School of Rural Public Health ▪ Texas A&M University System Health Science Center

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MUJER Y CORAZÓN:

Community Health Workers And Their Organizations In Colonias On The U.S. - Mexico Border

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With the colonias as context, the report analyzes community-health worker (CHW) *organizations* and community-health worker (CHW) *practices*. Its goal is to understand how and why these organizations and workers do what they do and why they are key resources in colonias for improving the health of the communities and enabling the population to make the most of available resources. Moreover, it examines their relationships with and their impact on the communities they serve. Finally, the report discusses the research and policy implications of the study findings and how these results can support and advance the crucial work of CHWs and the organizations they represent.

To accomplish the goals, the study examined six CHW organizations and their workers in Texas and six in New Mexico. The research relied on interviews with leaders of the organizations and their workers, observation of the CHWs as they provided services, and focus groups conducted with community residents. This Policy Brief provides an overview of the main study findings and the policy and research implications of those results.

I. COMMUNITY-HEALTH WORKER ORGANIZATIONS

The study found that CHW organizations varied programmatically in their focus, structurally in their relationships to the communities served, and geographically in terms of the areas they served.

Programmatic Variation. The CHW organizations included in the study had a variety of programmatic foci. These included education and community building, early childhood development, community development, health, economic capacity building, child and maternal health, and environmental health. Of the 12 CHW organizations studied, seven had health as a major focus. The remaining five had a broader focus but included health among their goals in some form. However, even CHWs working in health-focused organizations were not precluded from practicing in a manner that addressed client needs well beyond strictly health-related issues.

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The US-Mexico Border and Colonias

- HRSA defines the border as consisting of 48 border counties in four U.S. states -- Texas, New Mexico, Arizona, and California.
- The U.S.-Mexico border region comprises an area that stretches 2,000 miles from San Ysidro, California, to Brownsville, Texas, and extends 62 miles north of the border into the US.
- The U.S. border population has a higher poverty level than the national rate, with more than 20 percent living below the poverty level as compared to 12 percent in the country as a whole (EPA, 1997).
- Three of the ten poorest counties in the US are located in the border area, and 21 border communities have been designated as economically distressed.
- However, these conditions vary among border counties: 55% of the population in Starr County, Texas lives below the poverty line as compared to only about 8% of the population in San Diego.
- Colonias are unincorporated rural areas along the border in Texas, New Mexico & Arizona.
- There are an estimated 1800 colonias on the Texas-Mexico border with an estimated population of 500,000 residents.
- In Texas, 46% of all colonias are small (< than 40 lots) and house 13% of the colonia population. About 7% are large (> 300 lots), housing 35% of all residents.

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This study was conducted under a Cooperative Agreement 5-U1C-RH00033 from the federal Office of Rural Health Policy in the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

Structural Variation. CHW organizations differed in their relationship to the communities they served. Some were deeply embedded in the community, focused on one or a few communities, and were served by CHWs who were both residents of the community and administrators of the organization. Others had very different structural characteristics. Some CHW organizations were much less embedded in local communities and more widely connected to regional, state, multi-state, or even national programs and resources. They had more complex administrative structures, and served large geographic areas. Others fell between these two extremes.

Geographic Variation. CHW organizations ranged from those serving one or a few colonias to serving only one part of a county to serving an area that encompassed several counties.

II. COMMUNITY-HEALTH WORKER PRACTICES

The study found that among the CHW organizations operating in the border-area colonias, the work of CHWs was a complex whole, involving five basic *domains of practice*. This was largely true, despite the particular programmatic focus of the organization and the CHWs' formal assignment. The essential message, however, was that from the perspective of CHWs, they viewed their role as practicing in all of these domains:

The **information and referral domain** generally included disseminating information on health and human services, immigration issues, and other essential topics in community settings, schools, churches, and homes.

The **education domain** included education about parenting, job-related concerns, health and well-being, and other topics. CHWs also typically received ongoing formal training on how to effectively perform educational functions.

The **community and capacity building** domain focused on creating social networks, identifying and nurturing leadership in the community, building economic capacity among residents, and preserving Mexican culture.

The **emotional support domain** included nurturing relationships with residents, based on creating and sustaining trust, respect and confidentiality. CHWs provided emotional support around many personal and community areas of need, such as social isolation, domestic violence, and family celebrations. This aspect of CHW practice was especially valued by new immigrants, enabling them to function more effectively in a new country.

The **advocacy domain** included acting with and on behalf of the interests of the residents, such as advising service providers and other organizations about how to most effectively interact with residents. The study found instances in which a CHW would accompany a resident to a clinic appointment, observe how the resident was treated, and teach the resident how to deal with the situation, (e.g. improve communication or deal with issues of cultural sensitivity). Advocacy was observed in multiple contexts (schools, immigration, and health).

Colonias, continued…

Examples of Health Challenges

- Hepatitis A and Tuberculosis are twice as prevalent along the border compared to the US as a whole.
- Chronic diseases, such as diabetes, are also a significant problem.
- Health problems in the border region are complicated by social, economic, and cultural factors, such as occupational risks, limited ability to purchase nutritious food, barriers to affordable medical care, and sometimes, cultural practices and beliefs about medical care.

Learning from Our Neighbors in Mexico

Under the direction of Dr. Ignacio Mendoza, former Head of Sanitary District III in Matamoros, a program called *Comunidades Saludables* was started. The underlying philosophy that guided this initiative was that one could create healthy communities. Dr. Mendoza and his public health staff created community-based clinics in poor neighborhoods in Matamoros and encouraged community involvement. Community volunteers were used to help the professional clinic staff reach out to residents and carry out both preventive and curative health services. Dr. Mendoza spoke widely about this initiative in Mexico and at international health conferences, such as one held in San Antonio. Dr. Mendoza's use of community health outreach workers in *Comunidades Saludables* has helped inform the development and use of promatoras/es in the colonias along the US-Mexico border.

III. COMMUNITY

The well-being of communities in which CHWs lived and worked was a primary motivation in their daily work. Community represents the intertwining of Mexican and border culture with the larger U.S. culture, social networks, and the formal and informal partnerships that CHWs established with residents. Community was a template that shaped CHW practices. Indeed, understanding CHW practices requires understanding that three elements formed the CHW practices system – a dynamic blend of CHW organizations, CHWs themselves, and the community. The study concludes that a major challenge to CHW practices is creating and sustaining a balance in the relationships among these three elements, a challenge growing more difficult as the employment of CHWs becomes more institutionalized and (Continued on pg 3)

professionalized. Greater imbalance in the CHW system practices poses a potential threat to the shape of CHW practices as currently perceived and practiced.

IV. PROGRAMMATIC AND POLICY IMPLICATIONS

The study findings raise a number of programmatic and policy issues. Some are specific to the study's focus, namely colonias located in the U.S. – Mexico border region. Others, though emerging from this context, may well apply more broadly to other settings, CHW organizations, and to the variety of CHWs across the country. This is particularly critical since there is increasing recognition of the critical role CHWs can play, of expansion in the types of organizations using CHWs, and of potential changes in their role as a result of calls for credentialing or certification and reimbursement. Further, these changes may lead ineluctably to changes in their relationship to the communities they serve.

Variation Among CHW Organizations: Policy Questions and Research Implications

The study findings suggest that the 'mix' of structural, programmatic and geographic features that CHW organizations adopt significantly affect the shape of CHW practices. Thus, these findings about the wide variation among CHW organizations raise several research questions about the effects of this variation and how to achieve the most effective mix among structural, programmatic and geographic characteristics. Examples of such ***policy-relevant research questions*** include the following:

- What is the most effective structural relationship for CHWs to have with the communities they serve? For example, how deeply should a CHW organization be embedded in a particular community? Does the nature of the programmatic focus of the CHW organization imply that one model of structural relationship to the community is more or less effective? How does the structural relationship to the community affect recruitment and retention of CHWs?
- Does the programmatic focus of CHW organizations affect their ability to recruit, retain and sustain a CHW workforce? For example, are narrowly focused C-HW organizations more or less able to attract and retain CHWs?
- What are the effects of differing geographic service areas on CHW organizations? For example, are some structures more effective for certain types of programmatic foci? Are there potential trade-offs between the availability of resources (e.g., state-level resources might be available for multi-county programs) and the ability to link the CHWs to their home communities? Or between sustainability of the CHW organization and retention of CHWs? Are there economies of scale associated with one model but more effective recruitment with another?

Acknowledgements

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Policies Affecting CHW Practices: Programmatic Implications and Policy Issues

Policies affecting CHW practices should recognize and consider the dynamic nature of the CHW system in which CHWs operate. This system in which CHWs practice has implications for policies related to the following five elements:

Recruitment. The study findings suggest that CHW recruitment policies should emphasize selecting workers from the community(ies) in which they will work and should seek individuals who demonstrate basic talents and a strong interest in the community and its people. CHW organizations should also seek individuals who are committed to ongoing learning, able to model the behavior and activities that will support both individual development and community capacity-building, and possess communication and other interpersonal skills that enable them to work with local people as well as external organizations. (Continued on page 4)

Useful websites: TDH's CHW website at http://www.tdh.state.tx.us/ophp/chw
CDC at www.cdc.gov or BPHC/HRSA at http://bphc.hrsa.gov/bphc/borderhealth/default.htm

Training. The study findings indicate that training for CHWs should recognize the importance of imparting information about the local community settings in which CHWs will function. Although a statewide or regional program may be charged with developing and implementing a CHW program, the training component should include input from local CHW organizations and local experts from the communities in which CHWs are expected to work.

Role Definition. Policies and programmatic decisions should encourage employment of CHWs in roles that reflect all elements of CHW practice. Some organizations and policy-makers tend to view the role of CHWs more narrowly, as a vehicle to market or promote a particular organization or service. Such a limited view of their roles is likely to generate problems in recruitment and retention of CHWs who have a natural inclination toward a more holistic approach to helping individuals and communities.

Credentialing/Certification. Policy development and implementation for credentialing, certification, and other recognition of CHWs by government agencies and funding organizations should ensure that full consideration is given to the range of work expected of CHWs, as well as the variety of community settings in which such work is conducted. Such policies should seek to ensure quality and effectiveness among C-HWs without creating unjustifiable hurdles that might exclude persons with significant abilities to meet local needs.

Recognizing the Role of CHWs and Cultural Connectivity. Regulatory and professional organizations should give full consideration to the capabilities of CHWs to work with and enhance the effectiveness of health professions, programs, and organizations in working with populations that require cultural "connectivity" and healthy community-building that goes well beyond popular notions of cultural sensitivity. In doing so, careful consideration is needed regarding whether CHWs must have the 'proper credentials,' or whether it can be optional. (A Report on the topic of CHW credentialing is forthcoming from the SWRHRC in the near future.)

Policies Related to CHW Organizations

Policies and programs should recognize the need for flexibility in contractual or programmatic relationships between funding organizations and CHW organizations, enabling the latter to manage CHW activities in a manner that balances community expectations with sponsors' expectations.

Local Control. Stakeholders argued that, regardless of the degree of external administrative control or sponsorship that is formally required of a CHW organization, a guiding principle should be assurance of a significant degree of local control and design in CHW service programming and implementation and sustainability.

Funding for Organizational Infrastructure. The study suggests that funding agencies should include a significant proportion of funding that can be allocated at the discretion of the local organization to support infrastructure development, evaluation and other capabilities that support effective implementation of the program being funded.

Flexible Forms of Funding for Community Development. To address gross disparities, some funding policies should be flexible, offering funding akin to community development block grants. These should be specifically targeted to CHW organization in colonias to support the broad-based development of healthy communities, not merely health initiatives aimed at individual members of the community.

Need to Focus Regulation of CHW Organizations on Processes and Outcomes, Not Structural Features. The variation among CHW organizations suggests that different arrangements facilitate different outcomes, in terms of services to individuals and communities and their effect on CHWs. The findings point to the need for policies and programs governing CHW organizations that emphasize conformance to principles, competencies, core processes, and outcomes rather than compliance with specific structures or models. This recommendation reflects the fact that the diversity of communities and cultures in which CHW organizations and CHWs functioned were inconsistent with notion of *one size fits all*.

Related Research at The School of Rural Public Health

The Community Health Worker Certification Project (PI: Marlynn May, PhD; Funded by ORHP/HRSA)

Creating an Integrated Health Outreach System to Isolated Colonia Residents in Hidalgo County (PI: James Burdine, DrPH; Funded by The Robert Wood Johnson Foundation, BPHC, and HRSA)

Ingestion of Pesticides by Children in Agricultural Areas (PI: K.C. Donnelly, PhD; EPA and Rutgers University)

A Study of Work Injuries in Farm Worker Children in Starr County (2001-2006) (PI: Sharon Cooper, Ph.D.; Funded by NIOSH)

To request a copy of the report, please visit the Center's website:

http://www.srph.tamushsc.edu/centers/srhrc

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