.52). Relying on such catch words as “empowerment of individuals” belies some of the structural barriers in both the legal and medical systems that hinder individuals from improving their environment and health. Moreover, the individual argument can shift the debate away from fundamental social inequities which permit families to live in such extreme conditions of poverty.

The promotora program cannot bear the responsibility for all of these problems, however. Individuals must first be aware of the issues in order to consider their origins. Practically speaking, as noted in Chapter 5, barely enough time exists for the women to discuss the issues, let alone offer recommendations for societal overhaul. Nor is it clear that many participants are ready to consider these issues. Based on the size of the group, as well as the obstacles both ENHS and CLAP have faced organizing around individual issues, the program coordinator made the decision to focus only on education about individual action rather than on advocacy and community organizing. While in the future

she hopes that advocacy will be incorporated into the project, presently she feels that, “we just don’t have enough person power right now.”

Although not addressed in the presentations, collective action is the next logical phase. Recently a party participant asked, “if the government knows that all these houses have lead paint, why don’t they do something about it?” The promotoras were not prepared to respond to this question. Nevertheless, the fact that this woman had a public space in which to voice such concerns is a step in the right direction.

In the past, some promotoras have moved away from their role as outreach coordinators and have focused more on advocacy as they helped families “negotiate the ‘bureaucratics’ of the health care system”(Joel S Meister, 1992 p. 214). Whether the promotoras are able to move to this plane remains to be seen. Either way, while this program should not be used as a panacea for the fundamental problems of poverty and unequal distribution of resources in Rhode Island, it has excellent potential to improve health in the Providence Latino Community. What makes the promotoras unique in this state is not simply their dual focus on developing leadership and improving the health of the community, but their recognition that these goals are intrinsically linked.

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