Con el favor de Dio□s: the role of promotoras/community lay health workers as spiritual helpers in supporting diabetes self-management among Mexican Americans

Con el favor de Diós: The role of Promotoras/Community Lay Health Workers as spiritual helpers in supporting diabetes self-management among Mexican Americans

Emma Torres

Campesinos Sin Fronteras

P.O. Box 423

Somerton, AZ 85350

(928) 627-1060

Fax: (928) 627-1899

ecarni1@aol.com

Maia Ingram

Mel and Enid Zuckerman College of Public Health

University of Arizona

P.O. Box 245209

Tucson, AZ 85721

(520) 626-2267

Fax: (520) 626-8716

maiai@u.arizona.edu

ABSTRACT

There is evidence that individual spirituality positively impacts health behaviors and health status, as well as the ability to recover from illness. Among Latinos, spirituality and belief in God may serve as a cultural resource and a source of social support, as well as coping mechanism for disease-related stress. This article describes the results of a qualitative study investigating the role of the lay health worker, or *promotora*, in serving as a spiritual helper to Mexican Americans with diabetes. Results demonstrated the centrality of spirituality in the daily life of clients. *Promotoras* utilized the spiritual orientation of their clients to stress personal responsibility for self care in partnership with God, in communal sharing about how spiritual concepts can be applied to one's life, and by serving as spiritual counselors in times of crisis. Findings have implications for programs serving Mexican American communities.

BACKGROUND

Mexican Americans suffer disproportionately from mortality and morbidity related to diabetes (West, Klein, Rodriguez, Muñoz, Broman, Sanchez, & Snyder, 2001; Venkat Narayan, Boyle, Thompson, Sorenson, & Williamson, 2003), a potentially debilitating disease that, if unchecked, can result in amputation, blindness, and renal failure. Mexican Americans, who make up approximately 9% of the U.S. population, are twice as likely to have diabetes than non-Hispanic whites of a similar age (Centers for Disease Control, 2002) and experience higher rates of nephropathy, retinopathy and peripheral vascular disease, all complication of diabetes (American Diabetes Association, 2007). Self-management through diet, regular physical activity and glucose monitoring, as well as compliance with medical treatment, is fundamental to controlling the progression of the disease. However, the sometimes drastic lifestyle changes that must be sustained over the lifespan can be overwhelming both physically and emotionally. Public health interventions targeting Mexican Americans with diabetes have sought to provide culturally competent and community-based self-management education programs (Carbone, Torres, Goins, & Bermudez, 2005-2006; Mauldon, Melkus & Cagganello, 2006). Central to many effective interventions is the community health worker, or in Mexican American communities the *promotora,* in which services are provided by an individual from the community who has a profound and personal connection and commitment to the cultural identity and needs of her clients (Corkery, Palmer, Foley, Schecter, Frisher & Roman, 1997; Ingram, Torres, Redondo, Wang, Bradford & O'Toole., 2007; Ingram, Gallegos, & Elenes, 2002; Rhodes, Foley, Zometa, & Bloom 2007; Sixta & Ostwald, 2008). This article describes the results of a qualitative study investigating the role of the *promotora* in encouraging self-

management behaviors by serving as a spiritual helper to Mexican Americans with diabetes living in a U.S.-Mexico border community.

Spirituality and health behavior

Spirituality and its relationship to health and health behavior have been extensively studied in the health literature. The term spirituality is used to include not exclusively religiosity, but rather a wider view of "God" as a belief in a higher power which provides both meaning and purpose in life (Coyle, 2002). There is evidence that individual spirituality positively impacts health behaviors and health status, as well as ability to recover from illness and adversity (Chatters, 2000; George, Larsons, Koeing & McCullough, 2000; O'Connell & Skevington, 2007). The conviction that life has both meaning and purpose embodied in a higher power appears to motivate individuals as well as engender a positive state of mind and inner strength to deal with health issues (Chatters, 2000; Chandler, Holden & Collander, 1992; Coyle, 2002). Likewise, people may be better able to cope with or recover from illness when they believe responsibility for their destiny is not theirs alone, rather that they are in partnership with God (Coyle, 2002). Spirituality may also provide a means to make sense of suffering that otherwise seems random and without meaning (George, et al., 2000).

There is a small body of qualitative research confirming a relationship between spirituality and health among ethnic minorities. Musgrave, Allen & Allen (2002) stress that among women of color spirituality is most often rooted in Christian belief and is embedded in a larger network of personal relationships and community identity. Faith in God is closely associated with health (Magilvy, Congdon, Martinez, Davis, & Averill, 2000), while disease represents an imbalance in the individual (Musgrave, Allen & Allen, 2002). Ethnographic research has found that integration of spirituality is an essential part of healthy living among

Latina women (Higgins & Learn, 1999). Spirituality provides a source of inner strength for Latinas to overcome illness and other stressful life events (Dingley & Roux, 2003). Spirituality may also aid in acceptance of illness; in a study of Latinas living in a rural community, participants felt a personal responsibility for their health, but also recognized limitations in their ability to prevent, cure or control illness (Magilvy, et al., 2000). Focusing more specifically on diabetes self-management among Latinos, spirituality and belief in God may serve as a cultural resource and a source of social support as well as coping mechanism for disease-related stress (Devlin, Roberts, Okaya, & Xiong, 2006). A qualitative study found that Latino patients with diabetes often attribute self-management behaviors to God's assistance and support (Carbone, Rosal, Torres, Goins, & Bermudez, 2007).

Spirituality in health interventions

An underlying rationale exists for incorporating spirituality into public health interventions designed to promote self-management of diabetes and other chronic disease among people of Mexican descent. Those with religious coping skills appear to handle medical conditions better than those without (Chatters, 2000) and religious coping strategies appear to have a positive effect on the mental well being of patients. According to Reyes-Ortiz (2006), spiritual and religious activities are used by older patients in many settings to cope with chronic illness and disability and use of religion to promote individual and group healing is associated with feelings of self-worth and connection to others. A study of individuals with chronic disease documented a desire for spiritual and religious coping options such as praying alone, praying in a group, and discussing spirituality with others (Dale & Hunt, 2008).

The role of faith-based organizations in promoting health is discussed by Chatters (2000), however secular organizations may have a distinct purpose in integrating spirituality into chronic

disease programs. Secular programs have the advantage of being able to draw on spirituality as a resource from diverse religious perspectives while also having expertise in health related issues. The purpose of this study was to explore the use of the *promotora* model within a community-based organization in incorporating spirituality into a diabetes self-management education program serving a U.S.-Mexico Border community.

PROGRAM BACKGROUND

South Yuma County, Arizona, located along the U.S. border adjacent to Sonora, Mexico, is known as the lettuce capital of the nation. Yuma County has the largest number of farmworkers in the state, a large percentage of which is of Mexican origin. Agriculture accounts for almost half the employment in Yuma County, particularly during harvest season when here is a large influx of migrant workers. Border communities, Mexican Americans, and farmworkers all suffer disproportionately from diabetes in the U.S. (Bastidea, Cuellar & Villas, 2001; .U.S. Department of Health and Human Services, 2000), however, farmworkers are particularly vulnerable due to long work hours, difficult labor conditions and low access to health care (Villarejo, Lighthall, Williams, Souter, Mines, Badge & McCurdy, 2000). For these reason, diabetes is possibly the greatest health issue currently facing South Yuma County.

Beginning in 1999, *Campesinos Sin Fronteras* (Farmworkers Without Borders, subsequently referred to as CSF), a grassroots *promotora* agency in South Yuma County, began to address the burden of diabetes in their community. A *promotor/a* is an community health worker who represents the population he/she serves ethnically, linguistically, educationally, culturally and economically. In the case of *Campesinos Sin Fronteras* (CSF), most *promotoras* come from farmworker families or have worked as farmworkers themselves. Those who become *promotoras* tend to be natural helpers who are intrinsically motivated to help their community.

They transport friends to the local clinic or grocery store, make phone calls for those unable to use a telephone, or initiate fundraising activities to help a needy neighbor. The majority of CSF *promotoras* are women, for whom conducting community health outreach and education is the first job out of the agricultural fields. Most have minimal education and only a small percentage earn degrees beyond high school. Many are monolingual Spanish speakers, although they are encouraged to learn English as part of their ongoing training.

As the CSF *promotoras* began recruiting members of the farmworker community to the diabetes program, they became aware of the tremendous challenge they had undertaken. On one hand, the community was keenly conscious of the prevalence of diabetes; it seemed everyone had a family member with the disease. On another level, it was clear that people knew very little about how to prevent diabetes or control it. For example, people diagnosed with diabetes, also known as *la enfermedad* (the sickness), responded to vague dietary restrictions from their doctor by barely eating or no longer sharing meals with their families. Some chose not to tell their family members that they had been diagnosed with the disease. Many people with diabetes reported being isolated from their families, expressed a fatalistic attitude about their health, and experienced feelings of hopelessness and despair. In response, the *promotoras* conducted outreach and follow up for the clinic-based education classes, seeking to increase both access to health care and self-management practices for those with diabetes. Central to the message was that people with diabetes did not need to give up the food they love, that they could share meals with their families, and that community resources existed to assist them.

The level of intimacy that the *promotoras* shared with their clients increased when they began to facilitate weekly support groups throughout the community, and the pervasiveness of depression among program participants became apparent. In the *promotoras'* view, many of their

clients were caught in a vicious cycle in which depression negatively impacted their capacity to manage their disease, which, as it grew out of control, was further debilitating to their mental health. However, when attempting to connect their clients with the mental health system, *promotoras* were stymied by the lack of accessible, culturally and linguistically appropriate mental health services and the reluctance of clients to seek mental health because they insisted that " *no estoy loco/a"* (I am not crazy). Once they overcame the stigma associated with mental health services and accepted the need for such services, clients were routinely asked to wait several weeks for a first appointment and many were dissatisfied with the services they eventually received.

The *promotoras* found themselves faced with an urgent need to address mental health as a major factor in the quality of life of their clients. Fortunately, the support group provided a safe environment for participants to express their emotions around the experience of having diabetes. Participants shared personal issues and crises with one another, resulting in a healing environment that encouraged all participants to practice better diabetes self-management. Within this environment, members of the group initiated conversations about the importance of faith, sometimes offering advice to others in the group about seeking God's support when they were in pain or feeling depressed. Observing the shared faith of the group regardless of religious orientation and the comfort that participants were both giving and receiving, the *promotoras* responded by employing spirituality as a specific approach in dealing with mental health issues related to diabetes. The *promotoras* began formalizing the use of spirituality as a motivational force in diabetes self-management by starting off each support group with a spiritual message. While careful to not promote any one religion, the messages emphasized the importance of

caring for one's own body, or alternately, the body that has been given to you, as an aspect of faith. These messages became the focal point of the support groups.

The natural integration of spirituality into the helping practices of the *promotoras* led to discussion in the agency about the use of spirituality. Historically, they had maintained a policy that as a secular agency, spirituality and religion were not subjects *promotoras* could use in their work to help others. However, the personal relationships they were developing with clients in the diabetes program made apparent the central importance of spirituality in their clients' lives. The *promotoras* felt an ethical responsibility to respond to this potential area of strength, especially since they tended to be spiritual people themselves. The agency made a decision to formally include spirituality in their work as *promotoras* within specific guidelines. First, they would ask permission of the group or person they were interacting with before using spiritual messages or language; and second, they would not refer to any one religion, but rather encourage participants to use their personal religious beliefs to help them in practicing self-management.

With formal acknowledgement of their approach, the *promotoras* were able to clarify how spirituality was providing hope and optimism to people with diabetes. For example, when visiting a client in great distress, the *promotoras* asked the participant if they wanted to appeal to their spiritual beliefs and ask for help from a higher power to get through a difficult situation. As a result, clients began calling the office and asking a *promotora* to come and visit them specifically to pray or offer spiritual support. In the support groups, participants testified that turning to a higher power helped them recognize their own responsibility to help themselves. For many, the use of spirituality fortified an inner strength to confront diabetes and lifestyle changes.

The *promotoras* also saw a transformation in the support groups when spirituality became part of the discussion. The majority of those in the groups had experienced depression related to

diabetes or to other life events, and they began talking about their experiences and even their contemplation of suicide. Group members discussed personal, emotional or spiritual ties they had outside the group, and how the impact of those relationships sometimes made self-management more difficult. Against expectation was the observation that Latino men, who made up about one third of participants, talked about their emotions and their need for positive encouragement. Thus, what had begun primarily as an educational endeavor took on a therapeutic dimension space in which participants shared and cried together and began healing emotionally and spiritually. This healing process allowed many participants to then focus on their physical health.

METHODOLOGY

Exploratory research into the use of spirituality in a diabetes self-management education program came as a result of funding from the Robert Wood Johnson Foundation Community Support for Diabetes Initiative. The CSF Director had a long-standing relationship with an academic partner who had been sub-contracted to oversee a participatory evaluation of their program entitled, *Campesino* Diabetes Management Program *(*CDMP*).* In addition to being committed to participatory evaluation, the CSF Director and Evaluator, both authors on this paper, were invested in developing *promotora* programs designed to meet the needs of the farmworker community. For both authors, participatory evaluation of CDMP provided an opportunity to investigate the effectiveness of the *promotora* in promoting diabetes self-management in a systematic and quantifiable manner, while also providing insight into the variety and intensity of *promotora* activities.

Participatory evaluation is a mutual learning process which relies upon community expertise to define and refine program indicators and outcomes (Wallerstein, 1997; Levin 1997). Although time consuming and potentially resource heavy, participatory evaluation offers

numerous advantages over traditional evaluation methods in which the evaluator is an outside party employed under the assumption that they are better able to view project outcomes with an objective eye. In the participatory model of evaluation, for example, the evaluator is more familiar with the daily workings of the program and better informed to judge the quality of data collection and interpret results. Further, the collaborative nature of the interaction between the evaluator and project staff ensures that evaluation measures are meaningful and responsive to the priorities and needs of the project. In addition, participatory evaluation also allows program evaluation to be flexible and thus respond to the changing priorities of the program. In the case of this study, spirituality was not a CDMP focus at its inception and therefore questions regarding its role were not included in the original evaluation instruments. However, as a collaborator closely engaged with the lessons being learned, the evaluator was aware of the growing emphasis on spirituality and chose to explore the concept through qualitative data collection with the *promotoras*.

CDMP evaluation utilized a mixed methods design which included clinical health outcomes, pre/post behavioral questionnaires, documentation of program activities, and interviews with project staff. The clinical outcomes of the project demonstrate improvements in health indicators among program participants and are reported elsewhere (Ingram, et al., 2007). For the purpose of this article, two data sources are utilized: participant contact logs maintained by *promotoras* and indepth interviews with project staff conducted by the project evaluator. The interviews offer diverse perspectives into the use of spirituality within the context of a secular health program, while the participant contact logs indicate the relevance of spirituality in the interactions between *promotoras* and clients. In both data collection activities, program

participants and the interviewees were consented using procedures and protocols approved by the Human Subjects Internal Review Board at the University of Arizona.

Participant contact logs

Consistent with the principals of participatory evaluation, CSF *promotoras* were involved in determining what to evaluate in their program and how to evaluate it. They decided to use participant contact logs to describe the intensity and distinct quality of their services. Each participant had their own contact log which was stored in their file so that *promotoras* could easily review previous activities with the participant. The logs documented: (a) the number of the contact, (b) date of contact, (c) type of contact, and (d) any comments the promotora wished to make about the content of their interaction. The *promotoras* identified the types of contacts based on their most common activities with clients which were defined as: phone contact, home visit, office visit, support group, diabetes self-management education session, family diabetes education session, and advocacy assistance. The purpose of phone, home, and office visits were mainly to provide support to the client, as well as to remind them of program activities, while the other types of contacts designated specific activities such as diabetes education or support group. The comments were optional and open ended. The *promotores* frequently filled out the comment section because it had the dual role of documenting the program as well as sharing client information. Over the course of the two-year data collection period, eight *promotoras* who worked with the program from CSF filled out the logs based on their activities. Two *promotoras,* who were with the program for the entire two years and the Evaluator monitored the quality of information being recorded to ensure that it was being entered in a consistent manner and with common understanding of the terms being used, for example for the types of contacts. The Evaluator met with the *promotoras* monthly to discuss issues related to evaluation. Data from the

contact logs were entered into a Microsoft Access database using a unique identifier for each participant and a secondary identifier for each of the contacts for that participant, allowing the Evaluator to analyze contacts by client as a documentation of their experience over time, by type of contact, or by content contained in the comment section.

Promotora interviews

As part of the effort to describe the role of the *promotora* in promoting diabetes self-management, evaluation included interviews with program staff designed to gain a comprehensive picture of the program as it was actually delivered, as well as to identify the key components of a *promotora*-driven diabetes self-management program. The evaluator developed a semi-structured interview guide that addressed the services *promotoras* provided, what was unique about their services, how they helped clients manage diabetes, and what kind of training they thought was necessary to do their work. In addition, there were two general questions regarding the role of spirituality, phrased as: a) For those participants who are spiritual or religious, how do you feel that their beliefs affect their diabetes self-management? and b) How important is religion or spirituality in the work you do as a *promotora?* The evaluator used the interview guide to introduce a subject and then answered follow up questions based on responses. The evaluator conducted interviews with all nine *promotoras* who worked with CDMP over the course of two years, eight from CSF and one from the community health center. Two *promotoras* were no longer working with the program at the time of the interviews. The interviewees were Mexican American, and all but one was from the Yuma area. They were all female and between 25 and 50 years of age. While most had not been formally educated beyond high school, several pursuing ongoing education. Of the two with a higher education, both were

educated in Mexico, one as a nurse and the other in psychology. The interviews lasted 45 minutes to one hour. The taped interviews were conducted, transcribed, and analyzed in Spanish.

DATA ANALYSIS

Data from both the interviews and the participant contact logs were analyzed using content analysis, described by Patton (2002) as a method of searching text, such as interview and focus group notes, for recurring words, concepts or ideas. These core consistencies or ideas are used to reveal patterns which are then organized into themes based on the recognition and reduction of patterns. To determine the extent to which spirituality was part of the interaction between the *promotora* and the client, text searches were conducted of the contact fields for the following terms in Spanish: *orar* (to pray), *Diós* (God), e*spiritual (*spiritual), *iglesia* (church), and *mensaje (*spiritual message). These terms were chosen after an overall review of the text to determine which words were associated with spirituality.

Analysis of the indepth interviews was straightforward, given that the concepts under investigation, spirituality and self-management, were directly elicited by the questions. Axial coding, or the process of identifying subcategories such as *esperanza* (hope) and *cuidarse* (take care of yourself), provided a second layer of analysis that deepened understanding of how spiritual beliefs impacted participant perspectives and actions related to living with chronic disease.

Trustworthiness and dependability of data are issues in qualitative analysis. Three characteristics of the study address these concerns. First, the partners on this study, the CSF Director, the evaluator, and the *promotoras,* shared a long term engagement not only through this study, but also in previous projects addressing diabetes self-management. The collaboration of the *promotoras* in identifying the research questions contributed to a common understanding of

the themes under discussion, and the commitment of the evaluator to the project enhanced credibility in data collection. Second, while there are limitations in the scope of this research, the authors triangulated two sources of data, the interviews and the participant contact forms, to support study findings. Third, the authors engaged in collaborative interpretation of results to validate that findings represented the beliefs of the *promotoras* and the participants themselves.

RESULTS

Participant contacts

Participant contact reflected growing integration of spirituality over a two-year period between December 2004 and December 2006. During this time, the promotoras documented approximately 13,715 contacts with 264 program participants. The majority of these were telephone contacts (57%), while 32% were in support groups, 4% were in home or hospital visits, 3% were in cooking classes, and 1% were in the promotora office.

The use of spiritual terms in the *promotora* comments is notable given that they were not specifically instructed to document interactions with their client that had spiritual content. The majority of the comments referred to the spiritual orientation of the participant rather than the use of spirituality by the *promotora.* The text searches yielded a total of 63 comments containing a phrase with spiritual content. Some comments used more than one term. The most common term was “spiritual message” (30). “God” was used 23 times and “church” was used 10 times. “Pray” was used 3 times. Although the 63 comments make up small percentage of the total, 55 of the 264 clients (20.8%) had a comment that included one of these terms.

“Ell mensaje”, or the spiritual message, which was a cornerstone of the support group format, was mentioned by 25 participants a total of 30 times. The comments suggested that participants reflected on the meaning of the message in the context of the support group or with

the *promotora*. Participants used the following words to describe interactions involving the spiritual messages: "*compartiendo sobre el mensaje"* (sharing thoughts about the message*); reflexión sobre el tema"* (reflecting on the theme of the message*);* and *"comentarios sobre el mensaje"* (commenting on the message*).* The support group provided a forum to discuss how the spiritual message could be applied to one's life.

When referring to God, participants revealed three general orientations toward spirituality and health. The first was an expression of gratitude that God had provided them with resources and tools, such as the support group, to deal with health problems. This orientation signaled the idea of a partnership with God, and was expressed as "she gives thanks to God for having learned to eat better and knowing people with the same problem in the support group" and "thank God for the group because he is very comfortable with it." The second orientation was gratitude to God for the act of healing or avoiding worse health problems. These were expressed as "she gives thanks to God because her husband is healthy" and "she gives thanks to God nothing happened to the baby". The third orientation reflected the role of spirituality in facing and accepting life-threatening illness. A man with cancer, "said the only thing he could do was place his faith in God" and another who needed dialysis, said that "he would last only as long as God wanted".

Three comments described situations in which the *promotoras* suggested to their clients that they use their spiritual beliefs to help them cope with adversity. A *promotora* advised a woman with a sick child "to have faith and ask God to heal her child and not to let her get sick like her oldest child". For a woman suffering from depression, the *promotora* advised that "she have faith in God and ask him for physical and spiritual health." In three instances, the clients

requested that the *promotoras* join them in using faith to help them accept and cope with illness, asking the *promotoras* or support group members to pray for them or for a sick family member.

The term "church" provided some insight into the role of institutional religion in providing a community. The comments described the role of church in the lives of participants, the social importance of going to church, and what activities they engaged in as part of the church member. Finally, throughout the comments common phrases from the clients such as "*con el favor de Dios*" (with the grace of God) "*gracias a Dios" (*thanks to God), "*vaya con Diós"* (go with God), and "*si Diós quiere"* (God willing) were documented as part of a common language that reflected a shared belief although not necessarily with a specific religious faith.

Promotora interviews

The interviews revealed a basic agreement among the *promotoras* that within the context of this particular community, characterized as Latino, farmworker and immigrant, spirituality has a central role in daily life. In keeping with the purpose of this article to investigate the use of spirituality within a secular diabetes self-management program, *promotoras* responded to questions about spirituality that sought to describe how spirituality figured into their clients' ability to practice self-management as well as the role of spirituality in their work as *promotoras.*

Spirituality and diabetes self-management. The *promotoras* described two general orientations of their clients towards spirituality that facilitated self-management behavior. The first was that once their clients understood diabetes self-management practices, their belief in God engendered a personal responsibility for them to improve their health. This concept was expressed as the belief that "God is the only one who can give and take life" and therefore each person has the moral responsibility to care of what God has given them. As one *promotora* described it, "It helps them believe that they should take care of themselves. When you believe in

a supreme being, well, we were created as we are, and it is so that we take care of ourselves; we should not neglect ourselves.*"* Related to personal responsibility was the belief that God will help the person who does their part. *"*The bible tells me that I don't have the right to take my life, because God gave life and only he can take it, right? In self-management of diabetes there is a part that says, God is going to help you, you do your part and I will do mine."

Secondly, the *promotoras* believed that spirituality provided their clients with inner strength and hope to face diabetes. "Having faith in something greater than themselves gives them strength that they otherwise don't have.*"* Spirituality provided a basic belief that "everything is going to be alright; by asking help from God they can keep going". One *promotora* observed that those who described themselves as spiritual were more likely to practice self-management than those who did not have this resource. "I think in many occasions these persons are maintained by their faith. The spiritual for them is to have strength that otherwise they wouldn't have. It helps them overcome situations that otherwise they could not overcome. Their faith is strength."

Promotoras as spiritual helpers. The interviewees described three distinct ways in which in their role as spiritual helpers they were able to promote self-management behaviors more effectively. The first was in affirmation of what they do. "I have faith that everything I do is going to work out okay; I have faith that they will hear the information, of course they are not always going to do it, but I have faith in what I do. So for me religion has a lot of power."

Spirituality also provides stamina to continue their work which was often emotionally and physically taxing.

> "There are times when you're working after 5:00 in the afternoon; the majority of us have found ourselves in this situation. There is so much need, and we are working at lunchtime as well to cover this need, and we keep doing it. So I think that the spirituality is important in providing motivation to help people keep going"

Secondly, the *promotoras* emphasized that spirituality is essential in helping people deal with crises.

> "You have to use spirituality sometimes, for example when the person you are visiting has lost a family member. You don't say, you are going to get through it, you are very strong. No, you need to tell them that the Supreme Being is going to help them get through it, and that everything is going to be alright".

A third way that the *promotoras* described spirituality as fundamental was in the increased intimacy or *confianza* they had with their clients as a result of shared spirituality.

> Well, your belief brings you (the client) strength, the belief that you have personally. And there comes a person from outside (the *promotora*) with information, a resource, and tells you that it is alright what you believe. And that strengthens this alliance between the *promotora* and the person. This has been something really beneficial for us and I believe that it is one of those things that has made the program what it is, that the *promotora* comes with a message not only physical but also internal and spiritual.

The *promotoras* also advised that spirituality be used with caution because while there is general belief in a power that created "*la naturaleza"* (all that surrounds us), on the other hand, if they mention specific religions they are exposing their own perspectives and thus compromising their legitimacy. One *promotora* explained, "We had really good results when we started offering spiritual themes, things that were religious but not from a specific religion. It was all very general, without offending anyone, in order to help everyone."

DISCUSSION

The literature suggests several ways in which spirituality positively impacts our ability to deal with illness. In the face of being diagnosed with a life threatening disease, belief in a higher power can provide meaning to what might appear to be senseless suffering, stimulate inner strength, and engender a feeling of partnership with God in overcoming adversity. Historically, faith-based institutions have provided a community of support for those experiencing illness. However, health organizations may have an important role to play in channeling spiritual beliefs

into concrete health behaviors. This exploratory research study investigated how spirituality can be intentionally integrated into a secular, community-based, diabetes self-management program. *Promotoras* are natural spiritual helpers because their own belief systems emphasize caring for oneself as an act of faith, and because their belief systems tend to reflect that of the communities they serve. Perhaps most important, however, is the fact that in their role as natural helpers, community members give *promotoras* the authority to appeal to their spiritual beliefs in responding to health issues.

Figure 1 About here

Figure 1 provides a graphical representation of triangulated data from the participant contact forms and the *promotora* interviews. The *promotoras* utilized the spiritual orientation of their clients to promote self-management in three ways. The first was to stress the responsibility that their clients had to God to take care of the life they had been given. Within this approach, partnership with God was emphasized as "you have to do your part" and God will help you. Second, through the spiritual messages in the support groups, the *promotoras* created an environment in which emotional and spiritual concepts could be reflected upon and applied to one's own life. This communal sharing of spiritual ideas also created a supportive community in which diabetes self-management was a common goal. Within this culturally familiar environment, clients were able to address feelings of depression associated with diabetes in a constructive manner. Third, the *promotoras* were able to act as spiritual helpers in times of crisis, responding to requests to pray with or for their clients. The fact that clients turned to the *promotoras* in these times of great need was reflective of their role as spiritual helpers. Self-management practices are often derailed in times of crisis, and the *promotoras* had the authority to stress self-care as crucial in helping them maintain the strength to deal with adversity.

Chatters (2002) promotes the use of qualitative data collection to inform and guide our use of spirituality in health care behaviors. The perspectives shared by those involved in CDMP lead to several recommendations on the use of spiritual helpers within the context of secular, health organizations that serve people of Mexican origin. Most salient was the need to have a clear program objective, in this case promoting self-management practices, for which *spirituality* is a means to an end rather than an end itself. This approach will assist the spiritual helpers in focusing on the specific health issue and not the religious orientation of their clients. It is also important to have formal guidelines regarding how spirituality will be used by the spiritual helpers to meet the health objectives of the program. The formal guidelines will help spiritual helpers to use spirituality in an appropriate and constructive manner. Finally, it is crucial that the spiritual helpers respect the spiritual orientation of all the individuals in the program. Aptly described by one *promotora,* preference for any one religious undermines the credibility of the spiritual helper in promoting health.

A major limitation of the study was that the potential of the *promotora* to serve as a spiritual helper emerged from program experience and was not an original focus of program evaluation. As a result, there were several weaknesses in the study methodology and the data analysis process. First, the *promotoras* were not instructed to comment on the spiritual content of their interactions with clients in the contact logs. While this may minimize concern that the *promotoras* were biased toward including spiritual content, the opportunity to capture the extent and quality of spiritually-focused interactions was lost. Further, there was no control over how terms were used; therefore, not all terms described the content of an interaction, but rather the common use of religious terms among program participants. Similarly, the intent of the *promotora* interviews was to describe the role of the *promotora* in diabetes self-management, but

not specifically as a spiritual helper. This was another lost opportunity to gather data relevant to the study. Third, since the concept under study was not identified at the outset, the two data sources were not intended to be complementary, and thus the data analysis process benefited only minimally from triangulation. Finally, the study did not gather data directly from the clients regarding their views of spirituality and health or the role of the spiritual helpers in helping them manage diabetes. In order to more fully understand the role of spirituality in a community-based diabetes program, studies focusing on the client perspective will be necessary.

CONCLUSION

Promotoras, or lay health workers, are credited with improving the health of marginalized populations by serving as cultural mediators between communities of color and the health care system, sharing health information, providing informal counseling and social support, and advocating for the needs of their clients. However, current literature does not consider their capacity to reinforce healthy behaviors by appealing to the spiritual beliefs of their clients as a resource for inner strength and guidance. Results from this study support the role of *promotoras* as spiritual helpers in encouraging diabetes self-management among people of Mexican descent. Spirituality was expressed as an essential part of the lives of those participating in the program, and intrinsic to the culture of the Mexican American community and the *promotoras* themselves as members of that community. In making the decision to formalize their role as spiritual helpers, the *promotoras* felt an ethical responsibility to respond to the needs of their clients. Focus on the specific program objective- that is, to promote self-management practices- ensured that the *promotoras* respected the spiritual orientation of each client.

LITERATURE CITED

American Diabetes Association. (2009). Complications of diabetes in the United States. Retrieved Jan 22, 2009, from http://www.diabetes.org/diabetes-statistics/complications.jsp.

Bastidea, E., Cuéllar, I., & Villas P. (2001). Prevalence of diabetes mellitus and related conditions in a south Texas Mexican American sample. *Journal of Community Health Nursing*, 18, 75-84.

Carbone , E.T., Rosal, M.C., Torres, M.I., Goins, K.V., & Bermudez, O.I. (2007). Diabetes self-management: Perspectives of Latino patients and their health care providers. *Patient Education and Counseling*; 66(2), 202-210.

Carbone, E.T., Lennon K.M., Torres M.I., & Rosal, M.C.(2005-2006). Testing the feasibility of an interactive learning styles measure for U.S. Latino adults with type 2 diabetes and low literacy. *International Quarterly of Community Health Education*, 25(4): 315-35.

Centers for Disease Control and Prevention. (2002) *National Diabetes Fact Sheet*. Atlanta, GA: U.S. Government Printing Office.

Chandler, C.K., Holden, J.M., & Kolander, C.A. (1992). Counseling for spiritual wellness: Theory and practice. *Journal of Counseling and Development*, 71, 168-175.

Chatters, L.M. (2000). Religion and health: Public health research and practice. *Annual Review of Public Health*, 21, 335–67.

Corkery E., Palmer, C., Foley, M.E., Schecter, C.B., Frisher, L., & Roman, S.H. (1997). Effects of a bicultural community health worker on completion of diabetes education in a Hispanic population. *Diabetes Care*, 20(3), 254-7.

Coyle, J. (2002). Spirituality and health: towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing*, 37(6), 589-597.

Dale, H., & Hunt, N (2008). Perceived Need for Spiritual and Religious Treatment Options in Chronically Ill Individuals. *Journal of Health Psychology*, 13(5), 712–718.

Devlin, H., Roberts, M., Okaya, A., & Xiong, Y.M. (2006). Our Lives Were Healthier Before: Focus Groups With African American, American Indian, Hispanic/Latino, and Hmong People With Diabetes. *Health Promotion Practice*, 7(1), 47-55.

Dingley, C., & Roux, G. (2003) Inner strength in older Hispanic women with chronic illness. *Journal of Cultural Diversity*. 10(1), 11-23.

George, L.K., Larsons, D.B., Koeing, H.G., & McCullough, M.E. (2000) Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology* 19(1):102-116.

Higgins, P.G., & Learn C.D. (1999) Health practices of adult Hispanic women. *Journal of Advanced Nursing*, 29, 1105–1112.

Ingram, M., Gallegos G., & Elenes J. (2005). Diabetes is a community issue: the critical elements of a successful outreach and education model on the U.S.-Mexico border. *Preventing Chronic Disease*. Retrieved October 1. 2008, from http://www.cdc.gov/pcd/issues/2005/jan/04_0078.htm.

Ingram, M, Torres, E, Redondo, F, Bradford, G, Wang, C, & O'Toole, M. T. (2007). The impact of *promotoras* on social support and glycemic control. *The Diabetes Educator*, 33 (Supp 6):172S-178S.

Kowalski, K., Hoffman, C.J., & McClure, A. (1999). Nutritional patterns and needs of migrant farm workers in Northwest Michigan. *Journal of the American Dietetic Association,* 99(2), 221-224.

Levin, R. (1999) Participatory evaluation: Researchers and service providers as collaborators versus adversaries. *Violence Against Women,* 5(10), 1213-1227.

Magilvy, J.K., Congdon, J.G., Martinez, R.J., Davis, R., & Averill, J. (2000). Caring for our own: Health care experiences of rural Hispanic elders. J*ournal of Aging Studies,* 14(2), 171-190.

Mauldon, M., Melkus, G.D., & Cagganello, M. (2006). *Tomando control*: a culturally appropriate diabetes education program for Spanish-speaking individuals with type 2 diabetes mellitus--evaluation of a pilot project. *The Diabetes Educator*. 32(5), 751-761.

Musgrave, C.F., Allen, C.E., & Allen, G.J. (2002). Spirituality and Health for Women of Color. *American Journal of Public Health*, 92(4), 557-560.

O'Connell, K.A., & Skevington, S.M. (2007). To measure or not to measure? Reviewing the assessment of spirituality and religion in health-related quality of life. *Chronic Illness*, 3(1), 77-87.

Reyes-Ortiz, C.A. (2006). Spirituality, disability and chronic illness. *Southern Medical Journal*, 99(10): 1172-1173.

Rhodes, S.D., Foley, K.L., Zometa, C.S., & Bloom, F.R. (2007). Lay Health Advisor Interventions Among Hispanics/Latinos: A Qualitative Systematic Review. *American Journal of Preventive Medicine*. 33(5): 418.427.

Sixta, C.S., & Ostwald, S. (2008). Texas-Mexico Border Intervention by Promotores for Patients With Type 2 Diabetes. *The Diabetes Educator*, 34(2), 299-310.

Venkat Narayan, K.M., Boyle, J.P., Thompson, T.J., Sorenson, S.W., & Williamson, D.F. (2003). Lifetime Risk for Diabetes Mellitus in the United States *Journal of the American Medical Association,* 290, 1884-1890.

Villarejo, D., Lighthall, D., Williams, D., Souter, A., Mines, R. Badge, B., Samuels, S., & McCurdy, S.A. (2000). Suffering in silence: A report on the health of California's agricultural workers. Davis, CA: California Institute of Rural Studies.

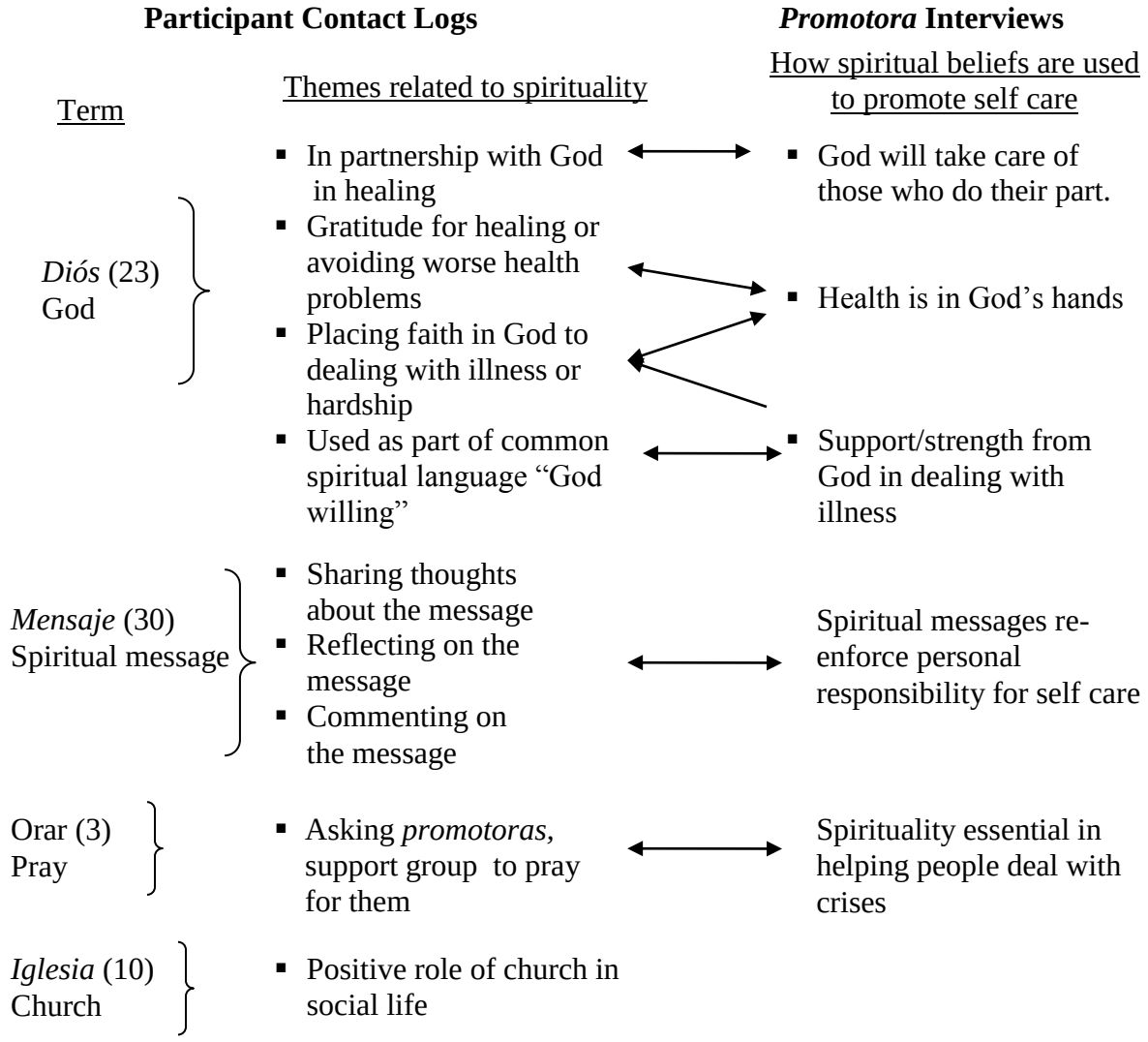
Wallerstein, N. (1999). Power between evaluator and community: research relationships within New Mexico's healthier communities. *Social Science and Medicine,* 49, 39-53.

West, S., Klein, R., Rodriguez, J., Muñoz, B., Broman, A., Sanchez, R., & Snyder, R. (2001). Diabetes and Diabetic Retinopathy in a Mexican-American Population: Proyecto VER. Brief Article. *Diabetes Care,* 24(7), 1204-1209.

U.S. Department of Health and Human Services Health Resources and Services Administration. (2000). Assuring a healthy future along the U.S.-Mexico border. Rockville, MD: U.S. Government Printing Office.

Figure Caption

*Figure 1.*Triangulation of Participants Contact Forms and Promotora Interviews



BIOGRAPHICAL SKETCHES

Emma Torres has been a strong U.S. Mexico border-community leader and a health advocate for migrant and seasonal farm workers in Western Arizona for more than 20 years. She is co-founder and Executive Director of *Campesinos Sin Fronteras*, a grassroots, community-based organization, and one of the pioneers of the Promotora model program in Arizona.

Maia Ingram has more than 15 years experience in developing and participating in community-academic partnerships and conducting meaningful, participatory evaluation of community-based programs addressing chronic disease, obesity, asthma, and partner violence. Her research interests focus on the community health worker model as a means to address health disparities.