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[SUCCESS STORY]
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A Global Health Model for Inclusion: From Venezuela to California and Back Again

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The Inspiration: Santa Ana, California

Santa Ana, California, is home to a large, monolingual Spanish speaking population. In 1993, America Bracho, a physician from Venezuela who had just completed her MPH at the University of Michigan, took a job working in Santa Ana. Her inspiration for founding the nonprofit Latino Health Access (LHA) came from her work as a Spanish radio talk show host in Orange County, California. Anonymous callers shared intimate issues that revealed deep needs within the community related to domestic violence, access to healthcare, mental health, and many other issues. The surprise came when Dr. Bracho tried to locate resources for them. Despite Latinos making up 23% of the population, there were no Spanish-language programs at that time.

Dr. Bracho and others conducted a study that revealed that diabetes was devastating the community, but there was no organization that could make improving health among Latinos a priority. They decided to form Latino Health Access (LHA) with the motto *Participation Makes the Difference* to address this issue. Dr. Bracho drew from her experience working with Community Health Workers, or *Promotores*, in rural Venezuela, to create the model for the agency.

The Venezuelan town where Dr. Bracho practiced medicine was underdeveloped and remote. There was no electricity or indoor running water, and preventable diseases related to poor sanitation such as diarrhea and parasites and communicable diseases such as tuberculosis and malaria were a major concern. It was 1982, and community health workers (CHWs) were starting to formally make their way into health systems after the Primary Care declaration of Alma Ata in 1978. The town began to use nurse assistants (NAs), whose job requirements, training, and scope of work were similar to CHWs in other countries, and were hired by the health department.

The nurse assistants were authorized to provide certain medications; trained to administer treatments, including those delivered intravenously; and in extreme cases, they could suture wounds and help in delivering babies. They also distributed food and educated the population on disease prevention. They were part of the local population and were respected and committed to the families they served, which led to great results in their localities. They knew and followed up with the people that were sick or had chronic conditions. They knew who needed help, and people were prompt to ask for help. They also had great relationships with doctors like America Bracho, who visited these areas once a week. These doctors would spend typically 1 to 3 years working in these remote areas. The nurse assistants stayed.

In 1993, many Latinos in Santa Ana lacked medical services, children were under-immunized, low-income and/or uninsured people had difficulties accessing services in English or Spanish, and people with chronic diseases were reaching the hospital emergency rooms with complications due to poor disease management. Neighbors did not know each other and their ability to access services, organize, and advocate was seriously impaired by the lack of relationships among them. Additionally, they had few safe gathering places and those who were undocumented lived in fear of federal immigration enforcement, as well as discrimination. Latino Health Access was created to address these problems. LHA served a largely monolingual community that worked multiple jobs with very little time to connect with others in their community. There was no doubt among the LHA team that Latinos had to find and meet each other and offer immediate services that could respond to the immense need around certain health conditions. The image of the NA/CHWs from Venezuela who were respected, appreciated, and effective inspired us. However, in Venezuela, their scope was limited to health promotion and disease prevention, and we wanted to go deeper into the social determinants affecting the Santa Ana community.

In the beginning, LHA created the first diabetes self-management program, invited communities to participate, and hired community members as CHWs. Then, with more capacity, LHA expanded services to include other chronic and mental health conditions, created additional relationships, and included more people.

The number of CHWs and the services they provided increased. Eventually, a policy department was created to organize and advocate for mid- and long-term policy and institutional changes. Today, LHA is an organization that is constantly learning and growing, always with the community at the center.

Challenges of Implementing the Model in the U.S.

Unlike in Venezuela, where CHWs were trusted and respected, the legitimacy of CHWs as health educators was challenged immediately in Santa Ana. There was fear among health officials that CHWs, who were not nurses or doctors, would misinform, if not outright endanger, program participants. However, this concern was allayed by an independent evaluation that offered positive outcomes. For example, hemoglobin A1c had declined significantly among those who were taught diabetes self-management by a CHW. These results convinced health officials including Kaiser Permanente, which began sending their primary care residents for rotations through LHA, and invited LHA to teach diabetes self-management to their Spanish speaking patients.

In Venezuela, as in many other countries, the NA/CHWs are allowed a high level of autonomy and a scope of work that includes clinical responsibilities. In the U.S., regulations do not allow that scope of work and autono-

my for CHWs, and traditional institutions and professionals see them only as "lay workers" or "paraprofessionals." It has taken time to help others see this more expanded role the *Promotores* can successfully play. This expanded role is still not widely embraced, as it requires a high degree of trust, and investing in ongoing training, but the trust is building.

Successes of Implementing the Model in the U.S.

Today, Latino Health Access employs 60 people, 38 of whom are full-time *Promotores*. LHA is credited with the following outcomes:

- The first surveys to assess health conditions among Latinos in Orange County, conducted by CHWs in partnership with Orange County Health Care Agency (OCHCA) to gather key information on children and maternal health;
- A partnership with OCHCA and University of California Irvine (UCI) to improve immunization rates;
- The establishment of the first programs in Spanish to prevent and manage chronic diseases, as well as those on mental health/intra-family violence, with positive outcomes;
- The creation of the first place-based/zip code intervention in Orange County, and one of the first in the United States in 1996;
- The creation of a park and community center in a densely populated, park-poor neighborhood;
- Joint-use agreements with schools, so children would have a place to play;
- A partnership with National Highway Traffic Safety Administration, parents, schools, and others to promote safe transportation and pedestrian safety;
- A highly activated community that is engaged in policy change;
- The creation of a highly trained team of *Promotores* that work on physical, mental, and social health, including the first CHWs devoted to housing;
- The creation of curricula to train *Promotores* and supervisors;
- The ongoing training of youth and adult community leaders; and
- The tangible contribution to the elevation of the CHWs model in the U.S. through trainings, public speaking, participation in national task forces and networks, and high-visibility media.

LHA is now celebrating its 26th anniversary. The book, *Recruiting the Heart and Training the Brain*, (Bracho, Lee, et. al, 2016), also in Spanish under the title *De la Compasion a la Accion*, offers a detailed description of the methods used by Latino Health Access.

Taking the Model Back to Venezuela

The current political situation in Venezuela is extremely complex. The report from the Office of the High Commissioner for Human Rights at the United Nations provides in-depth information about the tragic situation involving lack of access to medical care, medicine, food, water, and even freedom to dissent.

Dr. Bracho, who makes regular trips home to visit her family, began observing how families in familiar communities were now struggling to harvest food, obtain medicine, and find safe places for their children to grow and play. Dr. Bracho contacted several women from her

network and together, they decided to organize residents in the same way she had organized the residents of Santa Ana. They started small, with a few moms, and some visioning and dreaming.

Dr. Bracho and the moms again planned to multiply leadership, in much the same way that had garnered success in Santa Ana. They held many meetings and conversations with their neighbors and ultimately, the community decided to take over a nine-acre piece of land that had been a tourist destination and turn it into a health and wellness operation. The *Linternita* (Little Lantern) Foundation was created to raise funds and administer the project. Today, the project has 100 employees and a strong administrative group with the expertise and IT systems to assure transparency and proper management of resources. They cultivated two acres to produce thousands of pounds of food per month, run an afterschool program for 140 children *Promotores*, manage a local health office with two registered nurses, and provide a series of services and amenities that allow the project to generate income to work on its own sustainability.

Both Latino Health Access and Linternita Foundation continue to learn from one another, in a bi-directional global exchange of ideas about the importance of making it a priority to build and rebuild relationships in distressed communities, including those of the people affected by inequities at the center, assuring community inclusion, focusing on community strengths and reciprocity, showing solidarity, and addressing root causes of disease and despair.

Implications for Local Health Departments

The strategy and work of health departments could be enhanced with the additions and proper inclusion of CHWs. Engaging community members as co-workers, experts in their own right, and creating the mechanisms for them to inform, lead, guide, deliver service, and more can add tremendous value to what health departments do today. Addressing social determinants is becoming increasingly urgent and CHWs are essential staff members that live the data, care about the community well-being, relate as equals with community members, and could serve as connectors with systems and neighbors in effective ways.

What makes CHWs successful at LHA is the commitment to their autonomy; supervision that is well-grounded in respect for community voice; extensive and ongoing training using popular education methods; an attitude that administrative staff and technical staff are there to support the CHWs and the community, not the other

way around; and the respect of full-time employment with benefits.

Ginger Lee, who helped to build Latino Health Access for twelve years, now works as a Bureau Manager at the Long Beach Department of Health and Human Services. When the Health Department decided to improve its ability to engage the community in authentic and meaningful ways, Ginger suggested seeing if Latino Health Access could provide training. A total of forty-two staff members across seven City departments participated in the LHA training, greatly increasing the City's capacity to engage the community.

Leaders in local health departments now recognize we must center community voice if we are to achieve equity. Yet, health departments sometimes lack the skills necessary to do so. Conducting work with humility, working with community-based organizations who are experts in their communities, and learning from local and global partners are all steps in the right direction.

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