



## Neighbors United for Health

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### ABSTRACT

*Modeled upon the ecclesiastic community group concept of Latin America to unite and strengthen the bond between the Church and neighborhoods, a community-based organization created Vecinos Unidos por la Salud (Neighbors United for Health) to bring health messages into urban Latino neighborhoods. The model is based on five tenants, and incorporates Latino subjective norms to strengthen the bonds of group members with similar interest, lifestyles, language and acculturation.*

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### INTRODUCTION

The Latino population remains the fastest growing segment of the U.S. population.<sup>1-3</sup> As Latinos become assimilated; their lifestyles, food choices and related behaviors impact their health status. Latinos comprise a culturally, demographically and geographically diverse population, including persons of Central and South American, Cuban, Dominican, Mexican, Puerto Rican, and Spanish descent. The U.S. Census reports that Hispanics are the largest minority group.<sup>4</sup>

Community health promoters (*promotores*) are increasingly providing services for health organizations because of their unique ability to link the Latino community with health care services. The literature supports the unique role of *promotores* in amplifying community care networks, giving social support and education to community members, assisting access to care and stimulating communities to action.<sup>5-10</sup>

Integrating *promotores* into a community based prevention program for Latinos is typically successful because *promotores* come from similar backgrounds as the target population. They are neighbors, siblings, parents or friends who speak the same language and know the culture. After undergoing training

and relying on evidence based programs, *promotores* can be used effectively in clinics and community organizations, including churches and ethnic clubs, to share health information using informal chats (*charlas*) in their own language and within the context of their familiar surroundings.

*Promotores* and *charlas* are rooted in the Latin American culture, especially among neighbors within small towns and villages in the region. Drawing on the strengths of the Latino culture, small ecclesiastic community groups (*Comunidades Eclesiales de Base*) came out of the religious movement in Latin America to keep the Church alive and flourishing as liberation theology opened the doors of the Church to the poor and oppressed. Neighbors were encouraged to meet in small groups, usually comprised of extended family and neighbors, to pray, reflect on a spiritual reading and share their daily life events.

### DEVELOPING A MODEL FOR REACHING UNDERSERVED LATINOS

Modeled upon the ecclesiastic community group concept to unite and strengthen the bond between the Church and neighborhoods, a local community-based organiza-

tion created *Vecinos Unidos por la Salud* (Neighbors United for Health) to bring health messages into urban Latino neighborhoods. The *Vecinos Unidos por la Salud* model is based on five tenants. The model: (1) is driven by the local community and guided by a bottom-up/top-down approach, (2) utilizes evidenced based health education programs, materials and trainings, (3) has trained *promotores* and group leaders who serve as program champions, (4) empowers groups to organize themselves, and (5) ensures a consistent structure among groups. The model also incorporates Latino subjective norms to strengthen the bonds of group members with similar interest, lifestyles, language and acculturation.<sup>11</sup> As program champions, trained *promotores* and leaders

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from within the neighborhood encourage participation and disseminate culturally appropriate health messages in Spanish. This paper describes the basic tenants of the model and discusses one community-based organization's experience implementing the model.

### A COMMUNITY DRIVEN CONCEPT

A chronic disease prevention program successfully met its goals and objectives by using *promotores*, *charlas* and the *Vecinos Unidos por la Salud* model. The community-based organization had previously employed *promotores* to provide health classes in clinics, churches and clubs. Success rates were acceptable, yet feedback from attendees and *promotores* indicated that there was a lack of family orientation due to the setting and environment. At the suggestion of the community, *promotores* began to host groups in their home or the homes of participants. Within a short period of time, dropout rates decreased and the number of participants increased. *Vecinos Unidos por la Salud* groups often included immediate and extended families and close friends who previously met to chat about various topics before being "formally" made into a group. For the participants, the group was not new, but rather gave new meaning to coming together and a centralized theme to drive meetings. Once the group recognized that they had been "formalized," a *promotor* employed by the community-based organization explained the benefits of coming together to discuss health topics. The *promotor* was introduced as the *orientadora en salud*, which implies that the person not only promotes health but also provides information, guidance, leadership and trust to move the community to become oriented towards a healthy lifestyle.

In this new *Vecinos Unidos por la Salud* partnership, groups were responsible for assessing the needs of members and organizing groups while the community-based organization was responsible for providing training for leaders and the necessary resources and materials. Thus, from its inception, *Vecinos Unidos por la Salud* was driven by a bottom

up approach, while being informed and guided from the top down.

### AN EVIDENCED-BASED PROGRAM

With a strong foundation in evidence-based practice, the community-based organization promoted curriculum proven effective in improving health outcomes for use in this program. Evidence-based programs have been shown to be effective through research, are often easier to implement, typically have instructions on the application and can avoid the cost and error of developing assessment tools. Thus, evidence-based manualized curricula and programs for use with chronic illness in small groups were used to guide *Vecinos Unidos por la Salud* groups. Group leaders and *orientadora en salud* were trained to implement these programs in their groups.

### A TRAINED LEADER

Identifying a key group leader was important for the sustainability of *Vecinos Unidos por la Salud*. The leader was a volunteer, yet they benefited from the experience and knowledge gained from working with the organization. Additional training was encouraged (i.e., Red Cross, YMCA) to support their self-esteem and knowledge base when presenting with the *orientadora en salud*. The group leader was someone known by all group members, likely a leader among them in the past, and knew enough about participant's health history to focus on personal and meaningful discussions.

The relationship between the leader and the *orientadora en salud* was important since the program drew its strength from their unified roles as leader and educator. All leaders and *orientadoras en salud* met monthly with the community-based organization for training, giving group leaders the opportunity to interact with other leaders and to see what each group was doing. New health topics that were relevant, community driven and focused on current issues were discussed. Training material was reviewed, and the integration of skits, songs and other tools were created or shared at monthly meetings.

Disseminating health information to the community followed a sequential process. First, the neighborhood groups discussed their interests and topics they wished to learn more about. The leader and *orientadora en salud* then met with the community-based organization's health educator to discuss the feasibility of obtaining health information on the topic and the availability of evidence based programs to guide the group. At the next monthly leader meeting, the new idea was shared. If there was interest, the community-based organization either purchased training material or developed it, and leaders and *orientadoras en salud* were trained in the health topic and prepared to present with their neighborhood groups.

### Organizing a Group

A truly community driven intervention, all aspects of the group (i.e. location, number of participants, leader, time, agenda) were organized by the group, themselves. Many groups rotated meetings from home to home, a practice encouraged because it gave each member the opportunity to be host. Group size varied from five to 15. However, experience showed that the greater the number, the harder it was for the group to start and finish on time. Meetings were run by the leader with assistance from the *orientadora en salud*. To prepare for the meeting, the *orientadoras en salud* and the leaders met regularly to discuss new topics, select tools, complete assessments, meet with the community-based organization and community partners, and to discuss concerns.

### A Consistent Structure

In keeping with the tenants of the model, groups followed a consistent structure. Meetings typically began with an opening ice-breaker—exercise, dance, or other activity decided upon by the group and informed by the topic. This led directly into a 45-minute health lesson presented as a *charla*. The lesson was direct, factual and supported by evidence-based materials. Handout information was available. To wrap up the meeting, a healthy snack was provided by the group leader. While at times, the prepared food was not always considered healthy,



this provided a “teaching moment” for the *orientadora en salud* and often a transition in types of food served occurred. Group meetings were kept under one-and-a-half hours: 15 minutes for the opening exercise, 45-60 minutes for the lesson, discussion and questions, and no more than 15 minutes for the snack and socializing.

### LESSONS LEARNED

The *Vecinos Unidos por la Salud* model has demonstrated that participation among urban Latinos is favorable when following the five tenants described. Retention was also positive, when the group characteristics portray family orientation and include a home environment. This model has been employed to provide diabetes self management for diabetics and their families in addition to other chronic diseases, substance abuse prevention, stress management and family money management. Although caution is recommended for replicating the model among other minority groups, *Vecinos Unidos por la Salud* continues to show positive results among Latinos.

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