



# Symposium Report:

## *Lay Health Workers (Health Promoters) Project: Community Mobilization to Improve Cardiovascular Health in the Americas*

(Santiago, Chile, 17–18 October 2005)

Co-sponsored by the National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), USA, and the Pan American Health Organization / World Health Organization CARMEN Initiative

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## Background

Cardiovascular disease (CVD) is the leading cause of premature death in the region of the Americas, accounting for 31 percent of all deaths. Because CVD is caused by a variety of factors, interventions for prevention and control require simultaneous strategies targeting different levels and sectors. In view of this fact, given the steady increase in the prevalence of cardiovascular risk factors in all countries of the region, it is crucial to adopt measures aimed at containing the pandemic of these diseases.

To this end, the National Heart, Lung, and Blood Institute (NHLBI) and the Pan American Health Organization (PAHO) are pursuing a joint initiative to promote cardiovascular health in the Americas, based on their joint statement of August 2003, and the NHLBI's terms of reference as a designated WHO Collaborating Center.

This cooperation has resulted in the following **activities**:

- Organization of visits to share experiences, identify complementary activities, and develop recommendations for joint NHLBI-PAHO projects;
- Organization of a workshop to study new guidelines for the prevention and control of CVD in the Americas, and to identify the most effective strategies at the population and clinical levels for preventing and controlling cardiovascular risk factors;
- Creation of a planning committee to support NHLBI and PAHO in the organization of the Symposium—summarized in this report—on the role of lay health workers in promoting activities for the prevention and control of CVD in the Americas;
- Future activities: financial support is planned for pilot projects to undertake and evaluate community interventions to prevent CVD in countries of the Americas with limited resources, and to develop an instructor training program on the use and evaluation of the Manual for Lay Health Workers from NHLBI's Health for Your Heart Program [*Manual para Promotores de Salud del Programa Salud para su Corazón*].

The Symposium is an outcome of a broader joint NHLBI-PAHO effort to promote cardiovascular health in the Americas.

## Executive Summary

### General Objective

To exchange information on emerging models for programs that rely on health promoters to carry out community interventions and to take any lessons learned into account in the planning of future programs.

### Specific Objectives

1. Explore and identify the extent to which health promoters are currently used to address health issues in the Americas;
2. Build consensus on the concept and potential of health promoters and the difficulties inherent in promoting, preventing, and controlling the risks of developing CVD in the Americas;
3. Analyze the strategies, best practices and emerging criteria, with the purpose of implementing and evaluating projects led by health promoters; and

4. Offer recommendations for the development of conceptual models for pilot programs to carry out and evaluate the interventions of health promoters in the Americas.

## Framework of the Symposium

The definition ultimately arrived at for the concept of “health promoter” and the conclusions as to the usefulness and feasibility of incorporating this concept in cardiovascular health programs should be considered in the context of the title of this symposium: Community Mobilization to Improve Cardiovascular Health in the Americas. The primary goal, therefore, is to support the prevention and control of CVD by tapping community know-how to disseminate knowledge and change harmful behaviors and habits (areas where traditional health interventions have a poor track record). Secondly, the goal is to use the strength of the organized community to improve health service coverage and the early detection of people at risk. Beyond facilitating changes in the behaviors of individuals, the strength of a community led and organized by health promoters can also bring about changes in social and environmental determinants to the benefit of cardiovascular health.

All of this notwithstanding, experience demonstrates that the community’s contribution—either through the health promoter model or community organizations that take part in health activities and decisions—has been used in different ways and for different purposes depending on the individual needs and reality of each country. Accordingly, several visions have emerged with respect to the role of health promoters, the scope of their work, and the characteristics required of people who assume that role. In this regard three important, but not necessarily exclusive, groups can be identified:

- Those who view the health promoter as a member of the community with training in health issues who helps to extend the coverage of the health sector: *considered as a way to make up for personnel shortages and as an additional source of labor;*
- Those who view the health promoter as a member of the community whose personal characteristics and additional training make him/her more effective at reaching people and the community and bringing about the desired behavioral changes: *the promoter complements the work of the health team with actions and interventions in which he/she is a stakeholder and possesses better skills to that end;*
- Those who attribute an additional value to the health promoter as a more active community stakeholder, *recognizing that he/she is an effective representative of the community* who, in addition to assuming health tasks and supporting changes, serves as a channel for communication between the community and the health sector, and represents community interests in dealings with local authorities.

With respect to these models, the consensus was that health promoters can be especially valuable to the success of cardiovascular health programs at any stage of an intervention in a given country.

This assertion is rooted in the fact that CVD can remain asymptomatic for a long period of time; are common and high-risk; are associated with behaviors and lifestyles; and, in most cases, are preventable or controllable. Therefore, information, education, and the development of know-how and skills for changing behavior are key to managing this health problem.

Changing behavior is not achieved through information alone or the instructions of health workers. On the contrary, it is achieved through a combination of factors, which, in addition to the two mentioned above, include many others, such as motivation and attitude about the change of behavior, the feasibility of the change, personal capacity to cope with adverse conditions, positive reinforcement, peer support, and the availability of models to follow (the promoter may serve as one such model), favorable settings, etc.

**In this context, health promoters are regarded as important participants, given their capacity to reach people and communities with information and skills; health promoters appear to have greater**

**potential for eliciting changes in behavior than classical health interventions, because they operate within the peoples' daily reality, gain their trust, and serve as a recognizable model within reach.**

The presentations of experiences involving health promoters were varied and described the general features of programs covering health problems other than cardiovascular disease. However, these presentations made it clear that health promoters perform their work under similar basic conditions, and that it appears both feasible and practical to employ these conditions in cardiovascular health programs. Moreover, there was also consensus that health promoters serve as a mechanism for delivering relevant information from the communities they serve to the health sector, which makes it possible to better match interventions to people's real needs.

The group agreed on the following core elements for achieving successful results in cardiovascular health projects involving health promoters:

- ensuring the structural, technical, and financial sustainability of programs;
- adequate promoter selection and training; the availability of a core set of systematized support materials;
- ongoing monitoring and positive reinforcement of promoters;
- evaluation of promoters and the results of their interventions;
- the insertion of promoters' activities within the broader context of health and extrasectoral strategies; and
- encouraging a cultural change among health professionals toward embracing and supporting these programs.

Additionally, there appears to be no significant difference between paid and volunteer health promoters (this will depend on each case) or in the number of health programs that each promoter works on at the same time.

Special consideration was given to the idea that health promoters should be part of the community served and should work "from the inside." In some cases, health promoters from outside of the community are used, but the work they do is considered more as "health education" and not characteristic of health promoter activities, which are more comprehensive in nature.

Likewise, emphasis was placed on the idea that the health promoter should be respected and considered another member of the health team, but by the same token, should not be integrated to the point where he/she is no longer perceived as representing the community but instead as a staff member of the system.

One presentation emphasized the decision not to use health promoters, opting instead to formally incorporate organized community groups into the work of health facilities and the health system. This was achieved through "health committees" that participate on the boards of clinics offices, hospitals, and area health bureaus. Community representatives serving on these committees act as a bridge between the two parties; they participate in decision-making and work to help change beliefs and behavior in their communities.

Toward the end of the Symposium, the participants worked to define baseline conditions and assess the Region's strengths and weaknesses in terms of implementing cardiovascular health programs involving the use of promoters. Among these conclusions, the following elements were considered positive, necessary, and, in large measure, present in most of the participating countries:

- (1) the availability of information;
- (2) the political will to address the problem of cardiovascular disease;
- (3) the existence of basic structures in terms of health services and health programs that make it easier to implement programs involving the use of health promoters;
- (4) the development of community health programs;

- (5) prior experience with health promoters (albeit in other areas of health);
- (6) a reserve of trained health promoters in many countries;
- (7) the existence of regional networks to support the sharing of information/experiences and to ensure the sustainability of interventions, thanks to regional commitments that extend beyond the term of the government of the moment; and
- (8) a growing awareness on the part of the community and the health authorities of the health threat posed by CVD.

Forums such as this Symposium are seen as opportunities for countries to come together and share experiences to improve health interventions and the sustainability of such programs.

The following common challenges and objectives were emphasized: ‘

- (1) the need to integrate cardiovascular health interventions in actions aimed at preventing and controlling the risk factors for noncommunicable diseases;
- (2) how to coexist with the high priority placed on maternal and child programs in the Region;
- (3) how to ensure financing, technical, and programmatic support for sustainable projects;
- (4) the need to develop suitable evaluation mechanisms (still under development);
- (5) the dissemination and use of work materials for health promoters and their adaptation and/or validation for use in the local culture.

**Inasmuch as this Symposium is part of a larger project still in development, which will continue to be improved in future forums and workshops, it is important to summarize those areas that generated group consensus and those that resulted in only general conclusions. This could be the starting point for future activities.**

### Areas of Consensus

- ✓ Effective cardiovascular health interventions should combine several strategies; one of the pertinent strategies—which is difficult to achieve through traditional health sector actions—involves changing unhealthy habits and behaviors;
- ✓ Information (knowledge) and enabling environments (i.e., creating environments that make it easier and more feasible for people to make healthy choices) need to be complemented with direct interventions designed to motivate people and strengthen their resolve to change their behavior, as well as support and follow-up activities to cement the new behavior;
- ✓ With respect to cardiovascular health programs, health promoters make their most useful and effective contribution to the educational component and boosting people’s capacity to change their behavior;
- ✓ In some cases, promoters can also serve as liaisons for community empowerment and advocacy with local authorities, working to establish enabling environments in their communities that promote healthy habits and behaviors aimed for the prevention and control of CVD.

### Areas under Discussion

- Should health promoters work exclusively in general health interventions or health promotion activities?
- Should health promoters work exclusively in health education activities or should they also be trained to carry out specific health actions (i.e., take blood pressure, administer injections, and attend births)?
- Should promoters be certified?
- Should health promoters work exclusively at the health center, or should they make house visits?
- Should promoters be paid?
- Should promoters focus exclusively on cardiovascular health, or should cardiovascular health be included in promoters’ interventions for other health problems?

- Should health promoters belong to and live in the communities they serve, or can outsiders perform these functions?
- Should health promoters be considered mere instruments of the health promotion strategy or are they, in fact, something more?
- With respect to the health promoter's relationship to the community... Is it a core and defining element of that relationship? Does that element change if the relationship is lost?
- With respect to organized community groups ... Can they replace the role of the health promoter? Can they take over complementary areas of health promotion, or is it possible for them to perform both roles?
- Are health promoters effective only in poverty-stricken or remote areas, or can they perform effectively in other social settings?

**At the close of the Symposium, the participants recognized and validated the work of health promoters in the various contexts described and considered health promoters a resource with vast potential in terms of cardiovascular disease, as agents of change, educators, and a means to perform limited health research and control interventions.**

## Opening Session

### Dr. Juan Manuel Sotelo, PAHO PWR/Chile

Dr. Sotelo noted the partnership between PAHO, the Institute, and the Chilean Ministry of Health, as well as Chile's efforts in the areas of health promotion and the prevention of non-communicable diseases (NCDs). Dr. Sotelo emphasized the need to work with human resources in the community and to take into account the experiences of the established actors in this area. He recalled that under PAHO's strategic orientations, the Primary Care Strategy includes new approaches to ensure that health services adequately respond to community needs. He mentioned the need for intersectoral and community action as strategies for changing health determinants. He conceded that more intense work is needed at the local level, with real community participation, in which health professionals recognize and learn what communities can contribute to the health services and to improving the CVD situation.

**On hand at the opening session of the event were authorities of PAHO, NHLBI, and the Ministry of Health of Chile, thus underscoring the priority accorded to cardiovascular health by the health institutions and the governments of the Region.**

### Dr. Gregory Morosco, NHLBI/USA

Dr Morosco made mention of previous efforts by NHLBI and PAHO, which laid the ground work for the Symposium and the resulting exchange of information between the different cultures and fields of study represented. He stressed the importance of sharing experiences and developing a common dialogue and shared vision as a means for making a qualitative breakthrough in terms of knowledge of cardiovascular health problems and what to do about them (the "Medici effect"). Dr. Morosco recommended that the Symposium entertain new ways of thinking and encouraged the participants to interact with one another and create networks for continuing the work of the Symposium and growing together. He concluded by recalling that progress and research on cardiovascular health problems will only be useful when people have access to that knowledge to improve their health.

## Dr. Alberto Barceló, PAHO/WDC

Dr. Barceló emphasized Chile's work on NCDs, recognizing its usefulness for other countries of the Region. He also thanked the NHLBI for participating in this joint program and the PWR/Chile for organizing the Symposium.

He also stressed the relationship between the primary care strategy and community service as necessarily elements for achieving health goals. According to Barceló, in tackling the problem of NCDs, it is necessary to address the health of the most disadvantaged sectors of the population, a task in which there have been successful experiences involving the use of health promoters.

## Dr. Pedro García Aspillaga, Minister of Health of Chile

Dr. García Aspillaga emphasized the importance of the Symposium and the need to seek the best ways to “swim against the current”, in an individualistic society with unhealthy lifestyles. Activities such as this one help forge networks and deliver the health message to political authorities beyond the health sector.

He presented some statistics on the Chilean situation with respect to cardiovascular health risks and NCDs, underscoring childhood obesity, poor eating habits, and lack of social support networks for people.

**The first presentation studied the role of health promoters, their relationship with the community and the health system, and their effectiveness in a variety of programs. In addition to the presentation of experiences involving health promoters, these presentations contributed theoretical and practical underpinnings for the Symposium's in-depth discussions.**

According to Dr. Aspillaga, the key to successfully changing peoples' attitudes lies in changing the attitude of the health team, which must be encouraged to fully and effectively embrace the concepts of health promotion and disease prevention so that it can credibly transmit them to the community.

He also conceded the mass media's influence on the population and underscored the need to work with the media and enter into a healthy dialog with it.

Finally, he reminded countries that tend to set the example for others—and that have experienced an increase in NCDs and their consequences—of their duty to provide information to and alert countries about behaviors that should not be emulated. He encouraged the participants to take advantage of the Symposium as a forum for sharing, pondering, and proposing responses to bring peoples together and facilitate their happiness.

## Presentation of Experiences: Module I

### The Growing Field of Health Promotion

*Dr. América Bracho, USA*

This presentation recalled the Declaration of Alma-Ata, emphasizing that the need to shift toward a primary care focus—since specialized care will not improve health and not all will have access to technology—is still

valid today. Primary care continues to be the strategy of choice for effecting change, and health promoters are an important piece of that strategy.

Health promoters—or members of the community working to improve the health of the community at large—have always been present, although the term “promoter” was only formalized in 1978.

Health promoters are part of the community and not health institutions; promoters are, in their own right, experts on the communities they serve, whereas institutions only give them technical know-how. A respect for health promoters is an essential part of work in this field. Thus, the health promoter model was used prior to its application to CVD prevention and health promotion.

While health promoters can be tasked to perform a variety of health actions (i.e., take blood pressure, administer vaccinations), one should never lose sight of the fact that their job is first and foremost to build healthy communities. Accordingly, health promoters should be perceived as an extension of the health center structure and as a member of the health team—but always working as a representative of, and from within, the community. Therefore, health promoters should be respected in their communities and have some degree of authority in them.

According to the presentation, the main characteristics of promoters include: the ability to interact with health professionals; creativity; courage; charisma that can inspire their community; and the ability to reach people with their message through a variety of avenues—in short, the work of the health promoter is a labor of commitment and love, not an intellectual endeavor.

Dr. Bracho recommends that, when selecting health promoters, preference be given to those who exhibit characteristics associated with commitment to the cause, a concern for social justice, a love of people, and knowledge of their communities. Building on this foundation, health promoters can be taught the needed technical know-how and skills. There is no technical program to teach people to be health promoters; after all, a promoter is a vehicle for reaching the community, and one that can be used to support many programs. There is no training course to remedy the poor initial selection of promoters. It is not in a program's best interest to recruit promoters from outside of the target community; such promoters cannot do their work the same way that a member of the community can because that essential component is lacking.

The health promoter is successful because he is perceived as an equal—a stakeholder concerned about his community—and although it may take him more time than a health professional to obtain the respect of his community regarding technical matters, once he has it, his capacity to reach people with health information is greater. The health promoter is a formidable educator, capable of examining the context of any program he is going to teach. A health promoter should not be removed from his community because in doing so he loses the essence of his strength; he should be respected and recognized as another member of the health team, but first and foremost as a member of the community. The work of the health promoter is a two-way street; in addition to providing the community with information, he also provides feedback and information from the community to the health team, which should be taken into consideration in the latter's decisions.

Likewise, it is also helpful to enlist health promoters who themselves have some of the risk factors or diseases they teach the community about. It is also helpful to have health promoters of all ages, depending on the target group. Speaking from personal experience makes for a better group dynamic and facilitates behavioral change. Promoters achieve results that the health team is incapable of by identifying with the people they serve: they can teach an illiterate person to manage his blood glucose by teaching him the basic numbers required for this task. Promoters can also mobilize to obtain additional resources or demand that the health center provide the necessary resources for the community. A physician does not respect health promoters

because of their training, but because they make real contributions to improving the health of his/her patients.

Dr. Bracho recommends that health promoters receive only technical certification (i.e., in the health program in which they receive training); however, promoters cannot receive health-sector certification as such, since the status of “health promoter” amounts to the personal status granted *de facto* by the community. Moreover, though both paid and volunteer promoters are known to exist, in order to build a sustainable structure, a group of paid workers is needed whose work is seen as an ongoing task of the health team that may be supported by volunteers. Some promoters continue to study and go on to become professionals; this is excellent in terms of personal development, but once they become professionals they can no longer serve as health promoters.

Dr. Bracho sums up the *main elements* of her presentation as follows:

*Basic health promoter skills:*

- Communication skills;
- Good knowledge of the subject matter;
- Good organizational skills;
- Good skills as an educator;
- Good advocacy skills;
- Ability to prepare the community for self-management;
- Ability to be a good coordinator of services;
- Good interpersonal skills.

*Core tasks in work involving health promoters:*

- Selection: based on basic personal considerations and their knowledge of the community;
- Training: knowledge and technical skills, with more emphasis on personal creativity and understanding of their own culture;
- Supervision: to be effective, the supervisor should also be trained in community work.

*Challenges and opportunities in working with health promoters:*

- Need for competent, personalized, and economical interventions (i.e., reaching people with a message and changing behaviors, and how to do so while respecting the local culture);
- The epidemic of obesity and malnutrition (i.e., simultaneously addressing health problems at two levels);
- Need for integrated interventions (i.e., carrying out necessary interventions in other areas to promote changes in unhealthy habits);
- Salaried vs. volunteer workers (i.e., a salaried core of health promoters should be in place to sustain the structure and ensure continuity);
- Certification only in aspects of their work in each program (not “health promoter” certification);
- Institutionalization (i.e., the promoter should be viewed as part of the health team, but not to the extent that he/she is no longer perceived as representing the community, and instead, as a staff member of the health center).

*Collaboration in the work of health promoters—other sources of resources:*

- Communities;
- Community clinics and hospitals;
- Universities and academia;

- Private foundations;
- Governments and political representatives;
- Religious sector;
- Corporate sector;
- Schools;
- Ministries/Departments of Health
- Nonprofit NGOs.

## Pastoral da Criança (Children's Ministry)

*Dr. Nelson Arns Neumann, Brazil*

The Children's Ministry was created in 1983 at the initiative of the Catholic Church to work directly with families in the home to promote cultural values such as brotherhood, social coresponsibility, and ecumenism, and to reduce child malnutrition and mortality and social marginalization, and thereby contribute to the integral development of children.

The core of the program is its volunteer promoters (usually women) who pay monthly visits to a group of families, providing with information and educational services and monitoring child development through regular measurements of the children's weight and height; they also provide families with information on immunization and oral rehydration therapy. Through this experience, promoters can help control respiratory infections and prevent household accidents. The initiative has had a visible positive impact on child malnutrition and low birthweight.

This work is performed by volunteers who are recruited from the community, each of whom is responsible for up to 15 families. Promoters receive formal training in the contents of the "Guide for Promoters" and are certified in the Manual's contents. Promoters must participate each year in a continuing education program. No candidate who wishes to become a health promoter is turned away. Leader turnover is high (20-30 percent), but because these individuals belong to the community and receive education through the program, even when they withdraw from the program, their training and greater knowledge represents a personal and social benefit.

The information system designed to monitor child growth and the program's activities not only makes it possible to quantify activities, but lays the foundation for developing a health profile of the communities covered by the program. Promoters meet regularly to share their experiences and solve common problems. The resources for workshops, educational materials, and administrative expenditures all come from different institutions and corporate sponsors.

The initiative has been adding indicators and interventions with a wider scope, such as measurement of "indicators of development opportunity" through these health promoters.

## The Way of the Heart: The *Promotora* Institute in Nogales, Arizona

*Ms. María Gómez-Murphy, USA*

Community participation is the best way to improve living conditions and health. Poverty is associated with low levels of empowerment, and that situation should be reversed.

The health promoter model creates an effective bridge between the traditional health system and populations with limited resources and access to health care. This model was developed in poor countries with limited

resources and insufficient numbers of health workers, and has since been successfully implemented in the United States. Most health promoters are community members who work with several health problems and people at the same time. Promoters work within the cultural and psychosocial context of their communities, and the community has access to them through various alternatives (i.e., churches, factories, supermarkets). Promoters are conduits for health information to their communities, providing information on strategies for the control and prevention of chronic diseases and helping to facilitate access to health care and social support programs.

The work of promoters can be measured by results in several areas such as changes in the behavior of people and families, and changes in the health status of a community or its access to care.

The Institute trains promoters in basic health topics, but cannot carry out health activities. Promoters are paid, since they should always be available to their community and that availability should be remunerated. However, their work is not considered a job but a lifestyle: they are health promoters available to their communities 24 hours a day. Promoters are ordinarily natural leaders with community experience and a personality consistent with the role they play in the community.

An additional effect of the program has been the changes that the promoters themselves undergo: some assume leadership roles in their community; some continue their studies and earn a university degree. Growing empowerment takes place within the promoter and his/her community. Thus, in helping others, promoters help themselves.

## Community Health Program: Managing Child Health Services

*Dr. David López, El Salvador*

Community Health Work is primarily carried out in rural areas where the health promoter is an institutionalized figure. This began in 1975 when 20 leaders from the rural communities were enlisted to perform health promotion activities. The preliminary evaluations showed positive results which kept the initiative alive. Finally, in 1989, the role of health promoter was formalized through the creation of the Community Health Program, to certify the skills and abilities of promoters.

Health promoters receive technical training to provide basic health services in rural areas, the primary objective being to change unhealthy behavior through self-care. Promoters provide home care, conduct interviews, give educational talks, do demonstrations, and, when necessary, make referrals to other levels of care. Hospitals take a positive view of the referrals received from health promoters, considering them to be both appropriate and timely.

Promoters monitor and provide support to individuals and families in their community, focusing on the areas included in the country's priority health programs. The information they collect is in turn consolidated into a management information system that makes it possible to assess the community's health status. Promoters know when and why a child does not show up for monitoring, the reasons why a family is at risk, and whether a pregnant woman is up-to-date in her prenatal care.

### *Main lines of health promoter activity*

- 1- Health promotion and protection as a main line of action;
- 2- Community epidemiological surveillance;
- 3- Promotion of the organization and community involvement;
- 4- Basic health care through:
  - a. preventive actions, preferably targeting women of childbearing age, pregnant women, and children under 5;
  - b. treatment of children under 5 on a priority basis;

- c. first aid;
- d. timely referral; and
- e. core data collection.

The role of the health promoter in fostering and promoting adult health is geared to reinforcing healthy lifestyles and preventing risk factors such as alcohol abuse, smoking, physical inactivity, obesity, hypertension, and a poor diet. The prevention of risk factors in adolescents, adults, and seniors is addressed according to the priorities of each age group.

The program has a solid foundation that makes it sustainable over time: the Ministry guarantees wages and uniforms for the personnel and the drugs required for the programs. Training, equipment, and materials are provided through agreements between the government and cooperation agencies, nongovernmental organizations (NGOs), social security institutes, etc., and periodic evaluations are conducted to certify results of the program and support its continuity. In order to improve the program, it is now necessary to address more matters related to environmental health, to make optimal use of the promoter's workday, and to make supervisors more available for follow up, evaluation, and in-service training of promoters.

In conclusion, Dr. López pointed out that dealing with the issue of cardiovascular health at this level presents an opportunity to strengthen preventive action at the individual, family, and community level, as well as opportunities to improve specific prevention activities targeting adults and seniors. He also underscored the importance of this forum as a means for authorities to welcome this initiative—a basic comprehensive care model—and the availability of 1,949 health promoters who can make this area part of their work.

## Citizenship-Building and the Reforms

*Ms. Nora Donoso & Ms. Teresa Boj Jonas, Chile*

In contrast to all of the other participating countries, there is no tradition of health promoters in Chile. The strategy is implemented through the *National Health Promotion Plan*, where the emphasis is on community participation, not the promoter.

The National Health Promotion Plan is part of Chile's health reforms, which recorded milestones very relevant for its development:

- a) Health promotion has been an official Chilean State policy since 2000:
  - a. The *Comité Vida Chile* ("Chile Life Committee") formally defines and then submits Chile's intersectoral goals in the area of health promotion to the President, thus committing the State to this task from the outset.
  - b. The Committee is comprised of representatives of Ministries from different areas of government; not only the health sector, but universities and the private sector as well.
- b) The new Health Authority Law expressly gives the Regional Health Secretariats the authority and responsibility for developing health promotion programs, whose scope extends beyond the classical definition centering solely on the recovery of health.

The activities take place within the framework of a comprehensive vision of health, which considers, *inter alia*, all systems and structures governing civil, political, social, economic, physical, and environmental conditions, as well as their implications and impact on health and the quality of life. The primary objective is to promote a convergence of the objectives, interests, and actions of different areas. Pilot programs are carried out, in which a number of institutions provide an integrated response to the needs identified. One such example is the support given families to obtain new housing, which includes services such as support for the family's integration into the new community, and drug and alcohol prevention programs, etc.

The emphasis in the Plan is on health determinants, addressing not only lifestyles, but living conditions as well. Its vision is a broad one and encompasses not only the healthy habits traditionally associated with health, but also social values, such as tolerance, respect for life, and pacifism. Citizenship-building is approached as a part of the process that begins with shared needs, aspirations, and experiences. The fact that a community is organized does not mean there is participation; also required is the capacity to have common objectives and to exercise the right and duty to make decisions.

*Vida Chile's* organizational structure includes a national committee, regional committees, and finally, community committees. Some 98 percent of communities already have their own Committee and Community Plan in place. Of these 338 plans, not all have achieved the necessary degree of maturity; some continue to be guided by curative objectives and not by promotion, whereas others are still headed by health workers. However many communities have taken charge of their plans and adopted their own health promotion objectives—some have even performed their own evaluations of their health situation. The most successful communities share some common ground: they tend to have mayors who are committed to health promotion and the sustainability of these efforts and local political support. In addition, the work is approached from an intersectoral standpoint and is not limited to the health sector.

Some results of this strategy are reflected in the significant gains in coverage levels achieved since the beginnings of the Plan, as well as in the achievement of intermediate goals and indicators defined in the Plan (process indicators and goals for this first stage). The challenge for the future is to incorporate the goals of health promotion as an integral part of the programs of the Ministry of Health and of all the other associated public organizations.

## Summary of Comments and Questions on Module I

Discussion ensued as to the role of the health promoter, and the possibility was raised that attempts to over-institutionalize this model and to remunerate promoters may detract from the original health promoter profile and objective. Examples were offered in which this had led to changes in health promoter selection criteria—and even resulted in the selection of people who did not belong to the target community. If we raise the academic requirement and overburden promoters with excessive duties and, thus, further isolate promoters from the community, the question becomes: Can outside promoters really connect with the community and promote change? Will promoters with more knowledge and technical skills set aside other relevant social elements?

Conversely, others suggested that all promoters want to grow and better themselves, but that does not necessarily mean that all will stop working as promoters for that reason. Indeed, some go on to study other careers and leave health promotion, but many others continue to better themselves and do not give up their health promotion role and, in fact, may go on to assume higher roles, becoming supervisors or promoter trainers. However, this growth process tends to pull them away from their direct role in the field; the field health promoter must stay within his/her community.

One of the health promoters in attendance stated that the decision to become a promoter is a personal choice. She said that she did not need external certification and that whether or not she were to receive a salary would not change her. She believes that certification attests to a person's knowledge in certain subjects (i.e., cardiovascular health, diabetes, maternal and child) but that there is no accreditation for being a promoter, as one is a promoter from the outset. She clearly affirms the idea that promoters should live in their communities and have their heart in their work.

Some participants were interested in knowing who provides health education and health promotion in Chile, since there are no health promoters in that country. They were informed that these tasks are performed by health workers (primarily nursing auxiliaries), educators, and people from other institutions. On occasion, these tasks are taken over by organized community groups; for example, parents' groups affiliated with the schools. The rural health post model is the only one in which the promoter belongs to the community. In this model, the paramedic auxiliary is in charge of the health post and is a member of the community, but he/she always has formal health training and is part of the health team.

The Chilean experience was discussed at length, especially the work done to bring about a convergence of the different institutions in Vida Chile. Participants voiced the need for perseverance, fulfillment of agreements, specific mutually beneficial work, and taking advantage of what each institution has to offer to implement promotion activities. It was conceded that the biomedical approach continues to prevail in many groups, as does the need to more effectively incorporate the community's vision and values.

The experience in El Salvador underscores the importance of securing the commitment of local government to fostering volunteerism and health promotion. Advocacy is important in this regard, but not all authorities respond to it in the same way.

The difference between promoters who emerge as a response to poor health service coverage and those of health programs that call for changes in behavior and healthy environments was pointed out.

Doubts continue to persist about the impact of paying promoters, as it may effectively turn promoters into employees. Moreover, it can lead to a conflict of interest in that the promoter should be a representative of his/her community, but in effect would become an employee of the health system.

One suggestion indicates that promoters do not "deliver" but "influence." Promoters can administer vaccines and are thus "delivering" health care, but their main role is to "influence" their communities to adopt healthy changes and behaviors.

## Presentation of Experiences: Module II

### The NHLBI Experience with Lay Health Workers

#### Overview of the Program *Health for Your Heart*

*Mrs. Matilde Alvarado, USA*

The NHLBI is one of the 27 institutes and centers of the National Institutes of Health, and is part of the U.S. Department of Health and Human Services. The Office of Prevention, Education, and Control coordinates the translation, application, and distribution of scientific research for health professionals, patients, and the public. One of the means for carrying out their task is the implementation of focused programs on the prevention and control of cardiovascular risk factors, developed through initiatives for multicultural communities, and centered on the work of health promoters.

The initiatives for multicultural communities are established to help eliminate disparities among ethnic groups and improve the quality of life. The target populations include Latinos, African Americans, Asians, Native Americans and others. The program for Latinos is known as Health for Your Heart. Its philosophy can be summarized as "people helping people," by increasing knowledge and molding attitudes to prevent heart disease, and by promoting behavioral changes with a view to maintaining a healthy heart. This approach in

the Latino population is based on the fact that it is a growing population, it has poor access to the health system, many Latinos lack English-language skills, and it has a high frequency of risk factors and mortality associated with NCDs. The strategies and information provided in English cannot be used by those who only speak Spanish, and the available translations were not culturally appropriate for these communities.

The NHLBI program Health for Your Heart initially conducted surveys to determine needs, waged media campaigns to disseminate knowledge about cardiovascular health problems, and put together educational materials. Subsequently, there emerged the need to systematically reach the community and ensure that health knowledge was being applied in daily life. In response to this concern, cardiovascular health programs were created with the help of health promoters, who served as bridge between the community and these programs and helped with the design of manuals and other tools for use by the promoters. Launched in 2000, the pilot program later spread to other agencies and community clinics at the national level so as to get to 2005 when the NHLBI establishes a training center in Gateway Community Health Center in Laredo, Texas. The goal is that Gateway Community Health Center establishes ties with three community clinics in Texas and trains the health providers and the promoters using the model of promoters as an extension of care to patients with cardiovascular disease risk factors.

Health promoters are primarily people who take action that leads to change. They are reliable and respected leaders in their communities, who influence values to change behaviors. Promoters work with love and passion to help their communities and are prepared to be trained as efficient promoters. Promoters rely on materials prepared by NHLBI to support their work--materials that are specifically adapted to the different cultures of the target population and presented in different formats to better address each objective and community (i.e., manuals, flipcharts, videos, picture books, collection of samples). The program uses a multiplier model for training; it starts by training leaders, who then train promoters, who, in turn, deliver knowledge and skills to the community.

### ***Health for Your Heart in Action***

*Dr. Héctor Balcazar, USA*

Dr. Balcazar presented three implementation models involved in the *Health for Your Heart* Initiative Program. The objective is to make the work part of the health system while maintaining the community model and giving priority to community action and participation. The objective, then, is that health promotion remain integrated and linked with all the parallel interdisciplinary processes that come together to improve individual and community health.

The first model is based on community groups such as grassroots organizations, in which the promoters work with these organizations and directly with the families. The second model is developed in a university context in partnership with the community, training promoters that take the health message to the community. The third model focuses on integrating promoters into the clinic health team.

The three project models share planning, implementation, and evaluation phases. Implementation requires a greater effort, not only in terms of training promoters, but also in order to accommodate the different cultural dimensions, monitor and supervise promoters, consolidate community support for the work, and provide feedback for evaluating the work.

In the first model, promoters were integrated into existing community structures. Promoters trained by the program interacted with families and the community through these grassroots organizations. In order to evaluate the results, promoters were analyzed as “agents of change,” the grassroots communities as “agents of context,” the family as “the object of change.” The program worked: the families changed their behaviors

after the intervention and also shared this information with other members of the community. Consequently, the promoters were validated as agents of change at the grass roots level.

In addition to achieving this central objective, the program also showed that it can work in different regions as well as in urban and rural areas; that it was able to secure the commitment of the grassroots organizations, whose support proved instrumental to the intervention's success; that the data collected were consistent; that the activities had been expanded to include screening and referral activities; and very importantly, that the program continues to operate in seven of the communities where it was implemented.

The objective of the university-community partnership model was to provide formal technical training to promoters in areas of public health. During the study phase, promoters received tutorial support from students from the master's degree program in public health, who later joined the program as volunteers. The group that received formal classes was then compared with a control group that had not received this training. The intervention strategies included the formation of community partnerships; an evaluation of community needs; promoter training; intensive, standardized community education by promoters; and the dissemination of educational materials.

The results were positive and included observable positive changes with behavioral variables associated with weight, physical activity, salt consumption, and fat consumption. Future challenges include integrating the intervention and the evaluation, since cardiovascular health problems show up in the context of other risk factors and diseases. Moreover, evaluations of the cost-effectiveness of this strategy are needed to compare this promoter-based strategy with other cardiovascular health strategies.

Other **conclusions and achievements** obtained through this experience include:

- ✓ Health promoters are effective agents of change and health educators;
- ✓ Health promoters benefit by promoting change among themselves;
- ✓ Educational materials must be adapted to the cultural context of the target population if they are to be successful;
- ✓ Health promoter work is ongoing—training, monitoring, and empowering people;
- ✓ The participation of graduate students in public health was very important to the results;
- ✓ Health promoters can adapt to different circumstances;
- ✓ The program for cardiovascular health problems was easily adapted to the control other diseases such as diabetes.

Looking back on the results obtained, the initiatives Health for Your Heart, has been strengthened and has completed 11 years in operation; the usefulness of the educational materials it produces has been validated; the health role of promoters has been validated; the mass media promotes cardiovascular health; Federal agencies finance program operations as part of their activities; the model is already being applied to other health areas such as osteoporosis and will soon be applied to cancer; and the model has been successfully used in different areas and different cultures. Moreover, some health promoters have enriched their personal development, going on to receive certification and study for other careers.

### **Health Promoters as an Extension of Care: The Gateway Community Health Center Experience in Laredo, Texas'**

*Mrs. Lucía García and Mrs. Lourdes Rangel, USA*

This experience features a comprehensive health care system for managing diabetes and CVD disease within the framework of an accredited and recognized organization. The organization has two community clinics

and rural facilities through which it provides weekly clinical services for some 16,263 users. During 2004, the organization provided health and dental care via 71,288 office visits.

The work of the organization is based on the use of best practices and includes the participation of individuals and institutions at different levels: NHLBI, Health Resources and Services Administration (HRSA), PAHO, the Robert Wood Johnson Foundation, Pfizer Health Solutions Inc., the Methodist Healthcare Ministries, patients, family members, medical service providers, medical staff, health promoters, the Board of Directors, and administrators.

The components that lend technical and structural support to the program are: (1) a health care system based on the principles of self-care; (2) an appropriate infrastructure to support the volume required that gives consumers options for the delivery of services; (3) a system for referral, follow-up, feedback, and registration that guarantees clinical practice based on consistent and integrated self-care; and (4) a system capable of recognizing and managing the depression associated with chronic illness.

**Specific self-care interventions integrate the promoter in patient management at the health center** as follows:

- Promoters guide the management and follow-up process of the disease and its progress, with due consideration for the associated cultural factors;
- Physicians support the work of promoters;
- Guidelines and procedures are available for the work of promoters and for evaluating their performance;
- Guidelines in place for referring patients to a physician, hospital, or a promoter;
- Clinical and administrative information is managed through databases that facilitate analysis and conclusions.

The program has reaped benefits from the standpoint of health providers and patients alike. The providers report more efficient use of their time; an improvement in control of diabetes and cardiovascular risk factors in their patients; have an evaluation of social as well as medical needs. Promoters: strengthen the treatment plan; extend medical services; identify referral facilities and the additional services required; and implement clinical protocols. Patients: receive more time for education, better health outcomes; and personalized care; demonstrate greater adherence to treatment; have better access to care; have their specific needs met with the appropriate referral; and receive better quality care.

The presentation concluded by underscoring that self-care is the key to good management of diabetes and cardiovascular disease and to emotional health, and that promoters play a central role in terms of their implementation and follow up.

## Summary of Comments and Questions on Module II

### Evaluation

One of the most discussed topics was the evaluation of interventions. Which indicators can be used for this purpose? Which measurement instruments are useful? How does one move from process indicators to outcome indicators? The consensus was that there is still very little experience available for evaluating health promotion activities, prompting the question: Which specific health promoter task(s) should be evaluated: changes in the behavior, knowledge, or attitude of the community? Ideally, changes in the prevalence of risk factors should be measured; however, at the beginning it is only possible to measure the process. Training is required in this area.

## Political context

Does the situation change when a system of organized primary care is in place...where health promotion is defined within the public policies of the country...where there is a universal health system in place...and the government is committed to the issue? All of the participants agreed that political context makes a significant difference in terms of results. A pertinent issue is how to integrate promoters into the health team. Accordingly, there are several cultural barriers that need to be overcome.

## Accountability

The need for accountability with respect to health services was emphasized. A culture of accountability would help us to be more aware that traditional systems are not improving the health of chronic patients or reducing risk factors (How many patients monitored for high blood pressure still have high blood pressure, or how many people continue to gain weight even though they are in treatment?). Pertinent interventions are needed to change behavior, and in this sense, health promoters can make a significant contribution. In order to improve quality we must “activate” the patient so that he/she becomes an informed consumer.

## Roles and Limitations of Health Promoters

The work of health promoters cannot be limited merely to an educational role—it must be more comprehensive. The promoter must not focus solely on the disease, but on the person suffering from it. Can promoters work to develop protective factors instead of only correcting risk factors?

The promoter who practices primary prevention should also be able to accompany the person who develops the disease; if when someone gets sick, his care becomes purely medical, he loses the integrated support of the promoter.

What are the limits of health promoter activities? Can health promoters get involved in secondary prevention? Their role in replacing the health workers that are lacking should not be stressed to the point of losing the capacity to adopt complementary strategies to improve attitudes and foster changes in habits and behavior. Promoters are better poised than anyone to accompany the change with practical tools of support (i.e., instead of simply saying “eat less salt”, a promoter might teach a patient how to prepare an alternative condiment at a sustainable cost for the community). Consequently, we propose that a promotion area be created within the education sector and that promoters from that area engage in health promotion activities.

There is no consensus on a definition of health promoter or how to determine his/her effectiveness. There are significant differences between countries in this regard. What does a promoter’s degree of effectiveness depend on? Which of the associated resources should be provided to promoters? Do we put promoters in charge of a single program or do we put them in charge of several factors at the same time? Should promoters work alone or in teams? Where should promoters work? Are promoters less effective if they work with a poor population that is consequently more vulnerable and apt to have a diminished response capacity?

The evaluation of promoter effectiveness cannot be made outside of their context or the objective for which the promoters were prepared. There are scenarios under which it may be valid not to work with promoters.

In practice, promoters can and do perform activities other than education, among them screening, care, counseling, registration, surveillance, community representation, and serving as a bridge between health and the community.

Also discussed was the role of the promoter. Is the promoter part of the health team? What is the promoter responsible for? Is health promotion a profession or a natural skill? If “health promoter” is defined as

“someone who promotes health” then the job would entail, *inter alia*, advocacy, community mobilization, literacy, and health education. There are promoters who work within the political model (advocacy and mobilization), while others work directly with people in a more community-based model; however, both perform valid functions.

The health promoter model does not exist in Chile; health education is the responsibility of a paramedic auxiliary who is a member of the health team. Culturally, this education is not well received and has little success, except in rural areas. The people who come to the educational sessions are usually women who tend to drop out rather quickly; they claim to prefer instruction from health professionals. Likewise, there are no standardized educational materials for general use.

While there are some common themes, there are significant differences in terms of approach, and it is clear the work of promoters takes place in contexts that are not the same in all countries.

## Facilitated Discussion on How to Apply the Health-Promoter Model: Module III

### Objectives

- Identify emerging strategies and practices;
- Identify opportunities and differences between programs;
- Evaluate the feasibility of implementing a promoter-based cardiovascular health program.

### Venezuela

All activities are part of the primary care strategy. The focus is on education; work is carried out with organized communities and with health committees linked to clinics and the rest of the health care network. The proposed strategy is to foster CVD prevention at the primary level, using promoters for this task. In Venezuela, health promoters are volunteers. There is political support since a political decision has been made to tackle the problem of NCDs; the country employs a strategy similar to the CARMEN strategy. Programs are national in scope, but adapted to each local reality, in coordination with local health committees. In the case of the indigenous population, there are promoters who are part of the same community. In order to operate in these populations, anthropological studies must be conducted beforehand to design appropriate interventions.

### Nicaragua

The country wants proof of the effectiveness of the promoter-based intervention model through a pilot project before it can be implemented, especially since the objective is to change people's behavior and that is neither easy to do nor to measure. Accordingly, a unit will be created at the primary school level, because it is considered more feasible to change habits at an early age. Moreover, working with children, implies that the family must get involved. Promoters will be trained school teachers, since teachers already know the appropriate language to use to reach children. At the same time, promoters will be recruited and trained from among the ranks of the children themselves in order to better reach their peers. The country believes that this forum has shown that the family should be approached not only to deliver knowledge, but to encourage it to contribute actively to and promote its own health.

Emphasis is placed on the importance of having projects to complement the interventions with promoters in order to achieve a favorable context for health promotion (i.e., intersectoral work, commitment of city halls, inclusion of community representatives in decision-making, joint approach to various risk factors).

There is a national agreement, signed by all political sectors and the government, guaranteeing the continuity of health policies. Nicaragua has a family health-based National Prevention Plan that addresses the entire life cycle and all age groups. It includes specific objectives, proven strategies, and clear standards. Nicaragua believes that all types of work should be regulated and understood in order to provide stability over time and achieve objectives.

## Uruguay

The standards are insufficient for achieving the desired approach to health; they must be accompanied by a cultural change among the participants. Medical schools continue to turn out professionals guided by a different model of care; one that does not address the structural determinants of NCDs. The curative and hospital models are favored, in terms of prestige and income, above preventive models and primary care. The standard is inadequate because it fails to change the culture. Promoters cannot achieve results if they are made to compete against far superior contrary forces in the environment—How effective can promoters be against commercial interests and the media—and if they lack political support? Promoters will be used for community education in the prevention and control of risk factors, but at the same time strategies should be developed to secure a political commitment and intersectoral participation. Underscored in this regard was the antismoking legislation as the first real sign of political commitment to health promotion.

## Costa Rica

The health situation in Costa Rica is similar to that of the developed countries, with a high incidence of dyslipidemia, heart disease, and other NCDs. Underscoring this point is the incidence of heart attacks in the population under age 30. There is a significant disconnect between knowledge and practice. Costa Rica's health system is intersectoral and interdisciplinary in nature and still very much oriented to the disease-medical model. The system is in the process of adapting to the new paradigm; in which primary care is a priority and disease prevention and health promotion are at the core.

The objective of the work with promoters is to help put knowledge into practice. The country is well-positioned to implement promotion and prevention activities. Primary care personnel work with promoters, each responsible for a number of families. Promoter-led activities are also carried out in hospitals, schools, and the workplace. The country believes it is more efficient to conduct activities in those places because they provide a captive school-age and workplace population, and the activities are carried out in conjunction with other pre-established activities. Common structure is taken advantage of.

## Observations

Once again, the participants pointed out the need for health promotion activities that address all the necessary areas: political will of the part of the government, an adequate legislative framework, incorporation of the various actors, management systems (i.e., strategic plan, methodology for achieving intersectoral work to involve the community), evaluation systems, and the dissemination of programs.

## Cuba

The experience with health promoters in Cuba dates back to the 1960s. The model has proven successful, caused people to change habits, and increased life expectancy in the country. One of the reasons for using promoters was the lack of health professionals. At the same time, the primary care strategy was being developed, and it was initially thought that this strategy was sufficient in and of itself; however, practical experience showed that the physician alone was unable to secure the commitment of the entire family and community to health, and consequently Cuba has reinstated promoter-based activities. Still, in the absence of diversity, inequities persist. The promoters call attention to such differences to State health authorities when reporting on the status of their communities and in doing so call attention to the local level and its specific needs.

Information about risk factors is already included in school curricula, which means that the promoters' task is one of community orientation and organization. Promoters should come from the community they serve, so they can contribute to it. In order to support promoters, we must give them the social recognition they deserve and acknowledge the importance of their work.

How can we get the most out of promoters? In order to do so, we must support their work with training, educational materials, and resources.

## Colombia

The insurance-based system has divided the population according to the type of insurance and personal coverage they have, which hinders the implementation of social programs and activities with promoters. The type of financing to the system influences the actions that can be taken. How can habits be modified without adequate structural conditions?

## Observations

We need to evaluate the work of promoters: What do promoters do? How do they do it? Do promoters achieve results? How much does the promoter know about the health issue? How prepared are promoters to find solutions to the problems they face in the field? To this end, we need to clearly understand what they are expected to do, what the goal or objective of their activity is, who the promoters are, and their basic skills. The answers to all of these vary from country to country and program to program. Impact indicators will be seen in the long-term in the NCDs, but in the meantime, we should evaluate intermediate indicators, in addition to doing baseline measurements that will facilitate impact measurement down the road.

What advantages do promoters have? It is a natural role for many women in society; this role is recognized and valued and they are given space to operate; they can help solve problems that would not even be recognized at the health centers; they transmit people's concerns. Their biggest advantage is that they work with the family and the patient in a "natural" way; in their environment as it is, which enables them to visualize risks and protective factors more comprehensively, whereas the patient who walks in for an office visit only brings a part of his/her life.

Health promoters are not the only avenue of community participation. The need of promoters will be greater in countries that lack comprehensive health services and broad levels of coverage; conversely, it is possible that once a country has this structure in place there may be no need for promoters, but instead other forms of participation. The question is: Does any form of participation bring about an increase in healthy habits of the population?

## Viewpoint of Health Promoters

### Your Heart, Your Life: Outlook on Health Promoter Training from the Standpoint of Health Promoters

*Mrs. Odelinda Hughes & Mrs. Esperanza Vázquez, USA*

Ms. Hughes and Ms. Vázquez presented their personal experience through this activity, and gave practical demonstrations of educational sessions using NHLBI materials.

The presenters stated that the years they devoted to health promotion have been the most rewarding of their lives. They have given much but also received much in return from the community. The promoters not only deliver information to people, but serve as a model for them. They feel it important to understand the difficulties and real problems that people face to help develop appropriate strategies to elicit healthy changes in behavior. Both women suffer from chronic diseases, which cause people to relate to them better and give greater authority to their recommendations.

They based their work on manuals and add their own creative activities to better achieve their objective. They meet regularly with other promoters to learn from them and grow together. They have promoter support manuals to help them prepare classes. They state that promoters can share their personal experiences informally, but that the information they provide should be standardized and follow the manual.

They perform three people-oriented activities: training of new promoters, community work (i.e., schools and churches) and work in the clinic with patients. They pass on knowledge and skills related to the pertinent health topic and adapt their materials to the available resources in each location (i.e., TV, flipchart, video etc.).

In their demonstration, they began by encouraging people to participate with the use of symbols (i.e., they gave a necklace made of hearts representing “the people that helped me achieve my dreams, those that I will help, and those of people who are no longer around but nevertheless important”). They asked the participants to forget for a moment that they are doctors, noting that “when it comes to doctors there’s always a certain distance involved.” That phrase is relevant because it demonstrates the difficulty medical professionals have in relating to the daily life of people. One promoter with years of experience working in clinics also identified the barriers present with the physician. In each session, the promoter makes a suggestion and the session ends with a promise from the attendees.

With respect to high blood pressure, the presenters relayed key data on the magnitude of the problem and the damage it causes; they teach basic concepts of anatomy so that people can understand what high blood pressure does; they get participants involved by asking “Who here knows what their blood pressure is?”, comparing cardiac systole and diastole with a baseball batter as a way to make the concepts understandable with familiar language, convey information on the salt content of everyday foods, demonstrate using test tubes filled with salt to graphically demonstrate how much salt there is in a tablespoonful, teach how to prepare food with less salt and to prepare “salt of spices” with everyday dressings (i.e., emphasis on the idea of using substitutes to help people change their habits), provide “tips” such as how to block some of the holes in the saltshaker with clear adhesive tape.

They also performed another demonstration on cholesterol. They fashioned “blood vessels” from empty toilet paper rolls and then used modeling clay to block them. They used pneumonic devices to remind people of HDL and LDL cholesterol (“*Héroe Derrotador de Ladrones*” and “*Ladrón De Ladones*”), and illustrated the

amount of fat contained in a hamburger and a serving of French fries by using balls representing grease on a plate.

In short, these are theory and practice sessions. They are easily understood, and include recommendations that it is feasible to follow, and elicit a formal commitment from the attendees. The materials are developed by the NHLBI, tested in the community, and reviewed by experts in each subject.

## The Politics of Citizen Participation in Health

*Mr. Leonidas Rodríguez, Chile*

Mr. Rodríguez described a different experience in the work between the community and the health team, within the framework of a formal system of relations established under the regulations: the "Committees for Social Participation in Health," which should be set up in the Health Service facilities of Chile. Even with this backing, *the process of adapting both parties to achieve effective joint work and real participation by community representatives was a process that took several years to materialize.* The presenter stated that he learned that health is not just medical care and that the health team, for its part, learned that community participation is not a passive process consisting simply of receptiveness on the part of community members.

The Committee for Social Participation in Health is part of the structure of the Regional Health Services of Talcahuano and is comprised of 14 grassroots community organizations and five institutional organizations; this structure is replicated at the local level in the form of the Health Advisory Committee linked with the Regional Hospital and the Health Committees at the level of Primary Health Care Centers. In 2001, work began on integrating the participating parties and identifying objectives and strategies. The joint goals put forward were "to contribute to the strengthening and development of social organizations linked with the SST health network and create the conditions for achieving citizen co-responsibility in health care and healthier environments, while creating the conditions for the exercise of social control." One year later, progress was made when social participation was expressly incorporated into the Health Services' Strategic Development Plan, defining it as a "collective process through which we are involved in expressing needs; generating ideas; making decisions; formulating, implementing, and evaluating health programs and policies, using the means available; and creating the necessary opportunities in this process."

The group identified critical areas that posed a threat to social participation, designing a plan for their improvement. Significant areas included:

- (1) paternalism in working with social organizations;
- (2) the limited financial resources provided for social participation;
- (3) the lack of recognition and support for the work of the leaders of social organizations;
- (4) participation understood only as the information delivery and passive listening;
- (5) the fact that successful projects to build better relations with the community do not become stable programs;
- (6) the lack of mechanisms for coordination with other public and social sectors and ignorance of the existing network;
- (7) the limited role of Hospital Development Committees in decision-making and of social leaders in relevant matters;
- (8) the reluctance of technical staff to give up power; and
- (9) the lack of training in social participation and the absence of an integrated leader-technical personnel training mechanism.

Its first achievements were not geared to promotion but to more traditional health situations, but they represented an important step in the development of joint efforts and real integration. Currently, the future

looks bright; the challenges ahead are: (1) creating and supporting leaders with initiative and the capacity to respond; (2) developing community-based strategies to encourage people to take responsibility for their own health and to assume co-responsibility for health care and the promotion of healthy lifestyles; and (3) developing strategies that have a real impact on public management.

The Committees have a history that validates them and supports their future sustainability, since they are a formally and legally established organization with an approved training proposal and a social participation research project in which the UCM of Madrid and USACH of Chile participate. In addition, together with the health authorities, they have jointly initiated a “Participatory Budget” pilot project, whose objective is “to implement a formative pilot experience geared to the allocation of health sector resources in a participatory manner, involving different actors in this process with a view to developing new management capacities.” The project seeks to train the actors involved in how to initiate a participatory budgetary process, improve health in the jurisdiction through community initiatives, innovate in the management of budgetary allocation, and to set up a participatory planning mechanism in health.” They related with a great deal of pride the fact that the organization received the “Seal of Quality and Innovation Award” for its work.

## Summary of Comments and Questions on Module III

When asked how to reach the community or bring it together, the participants responded that this is accomplished by attracting people with what they traditionally look for in health (in this case, by going door-to-door to explain the benefits that the clinic offers, or setting up somewhere to take blood pressure readings; people will come, and that is where one can get them involved in educational activities). The most frequently-asked questions are about evaluation; promoters point out the improvement in the parameters of patients receiving medical monitoring who are at the same time receiving health education from promoters. The cost associated with promoters is offset with savings in medical visits and therapy for patients enrolled in the program (this is possible because the work of these promoters is integrated with that of the health team). The point was stressed that interventions in the general population should be evaluated differently from those in the high-risk population.

A representative from Peru reported a successful experience with pairs of promoters working with a health worker that provided training using standard materials. They held a series of 4-session modules with the community on topics such as self-esteem, “understanding my body,” sexually-transmitted diseases and cervical cancer, and prevention mechanisms. Following this intervention, the number of patients requesting Pap tests at the health center increased, as well as the number of women who asked their doctor about the test.

The educational model and support materials should vary with the focus (i.e. general population vs. high-risk population). In some cases, it may also be necessary to make regional adaptations-for example, in Brazil where there are geographical differences in diet.

It was felt that these educational interventions will be successful to the extent that they are accompanied by the rest of the promotion strategies (i.e., political support, enabling environments). It was also concluded that the work of promoters should be structured in a way that would make it sustainable and systematized; it cannot depend only on volunteers.

## Group Activity: Building a Common Vision of Cardiovascular Health

Southern Cone (Argentina, Brazil, Chile, Paraguay, and Uruguay)

### Opportunities to Implement Community Cardiovascular Health Promotion and Prevention Programs with Health Promoter Participation

#### Situational Diagnosis

**Argentina** does not have specific health programs as part of its structure. It is in the process of designing its program for cardiovascular health and NCDs and is still studying the data obtained from its National Survey of Risk Factors. At the local level, there are interventions in place to curb smoking.

**Brazil** has a unified health system; its National Health Promotion Policy has been approved, and it is working on risk factor surveillance. At the local level, important work is being carried out through NGOs, which work with a certain degree of autonomy using the general definitions.

**Chile** has a structured health system with a public-private mix. The country has a national situational diagnosis of risk factors, but without regional representation. Chile has official national health objectives for 2010, whose priorities include NCDs. The country does not work with health promoters

**Paraguay** has a mixed health system, and NCDs are the leading cause of death. The country is developing a new model of care that seeks to decentralize the *Municipios*. Surveillance and the information systems are found at the local level, and the country is looking to strengthen them. The country is working on the *Healthy Municipalities* approach. Its challenge is to work with promoters, not only at the first level but also in hospitals as well.

**Uruguay**. Some 13.5 percent of Uruguay's population is over the age of 65, and NCDs account for 70 percent of deaths. It has a mixed health system; this year it is beginning to work on developing a national health system: some chronic disease programs are up and running, and the country plans to administer a national risk factor survey in 2006. Morbidity is measured by hospital discharges. Health promotion takes place at the health centers, but not through promoters. Work is accomplished with a multidisciplinary team assisted by medical students: students must work in the public health services during the final 4 years of their formal studies.

#### Opportunities

- All the countries in the group are developing political proposals and changing the institutional culture to deal with the problem of NCDs.
- All have the expressed political will and government commitment to tackle NCDs.
- The countries have good information to facilitate the evaluation of program and intervention results.

#### Obstacles and Challenges to Implementation

- The local-level structure should operationalize cardiovascular health policies, regardless of whether or not work is done with promoters.
- A comprehensive approach is needed to address risk factors instead of individual interventions for specific pathologies.
- Policies are needed to institutionalize health promotion and the prevention of NCDs.

- Health promotion activities need to be coordinated with basic health care actions.
- Health teams need training on NCDs.
- Regulations are needed to govern healthy environments and tobacco control.
- Greater community cohesion is needed: there is no awareness of the risks of NCDs.
- Health information systems require improvement, including data on morbidity and risk factors.
- Appropriate communication strategies are needed for communicating with the community.
- The formation of regional partnerships is needed with a view to enacting healthy regulations.

### **Observation**

The population and politicians are not the only ones who fail to give priority to NCDs. Epidemiologists also prefer to work on emerging diseases because they represent an interesting challenge and also generate public alarm, and, in turn, the governments give priority to these diseases. The issue of NCDs needs more political backing.

Andean Region (Bolivia, Colombia, Peru, and Venezuela)

### **Opportunities to Implement Community Cardiovascular Health Promotion and Prevention Programs with Promoter Participation**

#### **Diagnosis**

- Programs are in place that serve as a basis or referent for implementing cardiovascular health programs;
- It is feasible to carry out pilot experiences in local areas, as a demonstration in how to obtain financing;
- Several countries have already developed clinical intervention guides;
- Baseline data on cardiovascular mortality are available; however, morbidity information systems are rare;
- Census studies and some baseline studies are available;
- Bolivia and Peru have national plans in place encompassing information, surveillance, prevention, and control;
- Insurance experiences that proved successful in other health areas could be applied to NCDs.

#### **Strengths**

- Andean network functioning;
- Weekly reporting of NCDs (Peru);
- Use of the mass media;
- WHO support;
- NCDs are recognized as a public health problem;
- Addressing risk factors can prevent disease.

#### **Obstacles and Challenges to Implementation**

##### **Weaknesses**

- The population is unaware of risk factors, and health workers are not trained in NCDs;
- Referral and counter-referral systems are not well developed;
- Health systems and health insurance programs are not prepared to manage NCDs;
- Interventions targeting NCDs lack political visibility, as their impact is long-term, thus diminishing political will;

- Interventions are more complex, due to the multicausal nature of NCDs and the need for achieving behavioral and social change (i.e., “it is easier to administer a vaccine”);
- Interventions must be complemented with public policies;
- Interventions range from prevention to rehabilitation.

#### Threats

- Maternal and child programs have the highest priority.

#### Challenges

- Obtain financial, technical, and programming support;
- Need to have evaluation mechanisms in place;
- Implement subregional cooperation and coordination;
- If no budget is allocated, progress will not be possible; resources are required.

Central America and the Latin Caribbean (Costa Rica, Cuba, El Salvador, Mexico, Nicaragua, Panama, and Puerto Rico)

#### **Opportunities to Implement Community Cardiovascular Health Promotion and Prevention Programs with Promoter Participation**

- Community health programs at different stages of development are operating in all countries of the group. They may have strong points and weaknesses, but they are operational and that provides a structured foundation on which to build.
- Trained human resources are available; there are promoters who are already versed in the work methodology, and consequently, it would be easy to give them specific cardiovascular health knowledge.
- Political will exists for addressing NCDs; though still incipient and lacking explicit priority, it exists nonetheless.
- Technical and financial assistance is available via international cooperation;
- Health systems are in place, organized into networks and by levels, with a primary care facility located close to the family and community; this facilitates implementation of cardiovascular health programs;
- Established interregional networks are in place, which make it possible to set subregional priorities and commitments, making them stronger and more sustainable;
- The possibility of sharing experiences between countries (i.e., this Symposium) improves interventions.

#### **Obstacles and Challenges to Implementation**

- Cardiovascular health programs should be adapted to the conditions in each region and community;
- Promoters should be trained and keep their skills honed through a mandatory continuing education program in cardiovascular health, since they have yet to receive training in this area;
- Political, technical, and financial viability should be constructed or strengthened in order to lend stability to the projects and interventions;
- The design of monitoring and evaluation systems is needed, as this area continues to be weak—focused more on the process than the result;
- Subregional commitment to the comprehensive implementation of cardiovascular health programs is needed.

English-Speaking and Francophone Caribbean (Anguilla, Bahamas, Canada, Haiti, and Trinidad and Tobago)

### **Opportunities to Implement Community Cardiovascular Health Promotion and Prevention Programs with Promoter Participation**

- All share similar problems: obesity, sedentary lifestyle, poor diet. The priority is on changing unhealthy habits, especially eating habits. The goal is an active population with greater awareness of its health that is more committed to making informed choices and improving its health. The result of this change should be a reduction in morbidity and mortality associated with CVD.
- The goal is to secure the commitment of communities to participate in sustainable primary care based on the health promotion approach. Educational programs on healthy lifestyles should be integrated into the school curricula. Education and information support informed decisions.

### **Obstacles and Challenges to Implementation**

- The community needs to be encouraged to get involved to increase its participation;
- Currently there are no promoters or volunteers (Aruba, Bahamas, Haiti, and Trinidad and Tobago);
- Services and health interventions are performed exclusively by health workers;
- Activities to raise awareness are needed to secure the support of the community;
- An understanding of people's needs is required to change behavior; accordingly, the decision-making process should not be unilateral;
- Health promoter activities should be as cost-efficient as possible, based on the available evidence;
- The concept and scope of health educators and promoters should be reexamined in situations where services are scarce and access to health care is limited;
- Volunteerism is not a spontaneous endeavor. Strategies must be designed to attract volunteers;
- Other sectors must be enlisted as partners to facilitate the implementation of interventions;
- The jury is still out on the question: "Who owns the programs: the health sector or the community?"

## **Closing Remarks**

The diversity of ideas and experiences and their confluence will bear fruit and generate innovation. Let us remember the "Medici effect" and think about achieving something new: in forming growth networks; in feeling comfortable in our knowledge and common thinking.

When facing common challenges, a united response is always stronger. We have the power of information and research to create something new. This lifesaving information should be transmitted and used. Our commitment and joint efforts will make the difference and motivate many others.

The goal of PAHO and the NHLBI—of initiating a dialogue, of sharing our visions, and moving beyond where we are now—has been achieved. We have sought the answer to a simple question: "How can we reach people with information in the communities where they live and work?" It is a simple objective with great potential.

Now is the time to roll up our sleeves and go to work to prove that this is not just another forum or conference: the dialogue does not end today, but rather it begins.

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