

**Community Outreach Along the U.S./Mexico Border: Developing HIV Health Education
Strategies to Engage Rural Populations**

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Abstract

Although there have been ongoing efforts in the United States to reduce new infections and improve care in people already living with the human immunodeficiency virus (HIV) and other sexually transmitted diseases/infections, Hispanics continue to bear a disproportionate burden of HIV/STI's. Reducing sexual health disparities is a key aspect in achieving health equity, and requires prioritization of groups most at risk for HIV/STI infection and least likely to have regular access to preventive healthcare. A growing body of nursing research highlights the need

for addressing HIV-related health disparities among Hispanics. Our research in the U.S. – Mexico border region contributes to our ability to respond to HIV-related health disparities in Hispanic populations in the border region and beyond. Nurses have much to contribute to community-based efforts to promote societal and structural changes to reduce HIV risk, and bring unique expertise, experience, and perspective to community mobilization efforts. The purpose of this article is to explore strategies in disseminating HIV health education information and research findings in rural areas along the U.S./Mexico border. We conducted a needs assessment of clinics serving rural areas to enhance our dissemination and outreach efforts and to inform the development of culturally and linguistically appropriate health education materials. Increased capacity to integrate screening, referral, and education into routine clinic visits may improve prevention education, screening, and treatment engagement for STI's and HIV. Translating local research findings into improved clinical practice and services can promote health equity among medically underserved people in our region. Prioritizing rural practitioners - who are often generalists and meet many of the health care needs of their community – is a replicable dissemination approach for nurses and other health professionals committed to building health equity.

Keywords: HIV; Health equity; Hispanic health; Rural health

Community Outreach Along the U.S./Mexico Border: Developing HIV Health Education Strategies to Engage Rural Populations

Background

Although there have been ongoing efforts in the United States to reduce new infections and improve care in people already living with the human immunodeficiency virus (HIV) and other sexually transmitted diseases/infections, Hispanics continue to bear a disproportionate burden of HIV/STI's (Centers for Disease Control and Prevention, 2011; Chen, Gallant, & Page, 2012). In 2009, The White House Office of National AIDS Policy (ONAP) began to engage diverse stakeholders to develop a coordinated and comprehensive response to the HIV epidemic. The ONAP developed strategies and overarching goals to reduce HIV infection, improve treatment engagement and outcomes, and reduce HIV-related disparities (ONAP, 2010). Reducing sexual health disparities is a key aspect in achieving health equity, and requires prioritization of groups most at risk for HIV/STI infection and least likely to have regular access to preventive healthcare.

The focus of HIV/AIDS prevention has been to move from individual risk behaviors to community mobilization focusing on empowerment (Harper, Willard, & Ellen, 2012; Parker, 1996). Community mobilization “engages all sectors of the population in a community-wide effort to address a health, social, or environmental issue... [and] empowers individuals and groups to take some kind of action to facilitate change” (Centers for Disease Control and Prevention, n.d.).

Coordinated by the local Department of Public Health, our HIV Community Mobilization Team was convened in 2013, and over a period of several months developed a cohesive mission

to advocate and promote a unified, inclusive, and community-based approach to improve HIV prevention, awareness, services, and public policy. With small groups of team members representing interests and concerns of our Lesbian, Gay, Bisexual, Transgendered (LGBT) community, healthcare providers, school-based personnel, faith-based organizations, and media groups, the team aims to mobilize community support for their mission. Our participation in this initiative sparked a desire to increase engagement with practitioners in rural areas, and to contribute to their ability to recommend appropriate sexual health screening and services for their clients, most of whom are Hispanic of Mexican origin.

A growing body of nursing research highlights the need for addressing HIV-related health disparities among Hispanics (González-Guarda, Florom-Smith, & Thomas, 2011; González-Guarda, Vasquez, Urrutia, Villarruel, & Peragallo, 2011) although most of the literature focuses on individual risk and risk reduction as opposed to social and contextual changes. Recognizing and responding to the diversity of Hispanics in the U.S., our research in the U.S. – Mexico border region contributes to our ability to respond to HIV-related health disparities in Hispanic populations in the border region and beyond. Nurses have much to contribute to community-based efforts to promote societal and structural changes to reduce HIV risk, and bring unique expertise, experience, and perspective to community mobilization efforts.

Community involvement has been shown to increase effectiveness of outcomes in HIV/AIDS programs. Community involvement facilitates conversations in communities to empower HIV/AIDS affected communities to take ownership of their health, in turn increasing health enhancing prevention behaviors (Campbell & Cornish, 2010). Communities face many challenges related to increasing HIV awareness and disseminating culturally and linguistically appropriate information. For example, many clinics lack the resources to spend adequate time

discussing sexual health and risk behavior and Hispanic women in particular may be reluctant to initiate conversations about their risk and/or exposure. Many rural communities are sometimes left out of these community discussions, and at times outreach resources do not extend to far areas of the county or other outlying counties. With this in mind, an interdisciplinary team participating in the community mobilization campaign is assessing rural community health clinic perspectives on HIV education and testing. The team is comprised of a public health nurse, a community health educator with a Masters in Public Health, and a Certified Health Education Specialist with a doctorate, affiliated with a School of Nursing. The outreach efforts also extend to the neighboring rural areas in the state of New Mexico.

The purpose of this article is to explore strategies in disseminating HIV health education information and research findings in rural areas along the U.S./Mexico border. The term “rural” is defined differently by government agencies and healthcare organizations, and is often a designation applied at the county level. For the purposes of this project, “rural” is defined as *an area outside of the metropolitan city limits in which residents have limited access to primary care and public health department services because of distance, lack of transportation, and/or limited availability of services at satellite clinics*. Because of our location in the border region, many of the areas served through this project are considered *colonias* – residential areas characterized by a lack of infrastructure such as water, electricity, sewer, roads, and other basic necessities. *Colonias* tend to have high unemployment and poverty rates, as well as increased health risks due to living conditions. In El Paso County alone, there are more than 300 *colonias* (Mora & Schultz, 2013; Texas Secretary of State, 2013). Many of the areas served through our project are adjacent to counties designated as rural by state and federal agencies, and our dissemination strategies are designed for geographically defined rural areas as well as

demographically similar regions adjacent to these boundaries. Although geographic designations often define rural areas for funding and/or service eligibility purposes, poverty and limited access to healthcare services rarely fall neatly into geographic areas. Healthcare teams serving rural areas should be aware of the complexity of rural health issues and the inconsistencies in definitions of rural across programs and policies.

HIV Rural Community Needs Assessment Process

Recent research conducted by our team assessed HIV risk behavior knowledge among a community-based sample of Hispanic (mostly of Mexican origin) men and women; significant gaps in knowledge were identified especially in terms of safe condom use (Martinez, Provencio-Vasquez, Mata, Arredondo, & DeSantis, 2013). These gaps in HIV risk behavior knowledge likely exist in our regional urban and rural populations, and discussions about risk knowledge can be part of clinical and community-based services. This research and community collaboration strengthened local existing community partnerships, and began broadening the scope of HIV discussion with practitioners. Health education is one way for clinicians to address individual risk knowledge and behavior. Accordingly, through this project we conducted a needs assessment of clinics serving rural areas to enhance our dissemination and outreach efforts and to inform the development of culturally and linguistically appropriate health education materials.

Setting

El Paso, Texas has a population of more than 800,000 and shares a border with Ciudad Juarez, Chihuahua, Mexico. El Paso city's limit extends to Mexico and cities of southern New Mexico. The rural communities included within this project were outlying towns that surround the city of El Paso, Texas within east and west areas of El Paso County and Dona Ana County, New Mexico. All of the communities served by participating clinics are predominately Hispanic

(mostly of Mexican origin), and many residents lack health insurance as well as access to regular medical care (Mora & Schultz, 2013).

Method

The HIV rural resource dissemination project was developed to assess services and resources related to HIV/ Sexually Transmitted Infections (STI) available in clinics serving rural communities. The long-term goal of our project is to bridge communication between local clinicians, our School of Nursing, and other stakeholders to improve community health services to rural populations on the broader topic of sexual health. The project prioritizes clinics in rural locations to determine services provided, familiarity with regional HIV/STI screening and treatment services, and staff preference for dissemination of community-based research results (e.g., through research briefs, staff trainings/in-services, or individual visits from university researchers and health education specialists). We also solicit input on developing culturally and linguistically appropriate sexual health promotion materials. For example, in a recent meeting with the entire caseworker team of one of our clinic partners, we shared our findings and they provided guidance on developing relevant and useful materials. This is a needs assessment rather than research with human participants; all information collected relates to services provided and preferences for dissemination of health education resources. Accordingly, an Institutional Review Board (IRB) did not review the project. However, the research studies mentioned here which provided the basis for health education materials were reviewed and approved by the University of Texas at El Paso IRB.

Development of HIV health information material.

When developing health education resources to disseminate research results from previous studies in the community, we first shared results with clinic partners serving people living with

HIV/AIDS. The initial feedback from practitioners enabled us to tailor the materials to our priority population and to design educational resources for clinic staff to use with clients in discussions of HIV risk reduction. Subsequent meetings with clinicians led to the need for educational materials that incorporated research results from local studies so as to make them more relevant to clients participating in discussions of HIV/STI risk and reviewing health education materials. Clinicians also suggested that these materials could be used to integrate HIV risk behavior knowledge into conversations with clients about sexual health and safer sex practices regardless of their HIV status. Ongoing discussions with clinic staff and practitioners helped our team realize that it was not only essential for patients being seen in HIV/STI care settings, but also in primary care and other clinic settings throughout the region. We began to prioritize rural communities and clinics where provider availability, transportation, and limited resources are often barriers to regular sexual health screenings and access to care.

Responding to input from our clinical partners, we are developing tailored health education materials including a waiting room presentation to show on clinic TV screens, colorful flipcharts that caseworkers can use as a visual aid when providing client education on safe condom use, and handouts designed to encourage clients to discuss these issues with their healthcare providers during their appointment. Our clinic partners found it helpful to brainstorm strategies to use local research results to communicate health education and risk reduction information with their clients. Evaluating and refining our dissemination strategies with input from our clinical partners will help us understand and respond to practitioner and client preferences.

HIV community mobilization collaboration.

As previously discussed, our team participates in a community mobilization effort organized through our local Department of Public Health, and contributes to the community's

discussion about HIV/AIDS along the U.S. / Mexico border. Collaborating in such discussion improves the facilitation of community change and increases social capital (Miller, Bedne, & Guenther-Grey, 2003).

In our initial outreach in rural communities, we realized that many of the clinics lacked the resources to distribute condoms to patients, and through our participation in the community mobilization project we were able to connect with Department of Public Health staff and expand their outreach and condom distribution program to several of the rural clinics we visited. Thus, we are often able to extend the reach of health department resources to clinics outside of the city limits, and were also able to distribute condoms and sexual health education materials to clinics who otherwise might not have received these resources.

In meeting with rural clinicians and staff we have identified clinics who would like to offer material on sexual health to clients as a way to begin their conversation with the clinician. During our assessment we were also able to identify additional services that are offered in New Mexico but not in Texas, such as a needle exchange program used in the field as a harm reduction intervention for injection drug users. Sharing these practices and services from bordering counties helps engage community stakeholders involved in the HIV Community Mobilization initiative, and broadens our perspective regarding policy alternatives and policy advocacy strategies.

HIV rural community needs assessment.

Clinics in outlying communities were located through internet searches, local resource guides, and word of mouth from nursing and public health colleagues. The nurse and the community health educator on our team contact clinics by phone to schedule a time to meet with clinic staff. The assessment takes approximately 20 minutes and is done with office managers,

supervising medical assistants, and directors of community clinics. The 29 questions query respondents on community demographics, migrant worker services, and other questions related to the population served. Participants also discuss existing protocol for HIV/STI screening, availability of sexual health education resources, strategies for discussions of sexual health and HIV/STI risk during routine visits. They also provide input on how we can facilitate patient/provider communication on sexual health risk and screening. Many of the other questions were adapted from an existing measure (Lifson, et al., 2009) that evaluates clinic staff ability to screen for HIV and STI's, manage clients infected with HIV and STI's, and access most recent sexual health guidelines, prevention materials and reporting guidelines. Following discussions with clinic staff, our team left an informational handout describing the purpose of the needs assessment, our desire to collaborate with rural community clinicians and administrative staff, and our contact information. To date, we have met with 8 of the 17 clinics prioritized for outreach.

Lessons Learned From HIV Outreach Strategies

Our interdisciplinary team benefits tremendously from being able to assess services provided in outlying communities. As expected, clinic prioritization of HIV/STI screening ranged from *“not much of a priority”* to *“high priority”*. Some clinics had informal referral systems to other practitioners that provide low-cost testing services in the communities they serve, while others mentioned that it was cumbersome to perform HIV and STI tests because the lab work took a while to come back with results taking longer than in the city. Most practitioners indicated that HIV/STI screening was based on either self-reported behavioral risk or presenting symptoms of HIV/STI's. Routine and universal discussions about sexual health were uncommon based on our assessment, and determination of behavioral risk is primarily at the discretion of the

practitioner. As expected, most of the clinics we visited also had wait lists for enrolling new clients and wait times to schedule a visit for established clients were lengthy. Several of the clinics we visited did say that if a client or someone really did want to get a HIV/STI test quickly they would refer them to the public health department where they could be seen faster.

We did encounter some unexpected difficulties in conducting our needs assessment. Some agencies that were satellite clinics, or part of a network of clinics, needed approval from administrative personnel at other locations which in some cases took time to obtain. As recent graduates with little experience in clinical settings, we felt like we had an advantage in that we were highly flexible but we sometimes found it daunting to go through several layers of administrative approval before visiting a clinic. We also realized that because it is our area of research focus, sexual health education and prevention may be a higher priority to us than to rural healthcare providers. In addition, clinicians with limited resources are often focused on treating chronic diseases and have limited time to deal with sexual health promotion and education.

Implications for Practitioners

We recommend and are advocating for increased training and resources related to HIV/STI screening for practitioners serving rural populations. Increased capacity to integrate screening, referral, and education into routine clinic visits may improve prevention education, screening, and treatment engagement for STI's and HIV (Lifson et al., 2009). Moreover, it is important that community health practitioners provide culturally and linguistically appropriate HIV risk reduction programs to reduce sexual health disparities (Lanier & Sutton, 2013; Rios-Ellis et al., 2008.).

This is a foundation from which we can continue our work with rural practitioners, and look forward to collaborations that build on the strengths of nurses and health education specialists in primary care settings. Community outreach strategies that engage rural health providers along the U.S. Mexico border are relevant and replicable in communities throughout the U.S., especially those in which sexual health issues are often addressed as part of a routine clinic visit for other health issues. We anticipate providing resources to other rural counties that surround El Paso County, sharing health promotion and education materials developed based on local needs and data while learning more about their resources, challenges, and opportunities to promote sexual health and reduce HIV/STI risk. Translating local research findings into improved clinical practice and services can promote health equity among medically underserved people in our region. Prioritizing rural practitioners - who are often generalists and meet many of the health care needs of their community – is a replicable dissemination approach for nurses and other health professionals committed to building health equity. We look forward to learning from our colleagues in nursing and public health through our outreach and dissemination efforts.

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References

Campbell, C., & Cornish, F. (2010). Towards a "fourth generation" of approaches to HIV/AIDS management: creating contexts for effective community mobilisation. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 22(S2), 1567-1579. <http://dx.doi.org/10.1080/09540121.2010.525812>

- Centers for Disease Control and Prevention (2011). *HIV among Latinos*. Division of HIV/AIDS Prevention. Atlanta: Centers of Disease Control and Prevention. Retrieved from http://www.cdc.gov/hiv/pdf/risk_latino.pdf
- Centers for Disease Control and Prevention (n.d.). *Community Mobilization Guide*. Division of HIV/AIDS Prevention. Atlanta: Centers of Disease Control and Prevention. Retrieved from <http://www.cdc.gov/stopsyphilis/toolkit/Community/CommunityGuide.pdf>
- Chen, N. E., Gallant, J. E., & Page, K. R. (2012). A systematic review of HIV/AIDS survival and delayed diagnosis among Hispanics in the United States. *Journal of Immigrant and Minority Health, 14*(1), 65-81. <http://dx.doi.org/10.1007/s10903-011-9497-y>.
- González-Guarda, R. M., Florom-Smith, A. L., & Thomas, T. (2011). A syndemic model of substance abuse, intimate partner violence, HIV infection, and mental health among Hispanics. *Public Health Nursing, 28*, 366-378. <http://dx.doi.org/10.1111/j.1525-1446.2010.00928.x>.
- González-Guarda, R. M., Vasquez, E. P., Urrutia, M. T., Villarruel, A. M., & Peragallo, N. (2011). Hispanic women's experiences with substance abuse, intimate partner violence, and risk for HIV. *Journal of Transcultural Nursing, 22*(1), 46-54. <http://dx.doi.org/10.1177/1043659610387079>.
- Harper, G. W., Willard, N., Ellen, J. M., & The Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2012). Connect to Protect®: Utilizing community mobilization and structural change to prevent HIV infection among youth. *Journal of Prevention & Intervention in the Community, 40*(2), 81-86. <http://dx.doi.org/10.1080/10852352.2012.660119>.

- Lanier, Y., & Sutton, M. Y. (2013). Reframing the context of preventive health care services and prevention of HIV and other sexually transmitted infections for young men: New opportunities to reduce racial/ethnic sexual health disparities. *American Journal of Public Health, 103*, 262-269. <http://dx.doi.org/10.2105/AJPH.2012.300921>.
- Lifson, A. R., Rybicki, S. L., Hadsall, C., Dickson, S., Van Zyl, A., & Carr, P. (2009). A training program for nurses and other health professional in rural-based settings on screening and clinical management of HIV and other sexually transmitted infections. *Journal of the Association of Nurses in AIDS Care, 20*, 77-85. <http://dx.doi.org/10.1016/j.jama.2008.09.008>
- Martinez, J., Provencio-Vasquez, E., Mata, H., Arredondo, S., & DeSantis, J. (2013). *HIV risk behavior knowledge among Hispanics: Implications and opportunities for practitioners in diverse settings*. San Francisco: 2013 Society of Behavioral Medicine Annual Meeting.
- Miller, R. L., Bedne, B. J., & Guenther-Grey, C. (2003). Assessing organizational capacity to deliver HIV prevention services collaboratively: Tales from the field. *Health Education & Behavior, 30*, 582-600. <http://dx.doi.org/10.1177/1090198103255327>
- Mora, A., Schultz, L. (2013). *Community health assessment and improvement plan – City of El Paso Department of Public Health*. El Paso, TX: Department of Public Health. Retrieved from http://home.elpasotexas.gov/health/_documents/El_Paso-CHA_Narrative_FINAL%20REVISED%20July%2031%202013%20COMBINED.pdf
- Office of National AIDS Policy, The White House. (2010). *National HIV/AIDS strategy: Federal implementation plan*. The White House.
- Parker, R. G. (1996). Empowerment, community mobilization and social change in the face of HIV/AIDS. *AIDS, 10*(3), S27-S31. [[MEDLINE](#)]

Rios-Ellis, B., Frates, J., D'Anna, L. H., Dwyer, M., Lopez-Zetina, J., & Ugarte, C. (2008).

Addressing the need for access to culturally and linguistically appropriate HIV/AIDS prevention for Latinos. *Journal of Immigrant and Minority Health, 10*, 445-460.

[\[MEDLINE\]](#)

Texas Secretary of State. (2013). *Directory of Colonias located in Texas*. Austin, TX: Texas

Secretary of State. Retrieved from <http://www.sos.state.tx.us/border/colonias/reg-colonias/el Paso.shtml>