

La Promotora

Linking disenfranchised residents along the border to the U.S. health care system.

BY DARRYL M. WILLIAMS

ON THE HOT JUNE DAY I ARRIVED Lorenza was sitting in her makeshift office in the double-wide mobile home that served as the clinic. Her government-issue metal desk was pushed against the wall next to a filing cabinet whose handles were loose and hanging down. She had a map of the *colonias* thumbtacked to the wall and a stack of appointments lined up on the seat of a folding chair. She asked if I would like to help her hand out fliers to the community, and I said sure.

Lorenza was the *promotora de salud* (health promoter) for the San Elizario clinic, in far eastern El Paso County, Texas, near the Mexican border. The clinic served a group of *colonias* inhabited by some 10,000 people. *Colonias* are unincorporated developments without public services—no water, sewage, or electricity. This cluster of them was created about twenty years ago when land developers broke up the fertile bottomland of the Rio Grande into quarter-acre parcels. The little plots were sold to families from the barrios of downtown El Paso who were anxious to make a better life for their children in the country. I was there to work in some of Texas Tech's outreach clinics, created to provide health care to *colonia* residents through shared teaching with the local nursing school at the University of Texas at El Paso.

Fitting In

MY ACADEMIC CAREER had been like many others, progressing from clinical training to research lab to administration. I had been away from patient care for some time and was looking forward to seeing patients again and to teaching

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Texas Tech medical students, residents, and nurses training in the *colonias*' clinics. I was a bit nervous about the endeavor because my clinical skills were a little rusty after so many years of paper pushing, and my Spanish abilities were nil.

Lorenza's job was to know who was sick, who was pregnant, and who was not taking prescribed medications so that she could visit them at home and make arrangements for care. In the mornings she helped in the clinic by taking vital signs and translating for patients.

In the afternoons she made her rounds in the community. She also offered classes to women in basic homemaking skills, parenting, first aid, and sanitation. She had studied these topics in a clinic-provided course for community volunteers. The class had been designed by a social worker who had patterned the curriculum on one used in her native Mexico for volunteers. Unlike in Mexico, in this American clinic the *promotoras* would be paid employees.

As we loaded into my car with the fliers, she explained that if *colonia* residents missed a payment to the developer who had provided them loans, he would foreclose on the land and sell it out from under them. The families who bought these plots worked hard to make them livable, building shallow wells and privies. Their lack of public health awareness led to endemic diseases such as hepatitis A. El Paso County contains more than a hundred *colonias*, many of them in the desert. The state of Texas has thousands of *colonias*, which some 300,000 people call home. Similar communities exist in the border states of California, Arizona, and New Mexico.

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The Local Scene

SOME OF THE HOUSES in the *colonias* were made from wooden shipping pallets and cardboard boxes, others had cinder-block additions and artistic brickwork. A tall fence and a herd of goats surrounded one house. A huge storage yard for rented portable toilets stood in the middle of the community. A wide canal that had once served as a cesspool had been drained and turned into a children's playground. As I went door to door with Lorenza, we handed out fliers about parenting classes to a few interested housewives. At the last street, a few yards from the Rio Grande and the Mexican border, some young men stood next to a car with out-of-state tags, fixing binoculars on the sagebrush across the river. "Drug dealers waiting for a shipment," pronounced Lorenza.

Learning From Lorenza

THAT FIRST DAY MARKED THE START of a several-year collaboration with Lorenza to get patients into the clinic, explain treatment plans, and follow up on care. Through her I learned much about how to begin handling the public health challenges in these communities.

For example, in the medical center we are often too quick to label patients as “noncompliant” and move on to the next case. When a patient in the clinic wasn’t taking medication we had prescribed, Lorenza would investigate, often discovering that the family had no money to buy the drug. She engaged in various counterattacks, including trying to get the patient on Medicaid, applying for indigent care at the county hospital, setting up a deal with the local pharmacy, or even buying the medications with her own money.

We worried about nutrition and diabetes in the *colonias*, and Lorenza started a nutrition class that involved cooking lessons and trips to the grocery store. She found ways to help families get food by brokering loans with the small food shops or getting neighbors to contribute groceries. We worried about gang activity, and Lorenza confronted a group of “taggers”—adolescent boys who sprayed their gang’s initials on property to mark their territory—who had splashed graffiti on a historical building. The graffiti stopped. We worried about teenage pregnancy, and Lorenza created a support group for teenage girls. When a child came to the clinic with burns

from a home fire, Lorenza visited his home, a windowless trailer. This inspired the entire clinic staff to pitch in for windows, blankets, a safe heater, and toys.

Equally important for Anglo clinic staff and students alike, Lorenza provided a window into the local culture. As part of our curriculum we invited presentations focusing on Mexican culture. One time she filled in for a

local *curandera*—a traditional faith healer—who had cancelled a session about common folk remedies and curing rituals. Lorenza arrived for the session looking like a different person. She had pulled her long black hair into a single braid that hung down her back and heavily shadowed her eyes. She wore dangling hoop earrings with blue stones and a long, intricately patterned, handwoven skirt. Under her arms she carried a striped blanket enclosing some candles and an assortment of strange bottles. She arranged the blanket over

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one of the tables in the clinic conference room, spread out the bottles, and lit the candles. She explained how the contents of the bottles could be used for various ailments and then performed a *limpia*—a cleansing rite for someone with a treatment-resistant fever or illness.

Lorenza spoke in a low voice while passing a hen's egg over me—her volunteer, pressed into service when the students held back. She swirled the egg through the air and spoke in Spanish in semi-intelligible prayer. After several minutes she looked upward, spread her arms, and became silent. She reached down, cracked the egg into a small bowl, and placed it on the floor beneath me. Later Lorenza told me she had dressed that way to remember from where she has come. She believes in modern medicine but is a religious person with faith in the power of herbs and traditional remedies.

The Making Of A 'Promotora'

I LEARNED THAT LORENZA HAD BEEN A SINGLE MOTHER, raising two children in a one-room adobe house with a dirt floor. Her husband was an abusive drunk, and she divorced him. At that point she had never worked outside the home and had little education or skills beyond those gleaned from migrant farm worker camps in California and Oregon.

Lorenza's first job was in an El Paso garment factory. Sewing an endless supply of buttons on an endless supply of denim pants wasn't much of a challenge, but it was a start. Soon she was a supervisor, traveling to other factories to train new workers and new supervisors. Over time she felt she could not continue because being a supervisor required her to choose sides, often against her friends in the production line. She began to help neighbors, speak out about nutrition in the schools, and work for community cleanup efforts—activities that led to her training as a *promotora* and to her clinic job. From there she was elected to the school board and, after a bout with cancer, joined the board of the El Paso chapter of the American Cancer Society.

Today Lorenza is a member of the inaugural class for *promotoras* at El Paso Community College. She also is working for a project under which she prepares other *promotoras* to teach mothers and grandmothers about infant care.

In my current clinic work along the border I continue to observe firsthand the effectiveness of Lorenza and other *promotoras* in helping their wrenchingly poor communities. Rooted in the culture of

the *colonias* and trusted by their residents, *promotoras* know about family situations that need attention and that influence the success of a patient's management. Recently they have demonstrated that

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they can successfully recruit enrollment in the State Children's Health Insurance Program (SCHIP) when more conventional efforts have failed. Immigrant populations are leery of SCHIP because they suspect that it may be used to block citizenship applications for a family member. They are intimidated by the program's application forms and unclear about SCHIP's benefits. *Promotoras* go to people's homes to explain how the program works, a method that has been more effective in expanding enrollment among immigrant groups than high-tech, media-based cam-

paings have been.

Lorenza understood the potential for *promotoras* to become an important force in health care delivery along the border even more clearly than I did. When the opportunity arose for her to organize and speak up for *promotoras*, she grabbed it. In 1996 Texas Tech's Office of Border Health became a subcontractor for the Border Vision Fronteriza project of the University of Arizona, funded by the federal Health Resources and Services Administration. We were tasked with developing a curriculum for a train-the-trainer program for *promotoras*, field testing the program, and enlisting women to participate. Lorenza joined our office staff and played a lead role in implementing the program. She saw that what was missing was recognition of the value of *promotoras* and a general agreement that they should be paid for their work. (Some clinics—not ours—thought that women in the *colonias* should be willing to volunteer a forty-hour week for the sake of their community!)

As we sat in the clinic over many a lunch of *burritos*, *gorditas*, or *flautas* bought from local vendors, Lorenza proposed to me and others that there should be a standardized educational process for *promotoras* that would permit certification and, in turn, mobility. With mobility would come a broad job market and an opportunity for impoverished women who had never worked outside of the home to make a living and help to support their families.

Replicating A Good Thing

THESE IDEAS HAVE CAUGHT ON. Clinics and hospitals all along the border are hiring *promotoras*. Many communities in other parts of Texas and in other border states are establishing training programs and organizing groups of community health workers. Interested visitors from all over the country have come to the four Kellogg Community Partnership clinics in the past few years. Parallel to these rural initiatives, national interest is growing in using community-based workers to help address the health and social problems of ethnic communities in our inner cities.

Detractors might say that the role of these individuals has not been convincingly demonstrated in measurable outcomes. I need only recall the scores of patients I have seen who have turned the corner in trying to take control of their illnesses after an encounter with a *promotora*. To many immigrants who live along the U.S.-Mexico border, effective, aggressive *promotoras* are the sole link to the health care system. Beyond the humanitarian reasons to engage *promotoras* in improving health care for border residents, national interests argue for doing so. The border is a fragile buffer zone dividing the rest of the country from a host of infectious diseases and other health issues faced by impoverished immigrants. Bolstering the work of the *promotoras* along the border could well help to protect the health of us all.

Bringing ‘Promotoras’ Into The System

THREE TASKS LIE AHEAD OF US before we can enlist *promotoras* as permanent members of the health care team. We must make sure that *promotoras* have been adequately trained to assume the significant responsibilities they are often given, that the training programs used are of demonstrably high and consistent quality, and that we find the means to assure that *promotoras* receive a living wage and are not expected to work only as volunteers.

Help may be on the way. During its 1999 session the Texas state legislature charged the state’s department of health with establishing a statewide advisory committee to examine the role of the *promotora* in health care delivery. This committee is defining a core curriculum for *promotoras*; establishing credentialing

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requirements for the individual *promotoras*, their instructors, and the institutions that train them; and suggesting how *promotoras* can be reimbursed within the structure of health care financing.

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Lots of changes have taken place since the day I first met Lorenza. The pallet and cardboard houses are gone from the *colonias* near our clinic, and water and sewage lines have been constructed for some of the community. Changes in Medicaid and other programs have made health care more accessible for many residents in the *colonias*. And Lorenza has become successful beyond any expectation I might have had that summer day five years

ago. Just recently she was recognized by the Health Care Financing Administration in a public ceremony in New York City. She was lauded for her accomplishments in mobilizing a grassroots effort using *promotoras* to encourage SCHIP enrollment in communities along the entire U.S.-Mexico border.

Yet some things remain the same. My little clinic still operates out of a double-wide mobile home and is the only source of health care for many of the people who come to see me. Family health care for some of my patients is still fragmented between the United States and Mexico. Clinic staff from Texas Tech and the University of Texas at El Paso still depend upon the *promotora* to provide care that we cannot. The current *promotora* in our clinic, like Lorenza, began as a student in one of our clinic classes.

In many respects, the access to health care that most of the rest of the nation enjoys has bypassed the poor people of the border region. But in their own quiet, forceful way, Lorenza and women like her in *colonias* from Texas to California are making the case for community-based health care. The rest of us need to keep working to assure their recognition and support.