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Preparing Promotoras to Deliver Health Programs for Hispanic Communities: Training Processes and Curricula

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Abstract

Training is an essential component of health programs that incorporate promotoras de salud (the Spanish term for community health workers) in the delivery of health education and behavioral interventions to Hispanics. During training sessions, promotoras are exposed to information and skill-building activities they need to implement the health programs. This analysis was one component of a broader study which explored program planners' approaches to recruiting and training promotoras to deliver and sustain health promotion programs for Hispanic women. The purpose of this study was to examine promotora-curriculum and training processes used to prepare promotoras to deliver health programs. The authors examined transcripts of 12 in-depth interviews with program planners and conducted a content analysis of seven different training materials used in their respective promotora programs. Interview themes and narratives included program planners' varying conceptualizations of promotora-training, including their personal definitions of "training the trainer," the practice of training a cadre of promotoras before selecting those best fit for the program, and the importance of providing goal-directed, in-depth training and supervision for promotoras. The content analysis revealed a variety of strategies used to make the training materials interactive and culturally competent. Study implications describe the importance of planners' provision of ongoing, goal-directed, and supervised training using both appropriate language and interactive methods to engage and teach promotoras.

Keywords

community health workers; curriculum; cultural competence; interviews; content analysis

Program planners working with Hispanic communities often engage community health workers (CHW), also known in Spanish as *promotoras de salud*, to deliver health education and promotion interventions aimed at reducing Hispanic health disparities (Ingram, Sabo, Rothers, Wennerstrom, & de Zapien, 2008). They recruit *promotoras* based on evidence of leadership skills, communication capabilities, and personal characteristics that reflect a high level of trust and respect within their communities (Jackson & Parks, 1997). The community health worker model is predicated on several interrelated concepts, including social networks, social support, participatory education, and community empowerment (Eng & Young, 1992; Israel et al., 2006; Satterfield, Burd, Valdez, Hosey, & Shield, 2002; Wallerstein, 1993; Zimmerman, 2000). The CHW model involves systematic training and

[1]**Note:** The Spanish term *promotora de salud* is the feminine form of the term *health promoter*. We opted to use *promotora* rather than the masculine *promotor*, given that this research focused on Hispanic women's health programs.

support of trusted and respected community members who engage in community outreach, participatory health education, and provision of social support to others within their personal and community social networks. The theoretical rationale is that CHWs contribute to community empowerment and social change as they engage community members in participatory education processes of consciousness raising, dialogue, and reflection (Freire, 1970/1974). In turn, the increased individual and community-level capacity building and empowerment contribute to improved access and utilization of health knowledge, resources, and services and to decreased health disparities (Forst et al., 2004, Ingram et al., 2008; Lujan & Dean, 2009; Persily & Hildebrandt, 2003).

For program planners working with Hispanic populations, *promotoras* are often seen as an important resource for the provision of culturally and linguistically appropriate services (Catalani, Findley, Matos, & Rodriguez, 2009). The federal Culturally & Linguistically Appropriate Services (CLAS) guidelines include 14 specific standards aimed at reducing health disparities in ethnic minorities (U.S. Department of Health and Human Services, 2007). These CLAS standards address the need to hire, train, promote, and retain staff who are ethnically representative of the target population (e.g., *promotoras*) as part of organizational efforts to enhance cultural and linguistic competency across the spectrum of service delivery (U.S. Department of Health and Human Services, 2011).

Strategies for enhancing the cultural appropriateness of health programs and materials include attention to evidential, linguistic, peripheral, sociocultural, and constituent-involving strategies (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). Evidential strategies provide evidence-based data, such as statistics and census data. Linguistic strategies involve using the target population's preferred language and using written and verbal language appropriate for the audience's educational and literacy levels. Peripheral strategies involve tailoring program aesthetics to the target audience's preferences (e.g., selecting color schemes based on target population's preferences). Sociocultural strategies pertain to identifying and incorporating sub-population's cultural values, attitudes, and beliefs within the health programs and program materials (e.g., incorporation of religious values or family involvement). Finally, constituent-involving strategies include working with members of the target population to help create and implement elements of the health program. The constituent-involving strategy of working with *promotoras* enhances the linguistic and, moreover, cultural competence of health programs.

In the United States, there are no national standards or recommendations for CHW-training competencies (Matos, Willaert, & Rosenthal, 2007). In states with CHW certification guidelines or requirements, training standards and competencies vary according to health focus (e.g., general health, disease specific), evaluation techniques (e.g., test, observed evaluation), and the organization hosting the training (e.g., community college, state-level agency; Kash, May, & Tai-Seale, 2007). The broad aim of training is to prepare *promotoras* with the necessary health-related information and skills critical for delivering community health programs (Jackson & Parks, 1997). Training also serves to cultivate social relationships among the *promotoras* and with health care team or project staff members (Matos, Rodriguez, Findley, & Catalani, 2009, Yu et al., 2007). Common recommendations for *promotora*-training components include practicing team building, enhancing interpersonal communication skills, and learning about the complexities of modifying health behaviors (Metzler et al., 2003; Pieper, 2008). Some *promotora* programs employ a train-the-trainer or peer educator approach to empower community members to deliver health outreach within their social networks (Reinschmidt et al., 2006, Wasserman et al., 2006). The train-the-trainer model, based on theories of adult learning and diffusion of innovations, is used in a wide range of community and professional education settings (Hill, Palmer, Klein, Howell, & Pelletier, 2010).

Despite the widespread use of CHWs, there is a dearth of information regarding the actual CHW-training practices. In a systematic review of CHW interventions, Rhodes, Foley, Zometa, and Bloom (2007) found that researchers inconsistently reported important training information. Similarly, in their analysis of CHW publications, O'Brien, Squires, Bixby, and Larson (2009) found that only 59% of the articles contained any information regarding the CHW-training processes. They noted the lack of specific information necessary for evaluation and replication (e.g., length of training, components of training sessions and training curriculum, and activities used to reinforce program information to provide health care within their communities) and suggested standardizing selection and training procedures to encourage “mainstream acceptance [of CHWS] into the healthcare workforce” (O'Brien et al., 2009, p. S267).

The aims of this research were to explore how program planners train *promotoras* to deliver health programs to Hispanic communities and to examine the curricula used in the *promotora* training. Examining the training procedures and materials is important because it may be associated with both *promotoras'* effectiveness in delivering the health programs and the program's overall effectiveness (National Training Center for the Prevention and Early Detection of Cancer, 1998).

Method

Using a primarily qualitative mixed-methods approach, we explored and evaluated program planners' *promotora*-training perspectives, procedures, and materials. Triangulated methods provided a more complex understanding of *promotora* training (Lindlof & Taylor, 2002). We conducted in-depth interviews to elicit planners' insights regarding *promotora* training while simultaneously collecting sample training materials and performing a content analysis to identify the type of information and skill-building activities planners used to train their program's *promotoras*. This systematic examination of *promotora*-training procedures and their training curricula will further understanding of the intent, mechanisms, and processes of *promotora* training and may eventually lead to the more comprehensive evaluations of the effectiveness of *promotora* preparation and capacity-building approaches. The research received approval from the University of South Carolina Institutional Review Board.

Sample of Participants and Training Materials

We identified and recruited a purposeful convenience sample of program planners involved in U.S.-based *promotora*-delivered health programs for Hispanic women and their families. Collectively we developed a list of potential participants through professional contacts, the literature, Internet searches for *promotora*-led evidenced-based interventions, and snowball referrals from other program planners. We intentionally recruited participants from diverse geographic regions, serving a wide range of Latino ethnic groups in differing program settings and organizations. The initial sampling frame consisted of 65 potential participants. The first author contacted each of these potential participants via phone and e-mail to invite them to participate in the study. A total of 24 individuals agreed to participate in an in-depth telephone interview.

At the time of the interview, we asked program planners to provide us with a copy of the *promotora*-training curriculum for review; 12 planners (50%) submitted the program training materials. In this analysis, we report findings from the interviews with these 12 participants.

Interview participants included programs' program directors, program managers, *promotora* trainers, and researchers. Organizations hosting these programs included universities (n = 4), community-based organizations (CBOs; n = 1), university–CBO collaborations (n = 4),

federally qualified health centers (FQHCs; *n* = 2), and a statewide government-run public program (*n* = 1). Program and curricula topics included general health, osteoporosis prevention, overweight and obesity reduction, cardiovascular health, nutrition and physical activity for parents and children, and general women's health (*n* = 2).

In-Depth Interviews With Program Planners

This analysis was part of a larger study in which we interviewed program planners about how they conceptualized the role of *promotoras* and recruited, selected, and trained these CHWs to deliver and sustain health programs. We conducted in-depth phone interviews that lasted approximately 30 to 90 minutes (average of 60 minutes) between June and September 2010. Interviews were transcribed into a Word document, and participants' identifying information was removed from the data. The qualitative analysis process involved open and focused coding, constant comparative analysis, and thematic analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Three researchers read and individually coded the same three interview transcripts and met to compare open codes (e.g., skill-building activities) and themes (e.g., “train the trainer”) before the first author created an initial codebook. The first author reread and recoded transcripts and compared, merged, and desegregated codes, expanding the initial codebook to include open and selective codes and then proceeded to code and recode all transcripts and develop the initial thematic analysis. This analysis focused on interview responses pertaining to *promotora* training.

Content Analysis of Promotora Training Materials

Five planners submitted the same curriculum, resulting in a sample of seven separate curricula for the content and readability analysis. Of the training curricula, six were in English and one in Spanish (Table 1). Training materials varied in length, amount, and type of information presented in curriculum chapters and in format. Three of the training materials were sent via portable document format (PDF) or data CD-ROM. Three of the curricula were printed, bound documents, and the last curriculum was a *promotora*-training program manual (book). The most common organizational format was the presentation of a health lesson followed by group learning activities or group discussions.

The content analysis of *promotoras'* training materials was primarily qualitative; however, some quantitative methods were employed to analyze the materials' readability levels. We used a preliminary coding scheme based on the five strategies to enhance health programs' cultural competence identified by Kreuter et al. (2003). Materials were also examined for format, written content, and skill-building activities. To code the curricula, the first author read and qualitatively coded/recoded all training materials three times and also calculated the texts' readability levels manually using the Simple Measure of Gobbledygook (SMOG; McLaughlin, 1969) and Fry Method of Readability (Fry, 1968) for English language materials and with the SOL (standards of learning) formulas for Spanish-language materials (Contreras, Garcia-Alonso, Echenique, & Daye-Contreras, 1999). Methods for calculating readability with these formulas are reported elsewhere (Contreras et al., 1999; Friedman & Hoffman-Goetz, 2006).

Results

In the following sections, we present the findings by methodology, first discussing the qualitative analysis of the interviews and then the content and readability analysis of the training curricula.

Thematic Analysis of Interviews With Program Planners

We identified several major themes within the program planners' interview narratives. These included the planners' philosophies, processes, and logistics to training *promotoras*; the characteristics of trainers and training leaders who instructed *promotoras* on how to deliver the program; the order of training and selection of the *promotoras*; the need for supervised, ongoing training sessions; and the types and format of training materials used (e.g., set curriculum, conferences).

Training the trainer: Identifying training leaders—Health program planners' narratives reflected a wide range of conceptualizations and applications of *promotora* selection and training practices. For example, some participants trained a cadre of community members using the health program's materials before they selected the best fit applicants to serve in their program. They viewed the free training sessions as a community service to individuals interested in learning about the health-related topic. Meanwhile, these trainings allowed participants to observe *promotora* candidates and select those who best exemplified the necessary leadership, communication, and program-related skills to carry out the program. Once selected to serve as the program's official *promotoras*, a more in-depth, ongoing, goal-directed training using culturally competent training materials and skill-building activities followed. Most participants reported they employed some type of train-the-trainer strategy in their approach to *promotora* preparation. A common practice among some programs was to include existing *promotoras* along with professional staff in the training of future *promotoras*, who, in turn, delivered the health program content to the intended community audience:

> The *promotoras* had the responsibilities to train since this has always been a train-the-trainer model. So, other promotoras would work with the professional team to train these new *promotoras* as well. (University)

However, in other programs, the *promotora* training was the exclusive purview of the professional team members, and *promotoras'* role was restricted to delivering the program to the community:

> I conducted most of the trainings. It was my responsibility. Or, at the very beginning there was another nurse, also a Spanish speaker, who trained the *promotoras*. We trained the trainers. (FQHC)

Order of promotora training and selection—The data indicated various approaches to selection and training, where some participants preselected *promotoras* prior to training and others invited potential candidates to a training prior to selecting the actual *promotoras*.

Other program coordinators selected *promotoras* before training them for the program. They screened and selected *promotora* applicants based on personal characteristics such as willingness to learn and passion to serve the community before they invested time and money into training them. Therefore, training was not intended only to be a community service; it also served as training for their position once they had been selected.

Training logistics—One area of consensus among the diverse program planners was the need for ongoing, supervised training and support over time. To adequately equip *promotoras* with the necessary skills and knowledge to conduct community health programs, planners provided ongoing training over time. As one CBO-based participant described it, “CHW training never ends. The *promotoras* always need to be being fed with more knowledge and with more information through more training.” Other participants discussed the importance of supervision during trainings to ensure that *promotoras* were correctly practicing the knowledge and skills learned during the training sessions:

> Our *promotoras* are always supervised. I think that is the key, supervision. There should not only be adequate training of *promotoras*, but there should also be adequate supervision for re-training. (University–CBO)

Goal orientation and evaluation were evident in planners' concerns about having specific training goals and objectives that enabled them to subsequently evaluate the effectiveness of the training in terms of *promotoras'* abilities to deliver the program or intervention:

> It should be a comprehensive training that is very ecological, contextual … and have a set of goals and objectives. The training should definitely have specific outcomes that planners and promotoras want to achieve. (University)

Training formats and materials—The training delivery formats varied among the 12 programs, with some programs adopting a single set curriculum and others using a combination of various training materials and curricula. Examples of the diverse formats and approaches included handouts and other print materials, PowerPoint slides, videos or DVDs; role-playing activities, and attending conferences. One participant described using a variety of formats appropriate for the *promotoras*' educational and literacy levels:

> We use a combination of adult learning techniques. But it was specifically for the target population. You are looking at a population with a very low literacy level or reading level. So, we chose a format that is very interactive. (CBO)

Training materials needed to include interactive techniques that could enhance *promotoras'* skills in delivering the program. The most commonly reported interactive skill-building activity was role-playing:

> Our training has a lot of skill building activities … lots of role-playing. We teach them [*promotoras*] how to deal with things that will come up within their classes or programs … what to expect. So I think they start with a framework, the curriculum, and practice leadership skills they need to teach the program through role-playing. (U-CBO)

Findings From Content Analysis of Training Materials

In the content analysis, we examined training materials for evidence of strategies to enhance cultural competence (Kreuter et al., 2003). Specifically, we examined the evidential, peripheral, sociocultural, and linguistic strategies used in planners' *promotora*-training materials (Table 2).

Cultural competence strategies—All training materials contained evidential strategies in their text. However, curricula varied in their use of the remaining three strategies. Evidential strategies included health statistics, facts, and references for health information. Peripheral strategies included the curricula's photographs and graphics of Hispanic women and their families, illustrations of Hispanic cultural items (e.g., Hispanic foods), vibrant colors throughout the text, spacing (whitespace), illustrated recipe books, *fotonovelas* (photo stories), and colorful flash cards to aid in learning program materials. Most materials contained sociocultural strategies that emphasized family involvement in the health program or in health decision making. The obesity-related program taught participants how to make cultural foods using low-fat ingredients. Two program curricula targeted cultural norms about diet and exercise (e.g., identifying common barriers to physical activities).

Linguistic strategies included use of Spanish-language text for one curriculum and use of plain language and easy-to-read vocabulary in some materials. One curriculum was written in Spanish only; however, it was written at a Grade 17 (college) reading level (difficult readability). Another (used in five different programs) was presented in both English and

Spanish formats and had the lowest readability levels as compared with the other training materials (SMOG = 9th grade, Fry = 7th grade). According to the readability testing conducted, training materials varied in reading difficulty level (see Table 1) from 7th grade to college level (15th grade) using the Fry readability graph and from 9th grade to college level (16th grade) using the SMOG and SOL readability calculations.

Constituent-involving strategies were interactive skill-building activities identified within the training curricula. These included group brainstorming, role-playing, small group discussions, individual goal-setting and problem-solving activities, and health-related games and demonstrations. Exercises intended to enhance *promotoras'* communication skills included conflict resolution activities, leading small group sessions, active listening activities, and using positive reinforcement. One training manual (FQHC) included instructions on how to deliver clear messages, adapt curriculum for different audiences, be open and non-judgmental to others' opinions, and share stories. Three training materials also included information regarding how to recruit and maintain program participants, provide social support, and encourage program participation.

Discussion

Initial training and ongoing support provides the basis for how *promotoras* deliver health programs and communicate health-related information to Hispanic women and their families. Without adequate and appropriate training, *promotoras* may not acquire the necessary program-related information and skills, thus affecting their ability to deliver the health program. To address the gap in research related to *promotora* training, we conducted in-depth interviews with *promotora* program planners and a content analysis of their training materials (O'Brien et al., 2009; Rhodes et al., 2007). Interview results identified planners' preferences for who should lead *promotora*-training sessions, logistics to leading the sessions, and the type of activities that should be used in trainings.

An interesting finding was that planners differed in their approach and use of the train-the-trainer method. Planners who adopted the train-the-trainer approach considered the *promotoras* as a resource and capitalized on their ability to train other community members to replicate the health education and outreach efforts (Persily & Hildebrandt, 2003). The opportunity to advance to the position of *promotora* trainer has implications for *promotora* career mobility. An important area for further research is the comparison of *promotora*-training outcomes based on the type, level, or qualifications of the trainers (e.g., current or former *promotoras*, health professionals, or others).

Consistent with past research, participants believed that training sessions should be ongoing, supervised, and goal driven to ensure that *promotoras* were correctly adapting the program to their audience, thereby preserving the program's integrity (Jackson & Parks, 1997; Nastasi et al., 2000). Participants also emphasized the use of role-playing activities as the predominant method to enhance *promotoras'* program-related skills, which is consistent with other research describing *promotora*-training activities (Hansen et al., 2005). In addition to role-play activities, the curricula used in training *promotoras* included a number of other interactive educational approaches. Future research could examine which type of training activities are most effective in enhancing *promotoras'* program-related knowledge and skills.

Using culturally sensitive health materials enhances *promotoras'* health-related knowledge and self-efficacy to lead health programs (Yu et al., 2007). All materials we examined employed evidential strategies to convey health-related facts and information related to the program. However, the degree of use of peripheral and sociocultural strategies varied. It is important for *promotora* trainers to use various strategies in their training materials and their

training sessions to enhance the target population's credibility of the information and comfort using the materials (Kreuter & Haughton, 2006; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

Planners' described using training materials written at lower reading levels as an intentional strategy to enhance *promotoras'* understanding reflected application of the principles of matching materials to the reading level of the target audience (Stableford & Mettger, 2007). Past research recommended writing health materials at a fifth- to sixth-grade level (Meade McKinney, & Barnas, 1994); however, the content analysis of the *promotoras'* training materials revealed that more materials were written at a high school or college reading level. Depending on the *promotoras'* literacy levels, the materials may have been too difficult to comprehend, which may have negatively affected the program if those teaching the information did not understand the health-related content. Program planners and *promotora* trainers should gauge the health workers' understanding of the health materials prior to their delivery of the health curriculum.

Limitations

This study was conducted with a relatively small convenience sample, and the findings cannot be considered representative or comprehensive. We included only 12 of the 24 interviews from program planners who submitted their curricula for review. As a result, program planners in states that require promotoras to be credentialed were excluded from this analysis. The sample included only those training curricula submitted by interview participants and was overrepresented by university and university-CBO–based program planners. The readability assessment was limited by the utilization of a select number of readability instruments to evaluate the reading level of the curricula. Readability instruments rely solely on word/sentence count and number of polysyllabic words to determine reading difficulty and do not consider images and layout, which may be associated with readability and people's comprehension of information (Friedman & Hoffman-Goetz, 2006).

Conclusions

Training is a crucial element of *promotora* programs because it prepares such community workers to deliver health programs to populations who may have no other form of health care (O'Brien et al., 2009). This study explored training activities and curricula to better understand the training processes. Study findings suggest that before the training sessions commence, planners should measure training materials' language and readability levels and pilot test the curriculum with the *promotoras* to ensure that they understand and feel comfortable teaching the material to program participants. After the initial training, researchers could examine the relationship between trainers and *promotora*-training knowledge and skill-related outcomes to identify any differences on training outcomes based on who led the training sessions. Researchers could also examine which skill-building activities best prepare *promotoras* for delivering health programs. After the initial *promotora* training, program planners should provide feedback and offer further, supervised training to *promotoras* to support and enhance their skills to deliver health programs (Centers for Disease Control and Prevention, 1998). This may, in turn, enhance their ability to teach participants how to prevent and manage chronic and life-threatening diseases (Stableford & Mettger, 2007).

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Table 1

Information on Study Programs and differences between Programs that did and did Not Provide training Materials for Review

Program Focus	Organization	Geographic Region	Language
Provided training materials			
Type II diabetes	U-CBO	Southwest	Bilingual
Type II diabetes*	U-CBO	Southwest	Bilingual
Type II diabetes*	U-CBO	Midwest	Bilingual
Type II diabetes*	U	West	Spanish
Type II diabetes*	U	Southwest	Spanish
Obesity/weight management	FQHC	West	Spanish
General women's health	U	East	Spanish
Family health/wellness	U	West	Bilingual
Family health/wellness	U-CBO	Northwest	Bilingual
Cardiovascular health	CBO	East	Bilingual
Osteoporosis	Government	West	Bilingual
Did not provide training materials			
Health literacy	CBO	Midwest	Spanish
Family health/wellness	U	Southwest	Bilingual
Obesity/weight management	CBO	Southwest	Spanish
Cardiovascular health	Hospital	Southwest	Bilingual
Obesity/weight management	FQHC	West	Spanish
Type II diabetes	CBO	Midwest	Spanish
Type II diabetes	CBO	West	Spanish
Obesity/weight management	CBO	Southeast	Bilingual
Family health/wellness	Hospital	West	Spanish
Obesity/weight management	CBO	Southwest	Bilingual
Obesity/weight management	CBO	Southeast	Spanish

NOTE: U = university; CBO = community-based organization; FQHC =federally qualified health center.

*Signifies the use of the same training curriculum.

Table 2

Culturally Competent Elements of Seven *Promotora*-Training Materials

		Program Curriculum (Total number of Strategies[0-5]per Curriculum)						
Strategies to Enhance Cultural Competence (Kreuter et al., 2003)	**Elements of the Training Curricula**	**A (3)**	**B (4)**	**C (2)**	**D (5)**	**E (5)**	**F (4)**	**G (5)**
Evidential	Provide history of role of *promotoras*	✓						
	National statistics about health topic		✓	✓	✓	✓		✓
	Contact information for health professionals	✓		✓			✓	
Linguistic[b] (readability levels)	Fry: mean = Grade 10.5 (for English)	15	14	10	8	7	9	
	SMOG: mean = Grade 11.8 (For English)	16.9	15.0	12.2	10.1	9.7	11.0	
	SOL: Grade 17.1 (for Spanish)							17.1
Peripheral	Photographs, graphics, and illustrations	✓	✓	✓	✓	✓	✓	✓
	Vibrant colors	✓	✓		✓	✓	✓	✓
	Spacing (white space)		✓				✓	
	Fotonovelas (photo stories)						✓	✓
Sociocultural	Emphasize family involvement		✓			✓	✓	
	Hispanic food cookbook				✓			✓
	Target diet and exercise cultural norms				✓	✓	✓	
Constituent involving	Role–play	✓	✓			✓	✓	✓
	Practicing conflict resolution strategies		✓			✓	✓	
	Leading small discussion groups	✓	✓			✓	✓	✓
	Sending clear messages	✓						
	Receiving constructive criticism	✓						
	Active listening practices	✓					✓	
	Use of learning games (Bingo)	✓			✓		✓	✓
	Using visual aids	✓						
	Adapting curriculum to audience	✓	✓					
	Being open and nonjudgmental	✓						
	Recruiting and maintaining participants				✓			✓
	Providing social support				✓			
	Encouraging participation	✓					✓	

NOTE: SMOG = Simple Measure of Gobbledygook; SOL = standards of learning.

[b] For linguistic strategy, we examined text readability level of the training materials using three readability instruments. We analyzed the six English-language training materials (A-F) using the Fry method and SMOG and the Spanish-language curriculum (G) using the SOL. We also counted any material written at a 10th-grade level or below as a "linguistic strategy" for the total strategies used count.