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Shifting identities:

The transformation of community health workers in highland Guatemala

Guatemala is one of the first countries in the Americas to establish community health worker (CHW) programs, and CHWs have served a central role in both large-scale national programs and small-scale nongovernmental organization (NGO) projects. The role of CHWs, including their training, responsibilities, and idealized identities, has never been uniform, and has fluctuated over time in response to changing international health paradigms, national socioeconomic and political processes, and local-level power structures and expectations of the position. In this paper, I examine the changing nature of CHWs in the Central Highlands of Guatemala by focusing on the case of the Behrhorst Clinic in Chimaltenango, Guatemala. The Behrhorst Clinic was one of the first to implement a CHW program in Guatemala, and is one of the few NGOs in the region to operate continuously since the 1960s, providing a unique case study to examine the history and transformation of CHWs in three distinct sociopolitical periods: the Primary Health Care era (1960s–1970s); the sociopolitical violence (1970s–1980s); and the aftermath of the violence (1980s–2000s). This longitudinal analysis of the Behrhorst health promoter program highlights central, ongoing issues facing CHW programs in Guatemala and beyond including: the political susceptibility of community participation and empowerment programs; community participation and representation; and the long-term and intergenerational impact of CHW positions that function as a mechanism for socioeconomic advancement through the provision of curative services. [community health workers, Guatemala, health promoters, Behrhorst]

Community health workers (CHWs) continue to be a central strategy in international and national health programs, yet the definitions and roles of CHWs vary widely over time, across national contexts, and even between programs operating in the same locales, creating a kaleidoscope of CHWs across time and space (Maupin 2011; Smith-Nonini 2010). While several large-scale studies compare CHW programs, focusing on variation in recruitment, training, and practice, the focus has been almost exclusively on national level programs in different countries at particular times (Gilson et al. 1989; Lehmann and Sanders 2007; Ofosu-Amaah 1983; Walt 1988). Although there is wide recognition that CHW programs are not static and instead change in relation to international policies, global health priorities, and national socioeconomic and political contexts and processes, little attention is paid to the evolution of CHW programs at the local level over time. As international agencies, national governments, and small-scale organizations revise and reimplement CHW programs over time, CHWs are interpreted within existing frameworks and expectations of the position established through previous programs and practitioners. As Kalofonos (2014) notes, detailed historical analyses of individual CHW programs and CHWs themselves are necessary in order to understand how they maintain continuity in their philosophy and practice or evolve in relation to changes within and beyond their communities.

In this article I address this issue by providing a case study of the Behrhorst Clinic health promoter program in Guatemala, one of the first and longest running CHW programs in the country. The Behrhorst program served as a model for community participation and development during the 1960s and 1970s and largely set the

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standard for CHW programs in Guatemala and the region. However, the philosophy, structure, and function of the Behrhorst program, as well as other CHW programs, has changed dramatically in response to larger socioeconomic and political processes as well as changes in the motivation and practices of CHWs. This longitudinal analysis of the Behrhorst health promoter program from the 1960s to the 2000s highlights central, ongoing issues of CHW programs in Guatemala and beyond, including: the political susceptibility of community participation and empowerment programs; community participation and representation; and the long-term and intergenerational impact of CHW positions that function as a mechanism for socioeconomic advancement through the provision of curative services.

The changing role of CHWs

Although emerging in several health and development programs since the 1950s, CHWs are most often associated with the Primary Health Care (PHC) initiative outlined in the Declaration of Alma Ata in 1978 (World Health Organization and UNICEF 1978). That Declaration offered a revolutionary paradigm in health care delivery that shifted the focus from modernization of health systems and vertical programs to a decentralized model based on community participation to identify and address local health concerns. Defining health as "a complete state of physical, mental, and emotional well-being and not merely the absence of disease or infirmity," PHC broadened the scope of health programs to focus on integrated development, including agriculture, education, and sanitation. Community participation is central to the PHC philosophy, and CHWs serve as the primary mechanism to facilitate this process, serving as the "bridge" between rural communities and health systems as they are able to introduce new ideas and practices in a culturally acceptable way while also connecting individuals to biomedical sources of care (Bender and Pitkin 1987). While characteristics of CHWs such as age and gender may vary widely depending upon particular context, the central notion of CHWs is that they are selected by their own communities and thus represent communal identity and will to address their own health needs (Lehmann and Sanders 2007; Newell 1975; Ofosu-Amaah 1983).

The Declaration of Alma Ata created a moral responsibility for low-income countries to implement PHC programs. For many countries, CHW programs offered the most economically feasible aspect of PHC while also not requiring changes in larger socioeconomic or political structures. Evaluations of national CHW programs during the 1980s demonstrate the limitations of many CHW programs, including infrequent supervision and training, lack of definition or scope of CHWs, lack of institutional support, and reliance on volunteerism (Gilson et al. 1989; Ofosu-Amaah 1983; Walt 1988; Walt et al. 1989). The debt crises of the 1970s and 1980s significantly affected national CHW programs, and structural adjustment programs reduced government investment in health and increased expectations of individual and communal contributions to health programs (Lehmann and Sanders 2007). While Mburu (1989) suggested that neoliberal reforms may reduce national interest in CHW programs, they have in fact increased in many countries, although there has been a general shift in the role of CHWs from advocates for social change to a technical and community management function (Lehmann and Sanders 2007).

Many scholars and activists, particularly in small-scale nongovernmental organizations (NGOs), have critiqued national CHW programs for limiting the level and forms of community participation. Rather than empowering communities to identify and challenge structures that contribute to poor health, many suggest that national programs restrict empowerment to the narrow sense of compliance, using CHWs as "lackeys" and effectively diverting communities' attention from the social inequalities that create health disparities in health (Green 1989; Werner 1981). In

contrast, Werner (1981) argues that CHWs should be "liberators," helping to free communities from exploitation and oppression. This social change model is heavily dependent upon the sociopolitical context in which CHWs act, however, and in many cases this type of activism has been heavily suppressed by military regimes (Barrett 1996; Green 1989; Heggenhougen 1984; Morgan 1987; Smith-Nonini 2010; Stark 1985). While some small-scale NGOs continue to work in this social change model, Lehmann and Sanders (2007) identify an increasing trend of NGOs using CHWs to address specific health issues, such as HIV/AIDS, maternal and child health, and malaria control. In these new models, CHWs serve as frontline medical workers, providing curative services as well as surveillance in rural communities.

In Guatemala, PHC has fluctuated in response to international and national processes. Prior to the Declaration of Alma Ata, the Ministry of Health (MOH) provided limited access to health care in rural areas, creating a space for small-scale NGOs to emerge to provide services to the majority indigenous population and many implemented CHW programs in the 1960s and 1970s. After the Declaration of Alma Ata, the Guatemalan government implemented a series of investments in rural health in the 1970s and 1980s, including the construction of over 600 health centers (Annis 1981). The government also created the rural health technician position and implemented a CHW training program during this time. Green (1989) criticized the MOH PHC program for limiting the role of CHWs to serving as points of referral to higher levels of care, thus increasing the reliance of communities on the state for curative services, diverting attention from social inequalities, and reinforcing the notion that biomedical care was the solution for suffering rather than social change. In 1997, the Guatemalan government implemented a new PHC program. CHWs continue to serve a central role in this system, serving as the primary point of referral between communities and higher levels of care. NGOs continue to operate CHW programs, although the nature and scope of their services have changed significantly over time in response to fluctuating international health policies, national economic and political strategies, and local contexts. This article addresses the continuity and changes in the role of CHWs in Guatemala by focusing on the Behrhorst Clinic. While there are several reviews of the Behrhorst Clinic (Luecke 1993; Muller 1991; Sorenson 1989), these studies focus on the history of the program from the 1960s to the 1980s. This study builds upon these previous studies by examining the continued shift in CHW identity and practice, particularly in regards to autonomy, in contemporary postwar context of Guatemala.

Methodology

This research is based on 14 months of fieldwork in the Department of Chimaltenango between 2002 and 2003, and is part of a larger project examining the history of community participation in health and development programs in the region (Maupin 2008, 2009, 2011). Former Behrhorst health promoters (CHWs) were recruited through the Behrhorst Clinic, where several continued to serve on the board of directors or hold other appointments in the Clinic. Clinic staff and former promoters also identified former health promoters in the greater Chimaltenango area no longer affiliated with the Clinic, whom I visited for interviews. These promoters in turn provided information to identify additional health promoters. Health promoters listed in previous literature and institutional documents not identified through snowball sampling were also identified and recruited. An attempt was made to contact and interview all health promoters identified throughout the Department of Chimaltenango. In total, I interviewed 19 Behrhorst health promoters who were trained between 1964 and 1989. Additionally, I interviewed the director of the Behrhorst Clinic, four staff members who worked at the Clinic as well as several individuals affiliated with the Clinic during this time period. Although I was

able to conduct only one interview with seven of the health promoters, I conducted multiple semistructured ethnographic interviews with 12 over the course of the research period. Interviews were conducted primarily in health promoters' homes or clinics, while interviews with Clinic staff were conducted at the clinic.

The Behrhorst health promoter

1960s–1970s

The Behrhorst Clinic was founded in 1962 by Dr. Carroll Behrhorst who came to Guatemala as a Lutheran medical missionary prior to moving to Chimaltenango, an area with limited access to biomedical services. The Behrhorst Clinic, which quickly grew to incorporate a small hospital, focused on providing culturally appropriate care to the approximately 200,000 inhabitants of the Department, 79 percent of which were Kaqchikel Maya (Hudgens 1977; Moore 1977). Diverging sharply from contemporary health models, the Behrhorst philosophy that emerged focused on the belief that improvements in health required changes in wider socioeconomic conditions. Moving from a focus on curative care, the Clinic revised its philosophy regarding health and development and reframed its strategic priorities to improve health as: social and economic justice; land tenure; agricultural production and marketing; population control; malnutrition; health training; and last, curative medicine (Behrhorst 1975:31). To achieve this, Behrhorst (1983:xxxii) argued that "the basic goal must be the empowerment of the people, particularly the poor . . . and this must mean the endowment of social and political power . . . " Central to this model of empowerment was the health promoter. Individuals serving as CHWs in Guatemala existed prior to this, as Catholic priests and catechists often undertook health promotion as part of their work, and Maryknoll nurses started a similar program of CHWs in the Western Highlands in 1963 (Behrens 2009; Cabrera 1995; Manz 1988). However, the Behrhorst program was first to develop a formalized CHW program in the area.

The first formal Behrhorst health promoter training program began in 1964. From an initial six participants, the program quickly grew to over 25 individuals, all of whom, with the exception of a few women who initially started as Clinic employees prior to this, were Kaqchikel men. While the idealized image of CHWs suggests that they are selected by their representative communities, none of these promoters were nominated or elected by their communities. Rather, they were recruited through various personalistic means, primarily through Peace Corps volunteers in the region and through Catholic priests who nominated catechists. These individuals were already involved in community development or religious programs and thus recognized as leaders in their communities, if not in their community then by external organizations. As one original promoter recounts, however, this type of personalistic nomination was not designed, but "was necessary" in order to gain access and community support in rural areas.

Another cohort of promoters was recruited between 1970 and 1971. This time Behrhorst (1975:36) stated that they had "learned better" and recommended that each rural community establish a community development committee that would not only nominate candidates for the program, but also supervise their work. However, Muller's (1991) evaluation of the program in 1978 suggests that of the 35 active promoters, all of whom were men, only ten were elected by community committees. The average education level for the promoters in both groups was fairly low, approximately third grade, although all were required to be literate, and the majority spoke both Spanish and Kaqchikel Maya.

Promoters received classes at the Behrhorst Clinic once a week for a period of one year before they were allowed to provide medical services in their communities. For curative medicine, promoter training focused on direct observation of patients in the Clinic's hospital.

This pedagogical technique facilitated diagnosis of disease, and prescription of treatment, by examining presenting signs and symptoms of real patients rather than theoretical cases presented in textbooks. While curative care was a central aspect of promoter training, it comprised less than half of the curriculum and was to be minimal in promoters' actual practice as it did not address the underlying causes of disease (Muller 1991:281). As such, promoters received training in "total community service," with courses in agriculture, livestock and animal husbandry, nutrition, public health education, and community organizing. Many promoters became actively engaged in these domains while awaiting their approval to practice medicine, and the majority continued participating in the training program after the required year.

After the year of training, promoters were required to pass a medical exam after which they received a diploma from the Clinic allowing them to practice medicine in their communities, which focused primarily on the establishment of a pharmacy and the provision of fee-for-service care. The legality of this certification was questioned by the MOH's local offices, and though promoters were restricted from administering medication with potentially severe side effects resulting from misdiagnosis, they were allowed to manage at least 60 pharmaceuticals as well as give injections (Muller 1991). Promoters purchased their medication through the Clinic, which established a medical cooperative run by the promoters in which the Clinic would sell the medication for their cost with a small 15 percent surcharge, and the cooperative then sold the medication to individual promoters at another 5 percent surcharge (Behrhorst 1975:39). Promoters then sold the medication to patients at a 10 percent surcharge, and were permitted to charge 25¢ for the consultation in 1978 (Muller 1991). Promoters did not receive a salary or assistance from the Clinic apart from their transportation fees for the weekly training programs, and their income associated with health promotion derived almost solely from their curative services

Consultations and the administration of medication became a central part of promoters' practice. As one promoter stated, this was "Because there was no doctor. We were the doctors in all the communities." Estimates of the number of patients seen by promoters range from 8,000 to over 35,000 a year for all of the promoters by the mid-1970s (Muller 1991:281–282), while Behrhorst (1975) estimated that each promoter saw an average of 1,000. This volume of patients represented a significant income, and Muller (1991:282) found that, among the eight promoters visited in 1978, the average salary was over $300 a month, ten times that of agricultural workers. Allowing CHWs to charge patients for consultations or medications is generally critiqued, as it incentivizes the prescription of pharmaceuticals, increases exploitation of impoverished community members, and diminishes interest in pursuing preventative health initiatives.

By 1978, many promoters began a process of self-examination and, fearing dependence on the Clinic, sought to establish independent organizations that continued and expanded Behrhorst's philosophy (Muller 1991:281). While promoters participated in NGOs that emerged from the Clinic focusing on agriculture and land tenure, they were also instrumental in the foundation of several autonomous programs including their own health promoter training programs. In 1977, there were 18 health promoter programs in Guatemala (Moore 1977), and the Behrhorst model served as the exemplar. Despite early conflicts, the MOH asked the Clinic to assist in training their own CHWs in the 1970s as it began to implement its own PHC programs in rural areas. At its height, the Behrhorst program had trained over 70 promoters in 50 communities throughout the Departments of Chimaltenango, El Quíche, and Sololá. As Muller (1991:283) states, of the 72 trained between 1964 and 1978, 40 continued to operate in 1978, a high rate of continuation for CHW programs, which he attributes not only to the economic incentives of curative medicine, but also to

these peoples' personal identification with the Behrhorst Clinic and program.

The role of promoters during this time, then, reflects the social change model of CHW outlined in the Declaration of Alma Ata, as many (though not all) balanced their practice of curative medicine with activism in integrated development programs and socioeconomic movements to address structural inequalities that create poor health in their communities. While curative services formed a central part of their work, and the economic incentive for continuation, many promoters extended the philosophy of the Behrhorst Clinic to organize their communities in order to critically analyze and address local and regional socioeconomic inequalities.

1970s and 1980s

The role of the health promoter, as with almost all aspects of Guatemalan society, was dramatically transformed during the height of the 36-year civil war that occurred from 1960 to 1996. The peak of the violence began during the Lucas García military regime (1978–1982), when mass killings replaced selective repression as government strategy. Massacres increased under the "scorched earth" campaigns of Ríos Montt (1982–1983), designed to destroy the physical and psychological support for the guerrillas by decimating rural Maya communities. By the end of the violence, nearly 200,000 individuals were killed, 83 percent of whom were Maya. The Commission for Historical Clarification (CEH) (1999) attributes 93 percent of the murders and disappearances to the national army or paramilitary forces, and 3 percent to the leftist guerrillas. Chimaltenango was one of the Departments most affected by the violence, due in part to the high proportion of Maya residents, geographical location, and the "rural awakening" in which rural communities began to question sociopolitical inequalities (Cabrera 1995; Davis 1988; Davis et al. 1983; Schirmer 1998).

The increase in government oppression stifled the growing development movement as development organizations and cooperatives became targeted by the military. For example, in 1981, Lucas García declared 250 active cooperatives illegal because of supposed "Marxist inspiration" (Davis 1988:22). In the Department of Chimaltenango, there were 313 registered nonNGOs in 1980. This number was reduced to 13 by September 1982, and the Behrhorst Clinic was one of two still functioning programs (Luecke 1993). Throughout the violence, the Behrhorst Clinic formally declared neutrality with the exception of allying itself with the poor, and vowed support for any health promoter who made the decision to continue. Between 1980 and 1982, 19 health promoters in the Departments of Chimaltenango and El Quíche were killed or disappeared. By 1986, only 15 of 47 promoters in the Chimaltenango area were living, forcing Behrhorst to ask the question "In training health promoters do we also destine them to die?" (Behrhorst 1993:89, 97).

The role and identity of health promoters during the violence is complex and resists any simple characterization. In a large part, promoters were persecuted by the military for their role as community leaders and organizers. As one promoter stated:

> All of the promoters stopped, because they said that every promoter in the communities was a guerrilla, because he was a leader. And so the army killed them, all they could. They killed my brothers, [others] left or died. . . . and they started to pursue us. But we were not guerrillas. We went to receive classes and we went to give them in the communities. It wasn't because we were guerrillas.

Another promoter, who started in the Behrhorst Clinic in 1963, similarly recounted:

> I was working in [a rural community] with a group of women. Someone took a picture of me with the women, during our talks about nutrition. We gave copies of the picture to some of the

> women in the community. But when [the army] started burning the villages, one of [the women] came to me, she found me, and told me that the army had my picture. They had the picture and were looking for all the women in the photo. Because we were organized.

Promoters were frequently accused by the military of supporting the guerrilla movement for practicing medicine in rural areas as well. Cabrera (1995) documents how the military restricted the amount and type of medication promoters were allowed to carry, confiscated books and medicine, and restricted the movement of promoters outside of their communities. Indeed, the book "Where there is No Doctor" was banned during this time (Muller 1991). Several Behrhorst promoters relayed similar stories of being stopped and searched by the military and their supplies occasionally confiscated.

While many promoters were neutral, itself a dangerous position, some promoters joined the guerrillas serving either as paramedics or actively taking up arms. As Cabrera (1995) notes, the guerrillas recognized the potential role of health promoters not only for their experience in community organization but also their recognition of the socioeconomic and political inequalities that influenced local suffering. Revolutionary ideology supported this questioning of the political system and attempted to use the identity of the health promoter as a representation of class, rather than ethnic, struggle (Cabrera 1995; Smith-Nonini 2010).

Of the 19 promoters I interviewed, only one explicitly stated that he joined the guerrillas during the violence. As he recounts, his decision to join the guerrillas was not only his training and work as a health promoter, but also additional training in liberation theology that he received from religious leaders and other organizations in the area. One of the most critical promoters of the Clinic during this time, he stated bluntly that "[Behrhorst] turned his back on the promoters. He turned his back on us," referring to the fact that Behrhorst failed to publically support the promoters in their cause with the guerrillas.

While the majority of the promoters who talked about the violence focused on the role of the military, some reframed the focus to the actions of the guerrillas:

> The promoters suffered during the violence. They suffered a lot. They were persecuted by the soldiers. The guerrillas attacked the promoters because they thought that when the promoters would gather the people in the villages for classes on nutrition, or health, or agriculture that the promoters were talking about the guerrillas. So they would go looking for the promoters. They would pursue them. The soldiers went through and burned the houses of the promoters and their fields and crops, leaving them with nothing. And then the promoters had to flee. And then lots of people in the communities died.

Support for the military among the promoters is uncertain, although the CEH (1999) identifies one Behrhorst health promoter as being a spy for the military during the violence. When I asked promoters about potential army spies in the Clinic, no one confirmed this and only stated that they had their suspicions of certain promoters but were not certain.

In addition to the military and guerrillas, promoters were subject to accusations deriving from personal and communal jealousies. In the highly polarized political context of the violence, accusations against promoters became a method through which personal grievances and aspirations for personal gain could be exacted through violence justified by the State (Davis 1988; Paul and Demarest 1984). The economic success of promoters as well as connection to external development programs often incited jealousies both within and between communities, which fueled some accusations of promoters supporting the guerrillas (Cabrera 1995). Communities that served the military by identifying insurgents were

often rewarded by receiving land titles previously held by those accused of being insurgents (Manz 1988), a practice that encouraged intercommunal conflict and often proved fatal for those accused. Additionally, in some cases communities blamed Behrhorst promoters for bringing violence to their community. As Stoll (1999) describes in his detailed account, many residents of Chimel, located in the Ixcan, suspected that their town was accused by the local landlord of associating with the guerrillas because one member, Victor Menchú, brother of Rigoberta Menchú, had a village pharmacy supported by the Behrhorst Clinic.

As a result of the violence, those promoters who remained in their communities had little alternative but to hide or reduce their work to curative care (Muller 1991:290). Behrhorst himself was forced to flee Guatemala due to death threats, leaving the Clinic in the hands of local staff. As the Behrhorst Clinic was forced to curtail nearly all of its social programs during the violence and focus primarily on curative care, the promoters became largely independent and "commercialized their knowledge" (Muller 1991:290). By 1981, the promoter program largely ceased to function as the Clinic, while remaining open, was unable to supervise the work of promoters. Promoters continuing to practice in their communities largely purchased their medications from private pharmacies, rather than the Behrhorst Clinic, and there was little contact between the majority of promoters and the Clinic during this time.

Other CHW programs throughout Latin America suffered similar fates during the 1980s, which called into question the feasibility of the PHC movement. As Heggenhougen (1984) argued, health care development in PHC requires, at its core, political and socioeconomic restructuring in most countries. In contexts of socioeconomic inequality and political instability, CHW programs presented a potential threat to the state because they encouraged communities to identify and address the social and economic factors that caused poor health (Heggenhougen 1984; Stark 1985). While the political violence against CHWs during the 1980s was due in large part to suppressing their role as "germs of change," violence against CHWs continues in contexts of political instability. As Closser and Jooma (2013) detail, female CHWs in Pakistan are victims of violence perpetrated not by the state, but antistate forces that link CHWs to state and international interests. Thus, in contexts of inequality and political instability, CHWs may be seen as targets by the state or antistate forces due to the very nature of their work in health promotion.

1980s–2000s

The return to civilian rule in 1985 created a space for aid organizations and development programs to restart work in rural areas. The Behrhorst Clinic continued in a limited fashion due to the decline of international funds and cessation of the majority of its extension programs. In 1987, however, former Behrhorst health promoters voted to restart the promoter program. Twenty original promoters reunited to join the program, while another ten who were active in 1981 declined to return to the Clinic. Another 14 individuals with no prior experience with Behrhorst also joined the program.

In their proposal, the promoters outlined the identity and role of the promoter in ways that reflected the previous model of Behrhorst promoter, while also adjusting certain aspects to reflect the postwar context. As detailed, the promoter's "primordial role is to prevent, more than cure, disease" and while they may cure common illness, they must know their limitations and refer patients to higher levels of care if necessary. The promoter is also to engage the community in integrated development projects in collaboration with local authorities, including agriculture, environmental sanitation, infrastructure, nutrition, public health, curative medicine, and health promotion. The criteria for being a health promoter also reflected the original model; between 15 and 50 years of age; literate in Spanish while also speaking the language of their community; be selected by their community; not have any

vices such as drinking or smoking; and importantly, not involved in any political party.

The proposal also outlined the promoters' requests for training and supervision in this revised program. Importantly, the promoters requested training in curative medicine provided in the old curriculum, including giving injections, solutions, and draining abscesses. They also specifically requested that the Behrhorst Clinic provide each of them with medical equipment, ranging from stethoscopes, otoscopes, blood pressure monitors, thermometers, scissors, bandages, and a copy of "Where There is No Doctor." Most urgently, however, the proposal requests that the Behrhorst Clinic provide them with a formal license, signed by representatives of the MOH, to sell medication and practice medicine, first for the old promoters with the new recruits receiving theirs after a year of training. Promoters reported that an official license would resolve many of the issues plaguing them in their communities, including conflict with the MOH and community accusations of exploitation or assisting the guerrillas. The promoters did not request any salary from the Behrhorst Clinic, but only assistance with their transportation. Promoters also requested monthly supervision by Clinic staff to monitor their practices.

After nearly two years of operation, the Clinic contracted an external evaluation of the promoter program in 1989, which at this time consisted of 18 promoters trained before 1981 and 19 who joined after 1987 (Sorenson 1989). In his evaluation, Sorenson emphasized the changing health care landscape in Chimaltenango and the ambiguous role of the Behrhorst promoter. By 1989, there were numerous private hospitals and clinics in the area as well as several alternative CHW programs, including the MOH's. In addition to a diverse set of CHWs, there was also an increase in individuals, particularly women, with auxiliary nursing degrees operating pharmacies in rural communities. Sorenson estimated that the Behrhorst promoters accounted for only approximately 2 percent of health promoters in the area and argued that they are not major drug suppliers in their community and do not fulfill an essential need in their communities as their practice is not directed toward the primary health needs of the community, specifically infant and maternal mortality.

More than this, Sorenson (1989) critiqued the disjuncture between the generalized model of CHW and the practice of Behrhorst health promoters, particularly their ambiguous legal status. As he notes, the international model of CHWs at the time emphasized their preventative role, providing health education in rural communities and serving as a point of referral to higher levels of care rather than providing curative services themselves. In the WHO model, CHWs can diagnose a set list of common diseases and administer a total nine medications, which does not include injections. The MOH's own model of CHW focused on preventative health and education, with limited curative training. In contrast, he notes that many of the older promoters have been practicing independently for several years, operating as "little doctors" in their communities and administering over 60 medications including injections, with no official legal status. While the 18 old promoters held an ID card as well as a diploma as "auxiliary nurse" from the Behrhorst Clinic, the new promoters were only issued the ID card yet still expected to operate as auxiliary nurses and provide curative services. The legal status of these diplomas and cards was uncertain, and the curative practices of promoters varied significantly from those outlined by the MOH. As such, Sorenson (1989) recommended that the scope of the Behrhorst promoters be redefined and brought into line with international and national models of CHWs, focusing on prevention and referrals, or the program should close.

The Behrhorst Clinic did not get to revise the program, however. By 1989 there was an internal division in the Clinic, during which time Behrhorst was removed from the board of directors and a rival faction took control of the Clinic. The internal conflict suspended all supervision of the health promoters and, as one employee at this time stated, "There

was confusion, the promoters didn't know where to go, with this group or the other." While the founders and original members of the Clinic eventually regained control of the Clinic, Behrhorst passed away in 1990, further deteriorating the administration and organization of the Clinic. While rebuilding in the early 1990s, the Clinic further reduced its work to curative services, leaving those promoters trained in 1987 without any supervision or continued training, which reinforced their autonomy and focus on curative services.

In 1994, however, the Clinic began another evaluation of the existing promoters with the goal of restarting the health promoter program. In a survey of existing promoters in Chimaltenango, the employee assigned this task summarized the experience as:

> I didn't find all of them. Some had died during the violence. Others were working on their own. And many had lost the objectives of their training here in the [Clinic]. . . . some completely changed their mission and vision, and were working as medics in their communities, charging their patients a lot, maybe taking advantage of them by charging exaggerated rates for the medicine . . . .
> I located about 8 or 10 promoters that returned for their training with us but since they had worked alone for many years they had formed their own system. They didn't permit the [Clinic] to supervise them, to evaluate them. Some had their own pharmacies in their houses. They had their own clinics. And so some didn't want to work with the [Clinic] anymore because it got in the way of the new work they had been doing, the lifestyle they had working as a health promoter.
> And so I kicked them out. I said, "these promoters are not following the teachings of Dr. Behrhorst. These promoters have dedicated themselves to exploiting their own people . . . ." [And] we didn't want them to stain the image of the [Clinic] with their purely personal attitudes.

The autonomy of the promoters and focus on providing curative services thus created a barrier for reinitiating the program. For while many promoters refused to relinquish their independence, the Clinic criticized the overemphasis on fee-for-service curative care as it contradicted the social change model of health promoter created in the 1960s.

The Clinic did initiate a new health promoter program in 1995–1996, with approximately 20 new candidates from communities not previously covered by Behrhorst promoters. However, due to a lack of external financing the program closed quickly. While some of the original promoters continue to interact with the Clinic, serving as board of directors members, the Clinic no longer provides any supervision or support for the promoters that it trained since the 1960s, leaving them largely independent and autonomous in their communities. Of the 19 promoters I interviewed in 2003, four continued to operate their own private pharmacies and offer consultations. As one promoter who started in the 1970s summarized:

> That is the history. And I am happy, then, because I am left with good experiences. And because of [Dr. Behrhorst], I am good. Not just me. The 45 of us that trained with the Doctor, all of us have improved. We all have a pharmacy. All of us have our pharmacy . . . . This was the idea to advance. Life doesn't want strength, it wants ideas.

For this promoter, the lasting impact of the health promoter position centers around the establishment and continuation of their personal pharmacies. Rather than physical strength or effort, the health promoter position offered an avenue for socioeconomic advancement through the implementation of new ideas and practices. Importantly, promoters' children have not pursued health promotion as

an occupation, but rather many have sought professional employment and education, with at least two becoming medical doctors. Part of the legacy of the Behrhorst promoter then is not only the short-term impact for the promoter, but also the intergenerational development facilitated by the socioeconomic benefits of the position.

Discussion and conclusions

While the history of the Behrhorst Clinic is unique, the experiences and transformations of the health promoters reflect larger patterns of CHW programs worldwide while also providing the basis for understanding contemporary CHW programs in Guatemala. Since the Declaration of Alma Ata in 1978, the CHW, with its link to concepts of community participation, empowerment, and democratization, has been a central feature of health and development programs. Changes in international policies, global health priorities, and national agendas continually modify the scope and role of the CHW, although there are few studies that examine the impacts of these changes on health programs or CHWs themselves over time (Muller 1991; Smith-Nonini 2010). The Behrhorst health promoter program provides a rare case study to demonstrate the evolving nature of CHWs under different socioeconomic and political contexts and highlights three important aspects in particular, regarding the introduction and change of CHWs in Guatemala and beyond.

First, the history of the Behrhorst Clinic demonstrates the political susceptibility of community participation and empowerment programs. Embodying the definition of empowerment that required the endowment of economic and political power to the poor so that they may express their demands on the system (Behrhorst 1975), Behrhorst promoters served not only to provide basic curative services to address primary health needs but also, in the Freireian sense, to facilitate the self-reflexive *concientización* of the population in which they question the social, economic, and political structures that create and reinforce inequalities, which manifest in poor health. The Behrhorst Clinic did not oppose the Guatemalan MOH or State. However, its focus on integrated development and social change raised awareness of the social origins of health, and also raised the profile of the Clinic, making it a potential target for ideological opponents.

The role of promoters as agents of social change directly contributed to their persecution during the violence. While many promoters did not engage in political struggles or take sides with either the guerrillas or military, their identity and practice represented the organization and empowerment of the rural Maya population, including not only self-reliance in improving their own health, but also education to recognize the inequalities reinforced by the social and political system that influenced disease and illness (Barrett 1996; Heggenhougen 1984), which the government feared (Cabrera 1995; Davis 1988; Davis et al. 1983; Manz 1988). For some promoters, this practice dovetailed with the leftist class-based ideology of the guerrillas, which viewed promoters as a mechanism for community organization and mobilization. Yet, the identity of the autonomous health promoter as a community leader, more than the actual link to the guerrillas, was justification for repression and nearly all promoters, regardless of political orientation, were subject to persecution (Stark 1985). Reducing their practice to the delivery of curative services within their communities thus became a survival tactic for those promoters who did not flee their communities.

In place of this model of health promoter, the Guatemalan MOH's CHW program focused on "empowerment" in the narrow sense of compliance as national CHWs served primarily as points of referral to higher levels of care. As Green (1989) argues, this model of PHC served as a means of generating "consensus" in rural communities by giving the appearance of state concern over rural health, while at the same time pacifying rural communities by diverting questions as to the social influences on disease while encouraging

biomedical explanations and cures for disease. While Behrhorst promoters did not join the MOH CHW program at this time, the impact of the violence forced those remaining in their communities to reduce their practice to the delivery of curative services as a survival tactic. This process thus further served to stifle questioning of the socioeconomic and political structures influencing health and transformed the position into one focused on providing curative services.

Second, the history of the Behrhorst health promoter program demonstrates issues of unequal community participation and representation. In the idealized PHC model, CHWs are to be elected by their communities in order to ensure that promoters represent the identity, felt needs, and will of the community; serve as a bridge to biomedical health services; and foster processes of democratization (Bender and Pitkin 1987; Maupin 2011). The extent to which this occurs is uncertain, however. Despite the emphasis in the 1970s that Behrhorst promoters would be elected and supervised by their respective communities, few promoters actually were. Rather, the first cohorts were primarily catechists, nominated by local Catholic priests and Peace Corps volunteers. As such, the selection of promoters reinforced existing power and authority structures in rural communities, and reinforced existing inequalities in participation (Maupin 2011), particularly the restriction of women in community development programs. While Kaqchikel women served key roles in the initial Behrhorst extension programs, and some continued to work as promoters through the 1970s, the position of health promoter was largely dominated by men. This pattern is a sharp contrast to other regions in Latin America, where the figure of CHW is ideologically linked to women's identity and practices (Ramirez-Valles 1998).

Along with this, rather than the unified homogeneous model of community presented in development programs, communities are the sites of constant struggles for power and authority as diverse actors with multiple agendas compete for the restricted access to external resources (Mburu 1989; Morgan 1987). While there is little discussion of community divisions in the 1960s and 1970s, community divisions heightened by increase in evangelical Christianity as well as introduction of new forms of community organization during the violence helped fuel accusations against promoters. In many of these accounts (Cabrera 1995; Stoll 1999), accusations derived not only from fears of assisting the guerrillas, but also from jealousies regarding promoters' increasing socioeconomic position relative to others in the community.

Third, directly related to this, the introduction of the Behrhorst health promoter introduced a new socioeconomic position in rural Maya communities that has continued to impact the expectations and practices of CHWs since. Prior to this, there were few opportunities for advancement in rural Maya communities with limited access to education and where a large percentage of the population migrated to coffee and sugar cane plantations. The health promoter position bypassed social, economic, and political structures to provide marginalized indigenous individuals in rural communities with access to education and training, which not only allowed them to establish lucrative curative services but also facilitated links to other organizations or opportunities. While the training in curative medicine, and thus ability to establish personal clinics and pharmacies, provided promoters with a new source of revenue that far exceeded other employment alternatives, the health promoter position served as a catalyst for activism among participants, fostering a synergistic process of social, political, and religious activism among some participants. The Behrhorst promoter program thus facilitated access to new external entities and sources of investment for community development programs, increasing the power and authority of promoters within their communities, and became a recognized avenue for socioeconomic development.

This social change aspect was a central part of the identity and status of promoters in the early period, however the impact of the

violence and subsequent reduction of services to curative care and sporadic institutional supervision largely redefined the position and set subsequent expectations for the role. By the late 1980s, Behrhorst health promoters were primarily independent providers operating private pharmacies and clinics. The failure to reimplement the program in the 1990s was due, in large part, to the autonomy of the promoters and resistance to institutional supervision or the restriction of their curative services. As one promoter suggested, the operation of a personal pharmacy was part of the lasting legacy of the Behrhorst program and a symbol of personal advancement.

This model of CHW, focused on curative care as a pathway for personal advancement, has significantly shaped community expectations of CHWs in Guatemala and individual motivations for participation, a factor that potentially creates conflict with other CHW programs. In 1997, the Guatemalan MOH implemented a new national PHC program (the Expansion of Coverage Program [PEC]) focused on improving access to basic health services in rural communities. CHWs are a central figure in this program, and by June of 2003 the MOH had recruited over 26,000 individuals to serve as CHWs throughout the country. The role of these CHWs, termed "health guardians or vigils," is largely restricted to serving as a point of referral to higher levels of care for individuals in rural communities lacking formal access to health services. As I have detailed elsewhere (Maupin 2012), this limited role, and particularly the inability to practice curative medicine, strongly influences participation and attrition in the national program. While research on motivations for participation in CHW programs in other areas suggest that individuals participate for the sense of community responsibility, to secure jobs, or receive access to formal medical education, motivations for participation in the Chimaltenango region of Guatemala focus largely on the hopes to receive training in curative medicine and establish personal pharmacies in the model of health promoters (Maupin 2012).

Yet, the extension of the PEC and introduction of the "health guardian" model of CHW challenged the authority and practices of established CHWs, in several ways (see Maupin 2012). First, while some small-scale NGOs continue to train promoters in the social change model and allow CHWs to provide a wide range of curative services, the number and impact of these programs has diminished as many NGOs collaborate with the government through the PEC, thus adopting the MOH's restricted model of CHW training. Second, the extension of the PEC and network of CHWs throughout Guatemala provided the MOH with greater supervision over health services in rural communities, particularly regarding the distribution of medication. Finally, the establishment of MOH CHWs who provide free, although limited, health services in rural communities present a potential challenge to promoters who provide fee-for-service care, and increased social and institutional pressure have caused some promoters to join the program and restrict their practices to preventative and referral services.

In the over 15 years since the PEC was expanded throughout Guatemala, the MOH model of CHW has become an established position within rural communities, existing alongside health promoters and other variants of CHWs. In 2014, however, the Guatemalan government began to dismantle the PEC, a process that continues through 2015. At the time of this writing there is no formal model for replacing the health services provided through the PEC or a method for addressing the tens of thousands of CHWs trained through the program. As such, the future of CHWs in Guatemala is uncertain. While the dissolution of the PEC structure, and subsequent reduction in MOH supervision, may provider greater space for established health promoters to practice curative medicine, it is not clear whether PEC-trained CHWs will also take advantage of this potentially temporary vacuum in institutional oversight to strive for more autonomy and establish their own pharmacies; whether they will seek new organizations for

additional training; or whether they will relinquish the role altogether. The strategies of CHWs will be diverse and will further complicate the kaleidoscope of CHW models and health providers in rural communities.

The existence of diverse models of CHWs within the same social space is not unique to Guatemala, and given the continual reinvention of CHWs to address specific health goals, this multiplicity of CHW types may be fairly common. The case of CHWs in Guatemala thus has several implications for contemporary programs, such as the One Million CHW initiative (Earth Institute 2011, Maes this volume). First, the rapid proliferation of a singular model of CHWs across varied geographic and sociopolitical landscapes potentially ignores or minimizes both the diversity of existing CHWs as well as local expectations of the position, which are rooted in historical experiences. Second, the mobilization of such large cohorts of CHWs demands greater attention to questions of sustainability, supervision, and support for the program and participants. Greater attention must be paid not only to institutional strategies for transitioning CHWs in the event of the program's end, but also to CHWs' own strategies to negotiate issues of autonomy and service delivery. As the case of the Behrhorst program demonstrates, there is a need for more ethnographic studies of the diversity and historical evolution of CHW models within a given social space in order to understand local expectations of the position, motivations for participation, and CHW practices. As CHW programs continue to gain favor in national and international health initiatives, there is a significant role for anthropologists to play in detailing the points of similarity and disjuncture between formalized models of CHWs and local realities, which strongly influence the nature and outcome of CHW initiatives.

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