Health Promotion in Latino Populations

Program Planning, Development, and Evaluation

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Chapter Objectives

On completion of this chapter, the health promotion student and practitioner should be able to

• Identify and discuss the importance for program planners to understand the diversity that exists within Latino/Hispanic populations and communities and the major cultural beliefs, values, familial, and community characteristics that exist within these diverse communities relevant to motivating the involvement and participation of Latino/Hispanic consumers in community health promotion programs.

• Identify health promotion and education program planning models to use as guides to practice and discuss their limitations in Latino/Hispanic tailored health promotion and education program planning.

• Explain why “culturally relevant” Latino/Hispanic community health promotion and education programs should emphasize the Principle of Relevance (starting where the people are) and the Principle of Participation (eliciting the participation of community residents) to encourage their learning, support, and sense of ownership in the program.
INTRODUCTION

A Latino Perspective on Health Promotion

This chapter presents a Hispanic/Latino perspective on the design of effective and culturally relevant health promotion programs. Generally, the process of program design involves four basic steps: Step 1—Program Planning, Step 2—Program Development, Step 3—Program Implementation, and Step 4—Program Evaluation (McKenzie, Nieger, & Smeltzer, 2005). This stepwise approach is outlined further within a “User-Friendly Worksheet for Developing Health Promotion Programs” (see Appendix A). The observations presented in this chapter include insights gained by the authors in their many years of research and program development within the field of health promotion. A major aim of this chapter is to provide scholarly and practical information for helping health professionals design and work with health promotion programs that serve Latino populations, in efforts to reduce or eliminate health disparities (Carter-Pokras & Baquet, 2002; National Alliance for Hispanic Health, 2001; U.S. Department of Health and Human Services [DHHS], 2000). This perspective recognizes that enacting healthy behavior change is not easy. It requires the acceptance of the need for change, motivation, and commitment to this change, as well as guided and sustained effort. These setting conditions for healthy behavior change are typically more difficult for many Latino and other racial/ethnic minority persons, especially when they reside within low-income neighborhoods or within unstable familial or other high stress living situations.

Cultural Enhancement of Program and Staff

In a quest to improve health promotion program effectiveness and staff capacity, culturally enhanced health promotion programs can be referred to as being culturally relevant.
(designed for relevance) or *culturally responsive* (designed for responsiveness) to the cultural needs of members of a targeted or special population. In contrast, health educators, health providers, or other program staff can be described as being *culturally sensitive, culturally competent, or even culturally proficient,* in their *cultural capacity* to understand, appreciate and actively engage members of a targeted or special population. The hallmark of cultural capacity among program staff requires their abiding respect for diversity and for the well-being of members of a special population (Sue & Sue, 1999). Cultural capacity is then translated into culturally responsive services when program staff deliver culturally relevant services or program activities. In addition, enhancing the cultural capacity of program staff involves increasing their clinical skills for being more responsive to diverse participant or patient needs. Thus, respect for diversity and community collaborations are key elements of culturally responsive health services and programs. The ultimate goal is to increase patient treatment adherence, satisfaction, and positive health outcomes.

Devoid of programmatic attention to cultural issues, many mainstream health promotion programs have exhibited limited success in attracting, involving and retaining Latino consumers/clients (Hirachi, Catalano, & Hawkins, 1997; Kumpfer, Alvarado, Smith, & Bellamy, 2002). Motivating Latino consumer involvement and participation in a health promotion program remains a major challenge. Nonetheless, this challenge can be met if program planners appreciate the cultural diversity that exists within a Latino community by understanding its prevailing cultural beliefs, values, and cultural norms, while also understanding the within-group variability on these characteristics that also exists among members of that community (Castro et al., 2006).

**Characteristics of Health Promotion Programs.** Initiating and sustaining health change efforts to reduce health disparities involves programmatic interventions that mobilize personal, interpersonal, and environmental resources in a unified and integrated manner. A well-designed and culturally responsive health promotion program helps sustain these efforts across time to produce genuine health-related changes and improvements in health. Health promotion programs typically focus on healthy change to reduce risks or the severity of one or more of the *lifestyle disorders: cardiovascular disease* (reducing elevated lipids, reducing high blood pressure), the cancers (screening for breast, cervical, colorectal, or other cancers), diabetes mellitus (promoting weight reduction, management of blood glucose levels), arthritis and other musculoskeletal diseases (Brownson, Remington, & Davis, 1998), as well as reducing the disease burden of addictive disorders (alcohol abuse, tobacco use, use of illegal drugs, excessive food consumption, other addictions). In general, one goal of health promotion programs is to reduce health disparities on one or more of the 10 leading health indicators: physical inactivity, overweight and obesity, tobacco use, substance use, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care (U.S. DHHS, 2000).

Thus, a health promotion program consists of a multisession program of organized activities designed to promote healthy *lifestyle changes.* A well-designed health promotion program will typically include several components: (1) informational knowledge to provide health information and to change maladaptive beliefs about health, (2) motivational messages to prepare the participant for behavior change efforts, (3) skills development via techniques that build capacity for change, (4) social supports that elicit the aid of significant others, and (5) environmental changes to reduce barriers to change and to mobilize resources for making health-related changes.
Infusing Cultural Responsiveness Into Program Design

The Principles of Relevance and of Participation.
Culturally relevant community-based programs should be designed according to two important systems principles: (1) the principle of relevance, “starting where the people are” and (2) the principle of participation, eliciting the participation of community residents, thus promoting their “sense of ownership” in the program, while also fostering “active learning” through participation (Minkler, 1990). The use of this approach operates as a community-grounded needs assessment to identify and respond actively to the most pressing health needs within a local community. Accordingly, from the perspective of the participatory social action research approach (Minkler & Wallerstein, 2003), community residents are invited to participate in the conceptualization and design of a health promotion program. Under the principle of participation, program developers elicit the views of community leaders, stakeholders, and residents regarding the nature and extent of important community health needs. This approach establishes a health partnership, while also challenging health professionals to apply their social, psychological, and medical knowledge toward addressing the community’s expressed needs (Rawson, Martinelli-Casey, & Ling, 2002). In summary, this health partnership “grounds” the health promotion program within the contemporary health needs and desires of local community residents.

A Principle of Cultural Relevance. An emerging principle for health promotion may be identified as the principle of cultural relevance. A health promotion program that is designed to effectively reduce or eliminate health disparities within a specific minority population requires that the health planner be deeply knowledgeable of the culture of the targeted group, while also having respect for members of that group, and consulting with members of that group to more fully understand the group’s cultural diversity and complexity in its values, major beliefs, customs, and traditions (Orlandi, Weston, & Epstein, 1992). In this regard, health promotion programs can contribute significantly toward reducing health disparities in Latino populations in several ways. These include the following: (1) facilitating consumer access to program activities in Spanish, as needed; (2) employing bilingual/bicultural staff and training them to become culturally competent; (3) integrating Latino cultural factors into core program components (family-oriented values, i.e., familism, personalismo, respeto, simpatia) (Castro & Hernandez-Alarcon, 2002; Marin & Marin, 1991); (4) adjusting program activities in accord with levels of acculturation, as these exist among program consumers; and (5) developing sensitivity to features of the local Latino community and its culture. A health promotion program can “work” when it offers health information, motivates and sustains healthy behavior change, and promotes this change in a culturally relevant manner using intervention activities that build on existing cultural strengths. The design of such interventions should also be guided by empirically based health promotion research that informs program developers and staff about empirically validated interventions “that work” in changing mediators of healthy behavior change (Kellam & Langevin, 2003; MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002).

STEP 1: PROGRAM PLANNING
Contrasting Roles of Theory, Models, and Grassroots Approaches

Contrasting Approaches to Health Promotion Program Planning. In the field of prevention science, a dynamic tension exists regarding competing approaches toward prevention program planning. Generally, the “academic
approach” emphasizes a theory- or model-driven “top-down” strategy that consists of an organized plan for program design. In contrast, the “grassroots community approach” builds a program from the “bottom-up,” based on sensitivity and responsiveness to current community needs. The strength of the “academic approach” involves its focused organization and planning; its weakness lies in a possible lack of fit with contemporary community needs and preferences, while its emphasis on fidelity in program delivery may introduce inflexibility to changing community needs. In contrast, the strength of the grassroots community approach lies in its closeness and sensitivity to local community needs and a sensitivity to the community culture; its weakness lies in a utilization of activities or interventions that may not be empirically validated and may be ineffective in producing healthy behavior change on targeted behaviors or on other important health outcomes (Schinke, Brounstein, & Gardner, 2002).

Importance of Theory to Guide Program Design. In the applied setting, many social service and health interventions are delivered based on units of service to address a specific presenting problem. Unfortunately, such interventions are seldom governed by a well-specified theoretical, conceptual, or logic model; they often focus concretely on service delivery with limited efforts to address the underlying “causal” disease mechanisms that this intervention purports to change. In contrast, the contemporary academic approach to health promotion program planning is based on several health promotion theories and models. Among these models, the most popular are the Health Belief Model (Becker, 1974; Hochbaum, 1958; Rosenstock, 1990), the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein, 1967), the Theory of Planned Behavior (Ajzen & Madden, 1986), Social Learning Theory (Bandura, 1986; Perry, Baranowski, & Parcel, 1990), Green’s PRECEDE model (Green, Kreuter, Deeds, & Partridge, 1980), and Diffusion of Innovation (Orlandi, Landers, Weston, & Haley, 1990; Rogers, 1983), the Stages of Change Model (the Transtheoretical Model) (Prochaska & DiClemente, 1992), Motivational Interviewing (Miller & Rollnick, 1991), and the Ecodevelopmental Model (Szapocznik & Coatsworth, 1999). Details of these theories and models as applied to health promotion have been described in detail by others (DiClemente, Crosby, & Kegler, 2002; Glanz, Rimer, & Lewis, 2002).

These classical theories and models of health and behavior offer important tools to guide health promotion program design, because they summarize the cumulative scientific knowledge gained from epidemiology, prevention science, health promotion, and other academic fields, as it describes and explains “what works” and “how it may work,” by “mapping out” processes that govern healthy behavior change. Understanding the major factors that influence healthy behavior change, as described by these theories and models, is essential to the design of a health program curriculum that incorporates the strongest scientific and evidence-based knowledge to design more effective health promotion programs.

The Challenge of Programmatic Integration. A contemporary challenge in the field of health promotion involves integrating these “academic” and “grassroots” approaches by using theory and models to guide program planning and service delivery, while also grounding these academic models within the “real world” context of local community needs and preferences. Furthermore, in the spirit of the community-based participatory research (CBPR) approach, and also to avoid a “one-size-fits-all” approach, it is desirable to obtain, “the best of both worlds,” by integrating the academic and grassroots approaches. This is accomplished by drawing from a combination of theories that use traditional individual-focused behavior-change
strategies, as well as by using social ecological and culturally relevant approaches (Glanz et al., 2002). In this regard, CBPR has served as a unifying translational framework, and under its basic social ecological model, it can be used as a framework for including cultural factors to restructure consumer environments, to eliminate barriers, and to facilitate healthy behavior change (Castro & Balcazar, 2000; Castro & Hernandez-Alarcon, 2002).

Anders, Balcazar, and Paez (2006) provide an example of designing a CBPR program that features a Promotoras de Salud Model as applied to cardiovascular disease risk reduction among Latinos/Hispanics. The Promotoras de Salud Model, a “natural helpers” model (Eng & Parker, 2002), builds from this ecological paradigm and incorporates cultural factors into a unified approach that addresses factors hypothesized to effect changes in health-related behaviors (Anders, et al., 2006).

Promotoras (lay health workers) are members of a local community who can be recruited and trained to administer a program or to offer health education or health promotion activities (Castro et al., 1995). They function as “cultural brokers” who serve the community and can translate bidirectionally from community to program and vice versa (Balcazar et al., 2006). Many programs have found Promotoras to be useful adjuncts to program recruitment and implementation because they offer personalized support (personalismo) that removes barriers to health care and promote self-care behaviors among women who are reached by these Promotoras (Reinschmidt et al., 2006). Often Promotoras enjoy greater trust from the local community (mas confianza de la comunidad). Confianza is a Latino cultural concept and refers to deep trust that is earned through established caring relationships. Confianza is often hard for new programs and program providers to attain, whereas Promotoras can facilitate the process of gaining confianza from the community and from individual program participants.

Concepts of moderators and mediators. A core question in the design of health promotion programs is “To effect changes in behavior that enhance health, where and how should we focus our intervention efforts?” The design of effective health promotion programs builds on epidemiological and other scientific evidence, on “what works.” Such program design efforts are enhanced by understanding the effects of moderators and mediators as intermediate “causal” factors that operate within the “causal chain” of events that produce health-related outcomes. A basic goal in the science of prevention is to eliminate or reduce risk factors that lead to disease, and/or to increase or strengthen protective factors that safeguard against disease (Hawkins, Catalano, & Miller, 1992). To illustrate this, Figure 10.1 presents a model that describes the temporal sequence of events involving types of factors that occur in three stages: (1) antecedents, initial factors or starting conditions; (2) intermediate factors, that include moderators or mediators; and (3) outcomes, that constitute results of this causal process.

In this simple model (Panel A), the presence of various setting conditions, for example, tobacco availability, operate as initial factors that directly prompt subsequent tobacco use. This model is presented in a compact and simplified form, given that in actuality a larger combination of factors operate in the manner summarized by this simplified model. For example, factors such as socioeconomic status (SES) and an urban/rural community setting are presented here succinctly under the general category of “Setting Conditions.” Thus, the physical and social environment in which a person lives presents specific “setting conditions” that can influence health-related behavior (D. A. Cohen, Mason, et al., 2003).

In the case of a moderator variable (an effect modifier), the influence of setting conditions on a health outcome can be moderated (can be modified) by levels of a moderator variable. Examples of moderator variables include the
following: gender—male, female; race/ethnicity—Hispanic, African American, white nonminority; levels of acculturation—low, bicultural, high; and traditionalism—traditional or modernistic. For example, based on epidemiologic survey data, gender can operate as a moderator variable related to an outcome variable such as heavy alcohol use. For example, in response to setting events (being in high school or being in college), the rate of binge drinking (consuming five or more drinks in a row) when in high school (12th grade), and also when in college, have been observed to differ consistently by gender. Epidemiological data confirm that for the period of the past 2 weeks, young males exhibit higher rates of binge drinking (33% in high school and 50% in college) relative to young females (23% in high school and 34% in college) (Johnson, O’Malley, Bachman, & Shulenberg, 2006). Thus, in this case, gender (male, female) operates as a moderator variable (an effect modifier) of the influence of the community setting (being in school) and the targeted outcome, binge drinking. As noted, this

![Figure 10.1 Basic Models of Moderators and Mediators of Tobacco Use](image-url)
gender effect is observed both within a high school setting and within a college setting.

Furthermore, Panel B presents a set of psychosocial mediators, intermediary factors that can aid in preventing tobacco use among adolescents. Mediators are “intermediate” or “in-between” variables that occur in time between the setting condition and the outcome (MacKinnon, Krull, & Lockwood, 2000). Mediators are part of a stagewise sequence of events that can be targeted for modification to attenuate this disease-related “causal process.”

In a review of several intervention studies, Tobler (1986) noted that certain interventions can operate as mediators that aid in reducing alcohol, tobacco, and other drug (ATOD) use among adolescents. Along these lines, Hansen (1992) developed a comprehensive review of various types of interventions to prevent substance use among adolescents within school-based settings. These include (1) giving informational knowledge; (2) changing values, normative beliefs, and/or life orientations; (3) making a commitment via a public pledge to avoid ATODs; (4) enhancing self-concept, self-esteem, or self-efficacy; and/or (5) teaching refusal and life skills (see Figure 10.1). Within an effective prevention program, one or more of these specific mediating interventions are ideally combined into a coherent “prevention intervention program.”

It must be noted that solely providing factual informational knowledge regarding the dangers of substance use has been shown to be a weak intervention and is usually not sufficient for motivating adolescents to avoid ATOD. In contrast, changing normative beliefs about the extent to which adolescent peers use tobacco may change current misconceptions regarding tobacco use, and this operates as a more potent intervention of avoidance of cigarette and other substance use. Similarly, increasing a youth’s self-esteem or changing self-concept (self-image) of the self as a “nonsmoker” has a weak effect in discouraging tobacco use. A more potent intervention involves increasing self-efficacy and refusal skills for avoiding tobacco use. The strategy of increasing skills to avoid tobacco use, in the form of life skills training (Botvin, Schinke, Epstein, Diaz, & Botvin, 1995) and refusal skills training (Kulis et al., 2005; Marsiglia, Kulis, Hecht, & Sills, 2004) have been shown to be the strongest mediators that help youth avoid the use of alcohol, tobacco, and illegal drugs.

In this regard, Anders et al. (2006) have used the CBPR approach with Latinos to change relevant health-related “mediators” to prevent chronic diseases such as cardiovascular disease or diabetes. This approach also includes attention to moderators that operate as contextual factors (level of acculturation, immigration status), social resources (social support, family cohesiveness, coping mechanisms), psychological responses (individual values or beliefs), and social supports (Promotora support and health education), as well as addressing multiple behavioral outcomes (diet, smoking, physical activity, alcohol consumption). The application of the Promotora model when integrated into a CBPR approach, and with a focus on changing “mediators,” contributes scientific capacity and cultural content to the design of health promotion programs. This also involves a focus on changing culturally specific mediators, such as family traditionalism, ethnic identity enhancement, teaching traditional cultural norms, and biculturalism, with the aid of Promotora-led activities.

The Role of Staff Cultural Competence

The cultural competence of program staff also serves as an important factor for increasing the effectiveness of health promotion programs. Cultural competence refers to the capacity of health professionals or of health service delivery systems to understand deep structure (Resnicow, Soler, Braithwait, Ahluwalia, & Butler, 2000) and to respond with cultural sensitivity to the health needs of a specific cultural subgroup (National Alliance for Hispanic Health, 2001).
Capacity for Cultural Competence. Figure 10.2 presents a series of cultural attitudes and capabilities ordered in sequence according to progressive levels of cultural capacity. From this perspective, the capacity for cultural competence varies along a graded continuum. A variation of this cultural competence continuum has been proposed previously by various scholars (Cross, Bazron, Dennis, & Isaacs, 1989; Kim, McLeod, & Shantzis, 1992; Orlandi et al., 1992), and has been modified and expanded elsewhere (Castro, 1998).

Along this cultural capacity continuum, the lowest capacity level is cultural destructiveness (−3), which involves overt discrimination and openly destructive attitudes that emphasize the “superiority” of the dominant culture and the “inferiority” of indigenous cultures. Next on this continuum, cultural incapacity refers to passive discrimination. This incapacity is superseded by cultural blindness (−1), an orientation which asserts that “all cultures and people are alike and equal.” Although universal equality is an ideal, it is not a reality, and this perspective glosses over the presence of health disparities and other forms of sociocultural inequity. Beyond these negative orientations, the first level of positive cultural capacity is cultural sensitivity (+1). Cultural sensitivity is characterized by having a basic understanding and appreciation for the importance of cultural factors in the delivery of health services.

Beyond cultural sensitivity, cultural competence (+2) involves the capacity to work effectively with members of a specific cultural group. Beyond cultural sensitivity, progressing to cultural competence requires greater depth in skills and experiences, thus moving beyond a superficial analysis of cultural features toward the capacity to understand and to work with cultural nuances. Cultural nuances are subtle but real cultural differences “that make a difference.” Understanding cultural nuances facilitates an accurate interpretation of the communications and behaviors exhibited by an ethnic minority client. Thus, the health provider can accurately infer correct meaning from such thought and behavior, as interpreted within the client’s unique cultural context. For example, among Latinos, a culturally competent health program planner would understand and appreciate the role of personalismo, the
importance ascribed to trust and personalized communications in interpersonal relationships. Accordingly, a culturally competent program planner would incorporate aspects of personalismo into a health promotion program to make it more culturally relevant for initiating and maintaining program involvement among Latinos.

Finally, cultural proficiency, refers to the highest and idealized level of cultural capacity. It is characterized by the health professional’s deepest understanding of cultural issues and their nuances for a specific cultural group. This would be reflected also in a health professional’s capacity for leadership in the design of effective health promotion interventions for ethnic minority populations. As noted, cultural proficiency (+3) is the highest expression of cultural capacity, and it serves as an ideal level of capacity, a state of high mastery that health professionals should aspire to attain (Castro, 1998). Here, it has been noted that cultural capacity is a skills level that is specific for a particular racial/ethnic or cultural group. For example, a Latino health provider may have attained the level of cultural proficiency when working with Mexican American clients, although may only have developed the level of cultural sensitivity when working with Chinese American clients (Castro & Garfinkle, 2003).

Origins of Health Promotion Programs

Health promotion programs originate under a variety of different “starting conditions” that determine a program’s purpose, identity, and developmental trajectory. Among the many possible starting conditions, the most typical ones are (1) local epidemiologic need, (2) a call for proposals, (3) tailoring of an existing program, and (4) community demand.

Local Epidemiologic Need. The direct approach to the establishment of a health promotion program emphasizes program development based on local epidemiologic need. In this approach, several observed cases of disease within a geographic area will signal the presence of a health-related problem. For example, low rates of vaccinations among Latino children within a local community might emerge as a potential public health problem based on clinical or epidemiologic evidence of higher rates of disease among children from a specific community.

A Call for Proposals. Response to a call for proposals is a second approach rooted in observed epidemiologic needs that can prompt the design of a health promotion program in response to such a call. In this approach, a sponsoring agency (the federal government, a state or county health agency, or a private foundation) identifies a particular health problem, identifies a targeted population or populations, and describes a relevant health promotion program that it seeks to fund. For example, a request for applications (RFA) or a request for proposals (RFP) from the federal government may announce the availability of federal funds to support health promotion research/service delivery projects to provide mammography screenings to low-income populations, such as among low-acculturated Latino women. The RFA announces available levels of funding and presents basic guidelines for program design and development. Under these basic starting conditions, a team of researchers/interventionists could develop a health promotion program proposal that includes a rationale for the program, a proposed curriculum, an implementation design, a timeline, and a budget. The sponsoring agency reviews the proposals submitted for scientific and programmatic merit, and the best proposals are funded based on sufficient merit as determined by a panel of expert reviewers.

Tailoring of an Existing Program. A third mechanism in the origin of a health promotion program involves tailoring of an existing program to create a modified program (Castro, Barrera, Martinez, 2004; Collins, Murphy, & Bierman, 2004) that better fits the needs of a specific group or community. For example, a community-based AIDS prevention program that has served Mexican Americans/Chicanos
in five cities in the southwestern United States may be adapted to serve Puerto Rican populations in the New England area and in Puerto Rico, along with Cuban populations in the greater Miami area. In this case, the target population remains Hispanics, but an intervention originally designed for Mexican Americans in the Southwest should be modified to serve Puerto Ricans and Cubans in other regions of the country. Here, cultural competence in program design and adaptation involves modifying the prior AIDS prevention curriculum to address somewhat differing needs and environments experienced by the local groups of Latinos/Hispanics.

Community Demand. Finally, a fourth mechanism for developing a health promotion program is community demand. Based on community organization and political action by a local group of concerned citizens and community leaders, this group may demand resources to solve a local public health problem. For example, a group of residents from an inner-city housing project that has been ravaged by drug abuse and violence lobbies the city council for funds earmarked to address this problem. United as a local housing coalition, this group ultimately procures funding for a 2-year project aimed at consolidating the citizens’ coalition and at educating all housing project residents on strategies for drug and violence prevention. In this case, the population targeted for this health promotion intervention is restricted geographically to those who are residents of the local housing project. Then, after this project is funded, community experts from the local university and from local community-based social service agencies may be hired as consultants to further design, monitor, and evaluate the program. In this case, a general program plan is funded and experts acceptable to the local community are subsequently hired to work out the details that aim to make the program successful.

These four types of “starting conditions” for health promotion programs, which have been observed in various Latino communities, illustrate the diversity of conditions that influence the identity, character, and development of a given health promotion program. In each case, the deeper goal is to develop and implement a health promotion program that is effective in meeting complex and pervasive health problems that affect members of a particular Latino community.

Facilitating Problem Conceptualization and Assessment

A Verbal Logic Model. A major problem in health promotion program planning is the challenge of conceptualizing clearly the set of conditions that may lead to disease, and consequently in further conceptualizing and planning a proposed intervention or program that can arrest or counter that disease-inducing process. In other words, the problem involves developing a clear conceptualization or logic model during the program planning phase by “capturing the story” (modeling the causal process) that describes this process. Figure 10.3 presents a simple descriptive “causal model” framework to help health promotion program planners and health educators to think about (conceptualize) and plan a prevention intervention that can be tailored to the needs of a targeted group or population. This verbal logic model is used as part of the User-Friendly Worksheet for Developing a Health Promotion Program (see Appendix A). The User-Friendly Worksheet has been used as a framework to help university graduate and undergraduate students in planning and designing a viable health promotion program.

A Disease Risk Model. This “descriptive causal model” consists of two related parts: (A) a Descriptive Disease Risk Model and (B) a Descriptive Prevention Intervention Model. This verbal logic model uses conventional sentence structure to help guide program planners in conceptualizing a plausible chain of
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events, “a likely causal process.” Part A, the Descriptive Disease Risk Model, describes a progressive disease process, whereas Part B, the Descriptive Prevention Intervention Model, presents a similar process while introducing a proposed prevention intervention. This model framework helps answer the question “What can be done programmatically in the design of a program for members of a targeted population to effectively counter the effects of a naturally occurring disease process?” The process that is “modeled” may or may not be entirely accurate, although the aim is to use theoretical and empirical health promotion knowledge and available local data as evidence regarding the events actually occurring within the local community. As shown in Figure 10.3, the sentence completion format prompts the identification of a specific “target group” by describing the group’s ethnicity, age, gender, community of residence, and other defining factors, for example, Latino 10- to 12-year-old males from El Barrio. The risk event(s) prompts information regarding events or conditions to which members of the target group are exposed, for example, adult family members who smoke cigarettes. The subsequent risk behavior(s) reflect reactions to the risk event, for example, as these youths would experiment with cigarette smoking. Then, future disease outcome(s) can be that these youths will develop lung cancer and/or coronary heart disease in adulthood.

A Prevention Intervention Model. Following this Descriptive Disease Risk Model analysis, under the Descriptive Prevention Intervention Model analysis, the program planner is challenged to identify and describe a competing healthy “causal” process. Here, the target population remains the same, and thus this item is automatically carried over as the starting point within the Prevention Intervention Model. However, in this model, a specific prevention intervention is proposed. For these Latino 10- to 12-year-old males (in the fifth and sixth grades) from El Barrio, this prevention intervention could consist of [culturally relevant information and refusal skills training]. The aim is to promote certain health behavior(s), whereby these youths would [learn how to respond assertively and to refuse and avoid offers to smoke cigarettes]. And accordingly, desirable health outcome(s) would be that these youths can [actively avoid early addiction to tobacco, as well as lung cancer and coronary heart disease developing later in life as linked to cigarette smoking].

A. Descriptive Disease Risk Model

IF Target Group (ethnicity, age, gender, community, etc.) [ ]

ARE EXPOSED TO Risk Event(s) [ ],

THEN THEY WILL Risk Behavior(s) [ ]

AND LATER CAN Disease Outcome(s) [ ].

B. Descriptive Prevention Intervention Model

BUT IF Target Group (ethnicity, age, gender, community, etc.) [ ]

RECEIVE Prevention Intervention(s) [ ],

THEN THEY WILL Health Behavior(s) [ ]

AND LATER CAN Health Outcome(s) [ ].

Figure 10.3  A Descriptive “Causal” Model Framework
As a second example, the Descriptive Disease Risk Model could state that: IF [adolescent Mexican American females (aged 13–18) (high school adolescents) from El Barrio] ARE EXPOSED TO [family cooking practices that feature high-fat foods], THEN THEY WILL [prepare high-fat meals for self and family] AND LATER CAN [develop obesity and non-insulin-dependent diabetes mellitus (NIDDM) by age 40]. In contrast, the Descriptive Prevention Intervention Model may state, BUT IF [adolescent Mexican American females (aged 13–18) from El Barrio] RECEIVE [training in heart healthy meal preparation], THEN THEY WILL [prepare low-fat, high-fiber meals for self and family and exercise regularly] AND LATER CAN [maintain normal weight and avoid the development of type 2 diabetes mellitus].

Key Factors in a Cultural Assessment of Health Needs

Acculturative Status. A major factor that describes the within-group variability existing among a Latino population is level of acculturation. For Latino/Hispanic clients, acculturative status refers to the client’s cultural orientation and level of involvement within their Latino culture, for example, Mexican, Cuban, etc. Here, it is noteworthy that most “acculturation scales” do not measure the process of acculturation (cultural change), but instead measure a current level of acculturative status, as measured on a hypothetical dimension (continuum) that ranges from an identity that is “very Mexican” (or very Hispanic/Latino) to an identity which is “very Euro-American” (Cuellar, Harris, & Jasso, 1980).

Within the past two decades, several second-generation acculturation scales for Latinos have been developed that examine acculturation as conceptualized according to two distinct and perhaps independent (orthogonal) dimensions (Cuellar, Arnold, & Maldonado, 1995; Marin & Gamboa, 1996). A related descriptive model of acculturation identities has also been presented based on this two-factor model (Balcazar, Castro, & Krull, 1995; Castro & Garfinkle, 2003; Castro, Nichols, & Kater, 2007). Recently, many scholars have criticized the original unidimensional measurement of acculturation among Hispanics/Latinos and other ethnic minority populations (Escobar & Vega, 2000; Hunt, Schneider, & Comer, 2004). However, despite the limitations of this elementary single-dimension conceptualization and measurement of acculturation, this simple approach still provides a useful indicator for assessing within-group variability in acculturative status among Latinos and other ethnic minority people. This approach adds useful information beyond the “ethnic gloss” (Trimble, 1995) involved in simply classifying persons as members of an ethnic minority group, such as being categorized simply as “Hispanic,” “Latino,” or “Mexican American,” etc.

As summarized in Figure 10.4, for the acculturation continuum, recurring thematic content within these scales involves five factors: the linguistic capabilities of the participant in English and in Spanish, that is, (1) speaking capabilities, and (2) reading capabilities, (3) their level of exposure to the Euro-American (non-Hispanic white) and to the Mexican or native Latino cultures (Mexican, Puerto Rican, Cuban, etc.), (4) the ethnic identity of the person’s current circle of friends (e.g., entirely Latino, from both, or entirely Euro-American or other), and (5) the level of pride that the person has toward his or her own cultural group.

As measured by a typical acculturation scale for Latinos, a prevailing concept in the literature about Latinos is that there exist three basic levels or types of acculturative status: low-acculturated, bilingual bicultural, and high acculturated (see Figure 10.4). In terms of the major sociocultural characteristics of members of these three subpopulations, low-acculturated clients are primarily Spanish speaking, have a cultural attachment with
their native Latino culture, maintain mostly Latino friends, and tend to express pride in their native cultural background. In contrast, high-acculturated Latinos are those who primarily or exclusively speak English, feel a closer attachment toward the non-Hispanic white (Euro-American) culture, have primarily or exclusively Euro-American friends, and may express little pride in being from a Latino culture. Here also, some high-acculturated persons who are strongly oriented toward assimilation into the Euro-American culture may no longer identify with Latino cultural activities. Such clients may also self-identify as being “white” or “American.” Furthermore, more complex ethnic identity patterns have emerged within contemporary American society with the increase in the numbers of mixed-ethnic heritage young adults, for example, youth having a Euro-American mother and a Mexican American father, based on ethnic intermarriages that increased in prevalence during the 1980s and thereafter.

Despite the limitations of a unidimensional measurement of this acculturation construct (Rogler, Cortes, & Malgady, 1991), this variable offers useful detail in measuring levels of the within-group variability that exists among Hispanics/Latinos, as compared with only using a demographic-level categorical label, for example, “Hispanic.” In summary, for Latinos(as), level of acculturation can be measured by using one of various scales that have been developed (Barona & Miller, 1994; Cuellar et al., 1980, 1995; Marin & Gamboa, 1996; Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987).

The present authors have developed and used a short scale in telephone survey research, in community-based studies, and in the clinical setting (see Appendix B; Castro, 1988; Balcazar et al., 1995). This acculturation index (the General Acculturation Index) can be used in conjunction with the acculturation continuum (Figure 10.4) to describe a Latino client’s level of acculturation. This index has exhibited sound psychometric properties (coefficient ranging from Cronbach’s $\alpha \geq .70$ to .85) with various Latino populations, and it can be administered by self-report or by

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**Figure 10.4** The Acculturation Continuum: A Conceptual Framework to Accompany the General Acculturation Index

SOURCE: Felipe G. Castro, Hispanic Research Center, Arizona State University.
interview with Euro-Americans as well as with Latinos (Balcazar et al., 1995; Castro & Gutierres, 1997; see Appendix B).

**Socioeconomic Status.** SES is a frequently used composite indicator of socioeconomic position based on indicators of education and income. Within many Latino communities, low level of acculturation is often correlated with low SES. Indeed, with upward social mobility, as some Latinos acquire new skills for economic growth (education, language, social contacts) and advance upwardly in SES within the mainstream American society, their level of acculturation also tends to increase concurrently, although some develop and maintain a bilingual/bicultural identity.

Thus, as observed at a population level, the association (correlation) between level of acculturation (toward mainstream American society) and SES is often positive. For example, in one community study with a total sample of 571 Latino women, among the subgroup of immigrant Latino women (Latinas) \( (n = 256) \), level of acculturation was correlated \( (r = +.22, p < .001) \) with these women’s highest level of education in Latin America (Balcazar et al., 1995). And, among a subgroup of U.S.-born Latinas \( (n = 315) \), level of acculturation was correlated \( (r = +.21, p < .001) \) with these women’s highest level of education in the United States (Balcazar et al., 1995). Both results illustrate how among Latinas, higher levels of education are associated with higher levels of acculturation. Also, in this total sample of women, level of acculturation was correlated positively with monthly household income \( (r = +.50, p < .001) \), underscoring the significant positive association often observed between higher levels of acculturation and greater incomes. However, it should also be noted that for most Latinas when observed at the individual level, this correlated process does not necessarily indicate the eventual occurrence of complete assimilation into mainstream American society, which refers to an ethnic person’s total immersion into the mainstream culture, and that person’s complete loss of identification with his or her own native ethnic culture. In other words, at the population level, these correlations reflect the apparent movement of Latinos across the acculturation continuum as they rise in SES, although this does not necessarily indicate that an individual Latina or Latino is motivated entirely by a desire to fully assimilate.

**Identifying and Segmenting the Population: A Basic Schema**

Most descriptive accounts of the characteristics of Hispanics/Latinos(as) emphasize the fact that Hispanics are a heterogeneous population (Marin & Marin, 1991). In fact, the U.S. Hispanic/Latino population actually consists of clusters of related subpopulations, identifiable by nationality—that is, Mexican American, Puerto Ricans, Cubans, Dominicans, and so on (U.S. Department of Commerce, 1993; Marin & Marin, 1991)—and by other indicators—for example, urban-rural characteristics, and so on. While nationality identifies meaningful subgroups within the Hispanic population, nationality alone is too coarse a category to yield distinct and meaningful subgroups in relation to health needs and for health promotion program design. Instead, health needs covary more meaningfully in relation to SES and levels of acculturation when assessed jointly (Balcazar et al., 1995). The availability of a meaningful and easy to use method for segmenting the Hispanic/Latino population would be useful for program planners who work with various members of this general population.

As noted previously, specific consumer or client needs experienced by various Hispanics/Latinos may be conceptualized using this two-factor model that jointly examines levels of acculturation and levels of SES, in a \( 2 \times 2 \) schema (Balcazar et al., 1995; see Figure 10.5). Level of acculturation when segmented (for simplicity) into low level \( (X = 1.00 \) to 2.39) and into higher levels \( (X = 2.40 \) to 5.00) identifies, respectively, the need for health education and services as delivered in Spanish (for
low-acculturated clients) or as delivered in English (for higher-acculturated clients). A proxy but less accurate measure that approximates this segmentation is a client’s self-report of whether he or she typically speaks in English or in Spanish. As also indicated by Figure 10.5, based on established group cut-points, a six-group segmentation can also be conducted. These two levels of acculturation can then be cross-tabulated with a Latino client’s lower or higher level of educational preparedness to comprehend programmatic information, by using the client’s highest level of education. Here, lower educational level (6 years or less in Latin America or 12 years or less in the United States) is distinguished from a higher educational level. When cross-tabulated with level of acculturation, as defined previously, this can yield four distinct Latino sociocultural groups (in a $2 \times 2$ figure) that segments the general Latino population into four distinct and more homogeneous subpopulations that have differing health and health-educational needs (see Figure 10.5 and Balcazar et al., 1995, p. 65).

Within this schema, the low-acculturated, low-educated group (Group 1) is the “least advantaged” Latino subgroup, both socially and economically, and this subgroup typically requires more intense health promotion program planning to fully address their needs. In contrast, the higher-acculturation, higher-education group (Group 4) is the “most advantaged” group and will respond to a health promotion program that is much different in design and implementation (Lopez & Castro, 2006). Here, it might be noted that Group 4 Latino clients would be able, linguistically and by health needs, to participate in a health promotion program that is designed for middle-class Euro-American clients, while Group 1 Latinos would not.

After specific sectors or population subgroups have been identified based on this $2 \times 2$ factor schema, this classification can be used to plan specific prevention interventions that take into account the subgroup’s distinct health information needs, such as language of intervention, as well as types and complexity of information that can be presented to them.
addressing the specific needs of each subgroup, it is clear that cultural competence in program planning and evaluation requires concurrent attention to both level of education and level of acculturation (Balcazar et al., 1995).

Another classification approach for Latinos examines peer group characteristics based on acculturation status and family variables such as family cohesion. For example, new studies have found that peer-group differences in family cohesion and acculturation are associated with different levels of cigarette smoking (Balcazar, Peterson, & Krull, 1997) and diabetes severity (Moayad, Balcazar, Pedregon, Velasco, & Bayona, 2006). It is currently postulated that high family cohesiveness that is often observed among low-acculturated peer groups may function as a protective factor against high-risk-taking behavior, a view described by some as being an Hispanic paradox (Castro & Coe, 2007; Palloni & Morenoff, 2001).

**Taking Stock of Resources: Financial and Staffing**

In assessing a program’s capacity for intervention or service delivery, a proposed health promotion program must establish a balance between program scope relative to two programmatic resources: (1) the available budget for program delivery and (2) the staff who are available to deliver the intervention. Even for a specific health problem, for example, weight management among overweight Latino men and women, the health service needs of most indigent groups or populations and their lack of resources create conditions of overall need that can far outweigh the programmatic resources available to meet those needs. Thus, it is often necessary to narrow the scope of the intervention to define, “a feasible, manageable, affordable set of behaviors and outcomes to address and measure in a program” (Windsor, Baranowski, Clark, & Cutter, 1994, p. 83).

Limiting the amount of staff-client contact, in terms of number of program sessions offered is one strategy to reconcile program offerings with available staff resources. In addition, offering programmatic content in a group format aids in maximizing the numbers of clients reached given the available program resources. Here also, a balance must be established in program design between (1) maximum numbers of clients that the program aims to reach; (2) the duration and intensity of program activities offered, that is, the “program dose” (e.g., number of sessions); and (3) the quality of program content. The best designed health promotion programs seek to maximize coverage in all three areas while also balancing this with the limitations of staff size, staff expertise and experience, and the number of hours of face-to-face contact that the staff can offer these clients/consumers.

**STEP 2: PROGRAM DEVELOPMENT**

**Focusing the Program’s Curriculum**

Regarding the conceptual steps involved in planning a health promotion program for various Latino populations, it is important to define the target group explicitly and to use public health and health psychology knowledge to design a culturally relevant curriculum that is appropriate in terms of level of acculturation, age or developmental stage, gender, health needs and preferences, etc. For these clients, the program curriculum for a disease-specific intervention, for example, diabetes prevention, may set a goal of reducing the prevalence of obesity within a targeted group of disadvantaged (low-acculturated, low-educated; Group 1) Latinas, aged 25 to 40. In addition, the proposed program’s curriculum of program content must also consider the complex of health risk factors and environmental barriers that co-occur with obesity among these disadvantaged Latinos and Latinas (Marks, Garica, & Solis, 1990). Such co-occurring factors may include limited access to health care, an exposure to impoverished living conditions that impose high levels of stress, limited access to healthier foods, comorbidity with other health problems, for example,
tuberculosis, and so on (Carter-Pokras, 1994; Giachello, 1994).

For example, in planning a program for diabetes risk reduction among disadvantaged Latinos (Group 1), the apparent “individual” problem of being overweight must be conceptualized and defined within the broader context of a family system, both core and extended, in which family members may regularly consume high fat foods when attending various cultural family activities and traditional celebrations, such as baptisms, quinceneras, weddings, birthday parties, etc.

Defining Program Goals and Objectives

Defining and setting goals and objectives of a health promotion program are an important task in translating health promotion theory and intervention strategies into a specific curriculum of program activities. Program goals are broad aims that give direction to the health promotion program, whereas program objectives consist of specific details that specify how each program goal will be reached. In other words, program goals are general—for example, “to increase rates of exercise among Latinas in the local community.” In contrast, program objectives are specific: “during the forthcoming month, participating Latinas, ages 25 to 40, will increase walking exercise from zero to three days a week, by walking for 15 minutes or more at each session.” Program objectives are stated to include four specific components: (1) the targeted population, (2) the timeframe or conditions, (3) a specific outcome, and (4) a criterion for achieving that outcome (McKenzie et al., 2005). Typically, each goal will have one or more objectives (see Appendix A, the User-Friendly Worksheet for Developing Health Promotion Programs).

Proposing Ideal Versus Achievable Program Goals

In the development of a culturally relevant health promotion curriculum to address health disparities among racial/ethnic minority populations, dedicated program developers tend to propose ambitious programmatic goals and objectives. This may be prompted by their desires to improve the health status of disadvantaged (Group 1) Latino populations (those least acculturated, least educated, and poorest Latinos), in light of their existing health disparities. In contrast, setting modest but attainable goals while also addressing barriers to full program participation constitute a prudent approach for designing a viable health promotion program that is more likely to succeed. As one practical issue, a participant’s acquisition of program knowledge and skills does not always progress in a cumulative and linear manner. For example, in a 10-session cancer prevention program that covers issues of prevention through screening self-examinations, healthy diet, and healthy lifestyles, a typical Latino program participant from the disadvantaged Latino group (Group 1) might miss attendance at 3 to 6 out of the 10 sessions due to transportation problems, unexpected family emergencies, personal illness, competing family priorities, or waning interest. Thus, a 10-session program may only succeed in imparting half its program content and skills, that is, a 50% exposure to the full “program dose,” with even less than that in the form of actual learning of program content. Having fewer sessions does tend to increase attendance per session (Kumpfer et al., 2002), whereas in contrast, a limit exists in the amount of information, skills development and overall learning can be incorporated into each of these individual sessions.

This situation prompts the need for program planners to incorporate repetition and review into the design of the health promotion program curriculum, as well as to set modest program goals. A general rule of thumb is to anticipate that clients from the most disadvantaged group may only exhibit a 50% acquisition (learning) rate of program content, relative to an ideal learning and/or skills development rate of 100%, if learning had occurred efficiently and in a cumulative fashion.
Accordingly, such experiences should prompt the program planner to set achievable goals and realistic learning objectives, relative to this ideal or complete mastery of program content.

In contrast, in working with the more advantaged Latinos, Latinos with higher education, high SES, and high acculturation (Group 4), and perhaps for those of high education and lower acculturation (Group 2; see Figure 10.5), goals and learning objectives may be set at 80% of the ideal. For example, among these more advantaged Latinos, an 80% attendance rate (8 of 10 sessions), and 80% correct learning on a knowledge test, skills acquisition at 80% of maximum, or course passage by 80% of the group of participants, constitute realistic goals, whereas setting these goals at 50% may be more realistic for Latinos from the disadvantaged group (Group 1).

Strategies for Strengthening the Intervention

A major but elusive goal in the design of effective health promotion programs is to design an effective intervention, one that yields empirical evidence-based data that it truly “works” in effecting a significant change on the targeted behavior or health outcome that the program purports to change, for example, weight loss in an obesity treatment program. This effectiveness is measured in terms of the magnitude of change from baseline to postintervention observations, on targeted health-related beliefs, attitudes, and/or behaviors. In other words, the intervention exhibits a significant effect size (Tobler, Lessard, Marshall, Ochshorn, & Roona, 1999), a measure of the strength of effect of the intervention on a specified health outcome (J. Cohen, 1988; J. Cohen, Cohen, West, & Aiken, 2003). In other words, “How much change did the program produce as compared with an inert program or placebo group?” For example, for a weight reduction program, how much weight loss was achieved per individual client, and across all participating clients? Many school-based prevention intervention programs exhibit small to moderate effect sizes on targeted outcomes (Tobler et al., 1999). In contrast, as community-based prevention interventions typically lack the controlled conditions of school-based interventions that foster consistent consumer participation, community-based programs are typically expected to exhibit intervention effects in the range of small effect sizes. In the extreme case, if an intervention program for weight loss produces no weight loss among program participants, then the effect size will be zero, leading to the conclusion that the program “did not work.” Changing specific health-related behaviors among residents of a small community poses a major health promotion challenge, and this challenge is even greater when working with disadvantaged populations.

A few strategies have been proposed that may strengthen a health promotion intervention. One strategy, (1) maintaining intervention fidelity, focuses on delivering a planned (often a manualized) intervention consistently and in the exact manner in which it was designed (Hansen & Collins, 1994). This quality control activity seeks to ensure that all clients receive the same and a complete “dose” of the tested and effective health intervention protocol. Clearly, a complementary strategy to ensure that a client receives the maximum intervention “dose” is to promote (2) full client participation and adherence with the intervention’s activities. However, as noted previously, among many Latinos, the effectiveness of these two strategies for promoting healthy behavior change is contingent on the availability of an accessible, well-designed, and culturally relevant intervention protocol that engages their interest and participation.

In this regard, a strategy for enhancing the magnitude of program effect is to (3) develop a culturally effective intervention, one that appeals and greatly motivates participation and learning among members of the targeted audience. A related strategy for enhancing program effect that is based on cultural relevance is to (4) target appropriate mediators of relevant behavior change (Hansen & Collins,
1994). Here, also, this strategy includes identifying culturally relevant mediators, which is possible when a program planner is culturally competent and fully understands the culture of the targeted group.

Another strategy to enhance intervention effect is to (5) establish environmental contingencies that prompt or reward healthy behavior change (Kazdin, 1994). For a given cultural group, this also requires in-depth knowledge of the cultural and environmental conditions that govern the occurrence of a targeted behavior and the use of these natural reinforcing consequences that produce change in a targeted health-related behavior or behaviors. Finally, another key strategy is to (6) develop a system of social supports, a system that will prompt and maintain healthy behavior change within a given community setting. Given the central role of la familia (the family) within Latino cultures, a culturally effective health promotion program curriculum for Latinos(as) should explicitly include family-related issues. Accordingly, the program curriculum would do well to include a module that devotes a complete session to Latino family issues and dynamics and that mobilizes family support.

STEP 3: PROGRAM IMPLEMENTATION

Flexibility in Program Development

Once a program operates effectively by developing “programmatic momentum,” a program tends to evolve and even develop “a program identity” as it establishes recognition within the local community. Although programmatic guidelines may give a program its direction, in time a program can serendipitously develop in a few unique and unexpected ways. This may be a positive or a negative occurrence as related to program effectiveness. Proactive program managers will detect such serendipitous and perhaps unexpected developments as related to initial program goals and objectives. Some of these unique developments can then be considered in relation to principles of prevention science and health promotion, and within the context of the original program goals and objectives, when considering possible program modifications for use in a new program cycle. In this regard, a major program challenge involves making indicated adjustments in program curriculum and activities, procedures and forms of delivery (program adaptation), provided that such changes do not detract from attaining established program goals and objectives and intended program outcomes (Castro et al., 2004; Collins et al., 2004).

Staff Development and Administrative Leadership

Role of Administrative Leadership. One factor that is seldom discussed in health promotion program design and implementation, yet which is critical to program effectiveness, is administrative leadership. The best administrators or program directors of health promotion programs with Latino populations appear to be those who (1) have a knowledge of the local community and an organized vision of the program’s purpose and direction; (2) can communicate this vision to program staff on a regular basis; (3) can build commitment and morale among program staff; (4) give staff members an appropriate voice regarding program policies and procedures; (5) plan meetings as needed to speak personally with community leaders and other community stakeholders; (6) maintain a balance between scientific agendas and cultural agendas in the ongoing evolution of the program; (7) are proactive in anticipating problems, and in searching for solutions that optimize program effectiveness given the available resources; (8) inspire confidence and trust among staff and community members as a dedicated leader whose agenda is driven by the goal of enhancing the health and welfare of the local community; and (9) exhibit strength and integrity in responding forcefully on behalf of the program, as needed.

A program director’s attention to these issues, in consultation with staff and/or with the
program’s advisory board, will prompt effective decision making on behalf of the project. Effective administrative leadership and oversight also involves making programmatic decisions that enhance the project by (1) garnering support for the program from the local community and from the funding agency; (2) strengthening staff morale and commitment to project goals; (3) maintaining fidelity in program implementation to the extent possible; (4) identifying serendipitous developments that may improve program effectiveness by making informed program adaptations when needed; (5) ensuring an effective program evaluation that documents program development as well as its effectiveness; and (6) meeting regularly with staff to assess program activities, engaging in problem solving, and planning for future activities and program growth. Effective program administration and management is often a “hidden factor” not examined closely in the past, a factor that may contribute significantly to a health promotion program’s overall effectiveness.

Eliminating Barriers to Participation

Specifically targeting treatment barriers in advance (de anto mano) will avoid major design errors and serve to inform program planners/providers of critical barriers to program adherence. There are a number of barriers that have been identified when working with Latinos(as)/Hispanics. These barriers can be grouped into categories such as (1) personal, (2) systemic, and (3) community-based. Personal barriers include, but are not limited to, a client’s or patient’s mental health status, cultural and linguistic background, education level, and family structure. For example, cognitive or educational capacity to follow through with program or treatment recommendations is critical. Among Latino populations, limited English-speaking abilities constitute an obvious barrier to understanding programmatic activities or treatment guidelines, unless program content is available in Spanish. Also, cultural beliefs that are in conflict with program information or treatment might not be so easily identifiable (e.g., use of herbal remedies). Furthermore, family structure may appear one way in a clinical or community program setting but may be completely different in the participant’s home. For example, the mother may bring the children for appointments or program sessions, but it may be the father who determines what is done at home. A “treatment boss” conceivably could be a family member, spiritual leader, or other influential individual. In that case it would be a good idea to know who that person is what she or he exactly will support in terms of program planning.

Regarding systemic barriers, access to the program site or clinic, bus lines, clinic or program hours, and physical appearance of a program location can all operate as barriers to participation in a program or treatment. White Memorial Hospital in Los Angeles serves as an example of a complete systemic makeover that led that hospital out of bankruptcy and into a successful inpatient and outpatient medical practice. The strategies used included community outreach, community needs assessment, and a public relations makeover. The hospital reinvented itself from a private, elitist hospital to a community-oriented hospital. It originally had been a private hospital, although the surrounding neighborhood changed to a mainly Hispanic, Asian, and African American population. The facilities are now attractive and culturally inviting and include ethnic art and signs in multiple languages that reflect the cultures of the local community. The hospital also has remarkable staff diversity.

Community barriers may be political in nature or simply a matter of tradition. Courting community leaders and collaborating with community needs may constitute the difference between program success and failure. Centro de Amistad, a community-based health services center located in the township of Guadalupe, Arizona, has united Yaqui Indian, Mexican Immigrant, and Mexican American populations to create a number of successful community-based health campaigns, such as a Promotora-led diabetes screening and management
program. Their success stems from collaborations with community leaders and representatives who participate in their program planning and implementation.

STEP 4: PROGRAM EVALUATION

Considerations in Program Evaluation

The Single-Group Repeated Measures Design. A program’s evaluation plan should be developed during the program planning stage and should serve as a core component of the total health promotion program. In formal program evaluation research, an experimentally sound evaluation design typically features an intervention group and a control group and the randomization of clients or schools to each of these groups depending on the unit of analysis (McKenzie et al., 2005). However, for many community-based health promotion programs, such design elegance is seldom possible. Typical in such programs is the absence of a control group and of randomization; in contrast, the opportunity to obtain multiple measures across specific time points to examine client progress is often possible. These conditions naturally yield a one-group repeated measures design. While this design has evaluation weaknesses, it does offer a viable program evaluation design that is applicable within many community settings (Windsor et al., 1994).

This one-group repeated measures design only allows program evaluators to draw limited but, nonetheless, useful conclusions regarding program effects. Given that internal validity is not an all-or-nothing condition, but rather a matter of degree, a well-developed and well-implemented single-group repeated measures design can yield a useful and reasonably valid outcome data regarding effects that are likely attributable to the program intervention. For many community service programs, such evidence of program effect, whether or not attributable exclusively to the intervention itself, serves as viable evidence that points to program effectiveness.

In addition, under this one-group design, much valuable process-related data can be gathered regarding the manner in which the program was delivered and the possible mechanisms of program effect. Such data can, “tell the story” of the program’s development and possible sources of program effectiveness. The well-planned and regular collection of specific measured variables along with qualitative narrative data (e.g., on a weekly basis), as obtained from key program participants (clients, health educators, administrators, etc.), can generate a stream of programmatic data that can describe the temporal growth of the program and its possible effects (Ulin, Robinson, & Tolley, 2005). Thematic extraction methods, such as those described from grounded theory (open coding, axial coding, in vivo coding, selective coding, process analysis, case analysis, and model building), can be used to build a rich and informative account of program process (Castro & Coe, 2007; Miles & Huberman, 1994; Strauss & Corbin, 1990). The popular program for the coding and analysis of qualitative text data, Atlas.Ti (Muhr, 2004), and other related programs can be used to conduct the analysis of such data (Castro & Coe, 2007).

Relating Evaluation Design to Programmatic Realities

Specific details on fundamental aspects and approaches for program evaluation of health promotion programs have been presented elsewhere (McKenzie et al., 2005). As noted previously, along with program design and implementation, cultural competence in the evaluation of community-based health promotion programs for Latino populations also requires an in-depth knowledge and appreciation of issues that affect program effectiveness with various Latino populations (Skaff, Chesla, de los Santos, Mycue, & Fisher, 2002). The evaluation program itself should include culturally relevant measures, for example, measures of acculturation that aptly evaluate population characteristics as well as
program effects on relevant outcomes, as specifically relevant for members of a targeted group of Latinos(as). Accordingly, the assessment protocol must consist of survey or interview items or questions that are matched to the linguistic and educational aptitudes of members of the targeted population. In working with various Latino populations, developing conceptually parallel assessment forms in Spanish as well as in English is often necessary (Geisinger, 1994; Gonzalez, Stewart, Ritter, & Lorig, 1995) (e.g., see Appendix B). The availability of simple, easily administered, and clinically useful measures that are reliable and valid for use with various Latino populations (i.e., available in English and in Spanish) remains as an important area for research and development that can aid in the design and implementation of health promotion programs for Latinos (Marin & Marin, 1991).

Process and outcome information that aids in program evaluation includes the systemic collection of brief but specific information on consumer/client adherence, information on barriers to program participation, and information on program-related health outcomes. In turn, when used under a formative evaluation approach, initial results, when used as early stage evaluative feedback, can aid in improving or fine-tuning program content and activities. Moreover, four types of client baseline information (collected at intake) will aid in describing and understanding the characteristics of the participating clientele. These major types of data are (1) group cultural characteristics, (2) sociocultural resources, (3) subjective health culture, and (4) access to health services. In particular, simple descriptive data on the acculturative and sociocultural characteristics of Latino program participants, as compared with those who have declined participation or who have dropped out, can yield valuable programmatic information on which clients the program has reached effectively and which clients the program has failed to engage (Lopez & Castro, 2006).

A similar strategy in the use of baseline and ongoing monitoring data can be implemented, perhaps more easily within a clinical setting. As clients complete a treatment or a follow-up session, the administration of a brief treatment summary form can generate significant data for monitoring the client’s progress and for evaluating program-related outcomes. The goal is to administer a simple form on a regular basis, so that it becomes a routine and standard aspect of a client’s clinical visit. Unfortunately, many clinical settings typically do not plan nor implement even this simple evaluation activity.

In contrast, invoking the principle of participation, while involving program or clinic staff in the planning, design, and implementation of a program’s evaluation plan can build their sense of ownership and participation. This is a particularly useful strategy during the present era of accountability in which program funding and a program’s survival is often contingent on documenting program effectiveness. Thus, beyond the issue of funding, program staff who are committed to the delivery of effective services to their clients can be encouraged to participate in the design and implementation of a program evaluation protocol. They can be advised that their effectiveness as interventionists and their contributions toward enhancing the health of their clients and community can be documented and their efforts refined, based on their active participation in the overall evaluation effort.

CHAPTER SUMMARY

In guiding the design of culturally effective health promotion programs for Latinos(as), many dimensions of cultural relevance and scientific intervention should be considered. Designing culturally relevant programs for a specific community involves “starting where the people are.” This means knowing well the culture of the targeted community and then building a framework from which to infuse “cultural relevance” into each of the four steps
involved in program design, and as outlined within the User-Friendly Worksheet for Developing a Health Promotion Program (see Appendix A). A thorough community-grounded needs assessment involves that community leaders and residents lay the foundation for culturally relevant program design.

Designing a culturally relevant program can also involve innovation, which involves introducing new cultural components based on identified community needs but added to the program curriculum in relation to an empirically based theoretical or scientific rationale and with design rigor. Thus, when infusing a program with culturally relevant activities for Latino populations, it is helpful to incorporate certain cultural features into program design. These cultural features can include the following: (1) specific cultural factors (personalismo, respeto, familism, gender issues, etc.), integral components of the health promotion program; (2) specifying cultural characteristics beyond demographics (i.e., level of acculturation, family cohesiveness, ethnic identity); (3) targeting specific subgroups and tailoring to their needs, without compromising program effectiveness; (4) incorporating CBPR methods for relevance and innovation to program design; (5) incorporating and building new conceptual frameworks or logic models based on cultural relevance and innovation yet based also on a scientific foundation; (6) establishing a mix and balance of quantitative rigor with depth and richness of qualitative cultural assessment; and (7) aiming toward both innovation and efficacy into the program design. Reaching communities with culturally relevant programs requires the “art of designing” health promotion programs that are relevant, innovative, and efficacious. Enhancing program design with the appropriate infusion of cultural factors is an emerging prerequisite for successful program planning, development, implementation, and evaluation of health promotion programs that effectively reach and inspire Latino/Hispanic communities with a combination of cultural responsiveness and strong science.

The next chapter presents a case study where the author tries to emphasize points made in the overview and planning chapters. The study is concerned with the application of concepts and approaches for bridging the gap between theory and practice. They provide an opportunity for the student and practitioner to get a “bird’s-eye” view of some of the specific methods and techniques of HPDP program planning, application, and problem solving.

NOTES

1. The Hispanic/Latino population of the United States numbered 41.32 million as of July 1, 2004, constituting 14.07% of the U.S. population, thus making Hispanics/Latinos the largest racial/ethnic population of the United States (U.S. Census Bureau, 2005). In this chapter, we will use the terms Latinos and Hispanics interchangeably, based on the dual usage that occurs within the contemporary literature. These terms refer to people living in the United States, primarily Mexican Americans, Chicanos or Chicanas who live in the southwestern United States, as well as Puerto Ricans (both from the Island of Puerto Rico and from the mainland United States), and Cubans, as well as other Hispanics/Latinos, which include Colombians, Guatemalans, Nicaraguans, and other immigrants and naturalized persons from Central America and South America.

2. This user-friendly worksheet has been used for several years in a graduate/undergraduate course titled Health Promotion in Minority Populations. This outline presents a series of questions that “walk through” the student across major steps and activities involved in health promotion program design.

3. The terms participant, consumer, client, and patient will be used interchangeably as participants or consumers who are the recipients of community-based health promotion programs, and clients or patients who are the recipients of agency-based health promotion programs. We are discussing program design as relevant to both settings and to persons who receive the health promotion program within these various settings.
REFERENCES


Health Promotion in Latino Populations


Hochbaum, G. M. (1958). *Public participation in medical screening programs: A sociopsychological...*
HISPANIC/LATINO POPULATIONS


Health Promotion in Latino Populations

(Eds.), Health behavior and health education (pp. 288–313). San Francisco: Jossey-Bass.


Appendix A

USER-FRIENDLY WORKSHEET FOR DEVELOPING A HEALTH PROMOTION PROGRAM

This user-friendly worksheet guides you through major steps involved in program planning, design, implementation, and evaluation by having you respond to questions in a brief “sentence completion” format. By answering each question, you will address a series of program design issues. In addition, the items not easily answered now will prompt you to think further about what you might do to complete the design of your proposed health promotion program.

This user-friendly guide has four major sections:

I. Program Planning
II. Program Design/Development
III. Program Implementation
IV. Program Evaluation

I. Program Planning
A. Identifying the Health Problem
   1. What is the targeted health problem or disease entity, and why is it important to eliminate or reduce it?
   2. What are the known or likely risk and protective factors for this problem?
B. Identifying the Population
   Describe your identified population in terms of
   1. Age group(s)
   2. Ethnic/racial identity
   3. Gender(s)
   4. Geographic area or residence within a local community
   5. Unique aspects of this problem for members of this identified group
C. Needs and Resource Assessment
   1. Generally, the needs and resource assessment will be conducted
      a. In the form of
      b. To ask about
D. Stakeholders
   1. The main constituencies or groups of stakeholders are
   2. The corresponding key informants from these constituencies are
E. Archival and Community-Level Data
   1. Community-level indicators of the problem are
   2. The most important archival data to be obtained are
   3. The most important variables to be examined are

II. Program Development
A. Guiding Model(s)
   1. Basically, the theoretical or logic model that can serve as the program’s guiding framework is
   2. Provide the logic model as a set of statements that describe the factors that logically “cause” the disease and the interventions that can break this causal process
B. Conceptual or Theoretical Framework
   1. The behaviors targeted for change are
   2. More specifically, the major theoretical framework(s) that can guide healthy behavior change in your program is/are
   3. Relevant concepts (constructs) or variables from this/theory/theories are
4. Describe how each of these constructs may contribute to healthy behavior change
5. Culture-specific factors to be considered in your program are

C. Goals and Objectives
1. Program goals and objectives will be to
   a. Goal 1. To
      * Objective 1.1: To
      * Objective 1.2: To
   b. Goal 2. To
      * Objective 2.1: To
      * Objective 2.2: To
   (Goals 3, 4, . . ., N, as needed)
   n. Goal N: To
      * Objective n.1: To
      * Objective n.2: To

D. Design Format
1. The experimental (involving randomization), quasi-experimental, or other proposed program design is
2. The group or groups to be involved in this project are
3. Observation points (pretest, posttest, follow-up) for data collection will be
4. Major outcome variables will be

E. Intervention/Curriculum, Social Marketing, and Diffusion of Innovation
1. Proposed name for the program
2. This program will fit the needs of the targeted group by
3. What are the major proposed intervention strategies
4. Number of program sessions will be
5. The major theme for each session will be
   (1)
   (2)
   (3)
   (4)
   (5)
   (6)
   (n)
6. Program delivery site(s) will be
7. What social marketing approaches will be used?
8. How will this program be implemented and its use sustained?

F. Outcomes and Outcome Variables
1. The major outcomes will be to increase and to decrease
2. Thus, scales or measured indicators of these outcomes will be

III. Implementation
A. Program Implementation
1. What are some practical aspects for implementing this program?
B. Program Administration
1. This program will be directed or overseen by
2. Staff training will involve
3. Other staff-related issues are

IV. Evaluation
A. Outcome Evaluation
1. The basic evaluation program approach will be
2. Expected short-term changes on specific outcomes will be
B. Process Evaluation
1. Indicators of fidelity in implementation and/or of quality in program implementation will be
2. Problems in program delivery or effectiveness will be identified by
3. Anticipated types of cultural adaptations that may be needed to make the program more culturally relevant are
4. Participant satisfaction and responses to the program will be evaluated by
5. Other issues
C. Data Analysis
1. What data analyses will be conducted to evaluate the extent of successful program effects?
D. Additional Comments
1. What other issues not yet covered need commentary?
Appendix B

GENERAL ACCLUTURATION INDEX

Please circle the choice that is true for you. Then add the circled scores to obtain the SUM below. Then divide the SUM by 5 to obtain the General Acculturation Index (AI) value.

<table>
<thead>
<tr>
<th>1. I speak</th>
<th>4. Currently my circle of friends are</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Only Spanish</td>
<td>1. Almost exclusively Hispanics/Latinos</td>
</tr>
<tr>
<td>2. Spanish better than English</td>
<td>(Chicanos/Mexican Americans, Puerto Ricans, Cubans, Colombians,</td>
</tr>
<tr>
<td>3. Both English and Spanish equally well</td>
<td>Dominicans, etc.)</td>
</tr>
<tr>
<td>4. English better than Spanish</td>
<td>2. Mainly Hispanics/Latinos</td>
</tr>
<tr>
<td>5. Only English</td>
<td>3. Equally Hispanics/Latinos and Americans from the United States</td>
</tr>
<tr>
<td></td>
<td>(Anglo Americans, African Americans, Asians/Pacific Islanders, etc.)</td>
</tr>
<tr>
<td>2. I read</td>
<td>4. Mainly Americans from the United States</td>
</tr>
<tr>
<td>1. Only Spanish</td>
<td>5. Almost entirely Americans from the United States</td>
</tr>
<tr>
<td>2. Spanish better than English</td>
<td></td>
</tr>
<tr>
<td>3. Both English and Spanish equally well</td>
<td></td>
</tr>
<tr>
<td>4. English better than Spanish</td>
<td></td>
</tr>
<tr>
<td>5. Only English</td>
<td></td>
</tr>
<tr>
<td>3. My early life from childhood to 21 years of</td>
<td>5. In relation to having a Latino/Hispanic background, I feel</td>
</tr>
<tr>
<td>age was spent</td>
<td>1. Very proud</td>
</tr>
<tr>
<td>1. Only in Latin America (Mexico, Central</td>
<td>2. Proud</td>
</tr>
<tr>
<td>America, South America) or the Caribbean</td>
<td>3. Somewhat proud</td>
</tr>
<tr>
<td>(Cuba, Puerto Rico, etc.)</td>
<td>4. Little pride</td>
</tr>
<tr>
<td>2. Mostly in Latin America or the Caribbean</td>
<td>5. No pride (or circle 5 if you are <em>not</em> of Latino/Hispanic background)</td>
</tr>
<tr>
<td>3. Equally in Latin America/the Caribbean</td>
<td></td>
</tr>
<tr>
<td>and in the United States</td>
<td></td>
</tr>
<tr>
<td>4. Mainly in the United States and some</td>
<td></td>
</tr>
<tr>
<td>time in Latin America/the Caribbean</td>
<td></td>
</tr>
<tr>
<td>5. Only in the United States</td>
<td></td>
</tr>
<tr>
<td>5. In relation to having a Latino/Hispanic</td>
<td>SUM =</td>
</tr>
<tr>
<td>background, I feel</td>
<td>Acculturation Index (AI) = SUM/5 = ____</td>
</tr>
<tr>
<td>1. Very proud</td>
<td></td>
</tr>
<tr>
<td>2. Proud</td>
<td></td>
</tr>
<tr>
<td>3. Somewhat proud</td>
<td></td>
</tr>
<tr>
<td>4. Little pride</td>
<td></td>
</tr>
<tr>
<td>5. No pride (or circle 5 if you are <em>not</em> of</td>
<td></td>
</tr>
<tr>
<td>Latino/Hispanic background)</td>
<td></td>
</tr>
</tbody>
</table>

SUM =
Acculturation Index (AI) = SUM/5 = ____
INDICE GENERAL DE ACULTURACION

Por favor, circule el número de la selección que sea más correcta para usted. Luego calcule la SUMA. Divida la SUMA entre cinco para obtener su Índice General de Aculturación.

1. Yo hablo
   1. Solamente español (castellano)
   2. El español mejor que el inglés
   3. El inglés y el español por igual
   4. El inglés mejor que el español
   5. Solamente inglés

2. Yo leo
   1. Solamente español (castellano)
   2. El español mejor que el inglés
   3. El inglés y el español por igual
   4. El inglés mejor que el español
   5. Solamente inglés

3. Mi juventud desde la infancia hasta los 21 años de edad la viví
   1. En Latinoamérica (México, Centroamérica, Sudamérica) o en el Caribe (Cuba, Puerto Rico, etc.)
   2. Principalmente Latinoamérica o el Caribe
   3. En Latinoamérica/el Caribe y en los Estados Unidos por igual
   4. Principalmente en los Estados Unidos y un tiempo en Latinoamérica/el Caribe
   5. Solamente en los Estados Unidos

4. Actualmente mi círculo de amigos está formado de
   1. Casi exclusivamente hispanos/latinos (chicanos, méxico americanos, puertorriqueños, cubanos, colombianos, dominicanos, etc.)
   2. Principalmente hispanos/latinos
   3. Mexicanos/hispanos y angloamericanos (norteamericanos, africano americanos [negros], asiático americanos, etc.)
   4. Principalmente angloamericanos
   5. Casi exclusivamente angloamericanos

5. En relación con mis raíces latinas/hispanas me siento
   1. Muy orgulloso(a)
   2. Orgulloso(a)
   3. Algo orgulloso(a)
   4. Un poco orgulloso(a)
   5. Nada orgulloso(a), o no tengo raíces latinas/hispanas

SUMA =
Índice de Aculturación = SUMA/5 = _____