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# COMMUNITY OUTREACH AND COMMUNITY MOBILIZATION:

## Options For Health At The U.S.-Mexico Border*

by

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"The truth is," he began very quietly, "we don't know what we are because we don't know where we are. And where are we?" he asked in a louder tone. "Just like our souls are between heaven and earth, so are we in between two countries completely different from each other. We are Children of the Border. . . . We are on the border between a land that has forgotten us and another land that does not understand us. . . . So what are we . . . migrant souls to do?"

Arturo Islas***

Health professionals working in the U.S.-Mexico border region, along with many of the artists and writers who make the border their subject, think of it as a special place, neither Mexico nor the United States, neither Latino nor Anglo, neither "first world" nor "third world," but some expression of both countries, both cultures, both worlds. Its liminality -- being at the edge, or threshold, or line between these worlds -- makes it both special and difficult to comprehend.[1] This paper recognizes this liminality and offers a brief and highly focused attempt to comprehend the need for and rationale of rather specialized efforts to address health care access issues along the border.

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*** Quoted from Migrant Souls, New York: Avon Books, 1990.

# Rationale For Community Outreach And Mobilization Models

Community outreach models share the recognition that a passive medical model -- in which providers wait inside their clinic for individual patients to arrive seeking help -- is not effective in the border region for many reasons, some of them cultural, many of them economic.[2,3,4,5] Research and experience lead one to conclude that poverty is the single most important barrier to adequate health care, but clearly not the only one. In areas where immunizations have been offered without cost, rates have remained low. Where prenatal care has been available and affordable, it has not been used according to professional standards of adequacy. Community outreach programs aim to overcome these problems, which may include lack of transportation or child care (economic issues), lack of information (an economic and cultural issue), lack of fluency in English (ditto), and a view of health and illness that defines care as appropriate for treatment of acute or emergent episodes only (again, both an economic and cultural issue). The most highly developed community outreach model is usually referred to as the "*promotora*" (or lay health worker, or community health advisor) model.[6,7,8] (In this paper, I will generally refer to the model as the "*promotora*" model, since most of the practitioners at this time are women, or to the community health advisor model, a term that is gaining wider acceptance in the U.S.) The *promotora* is a member of the community to be reached, who, therefore, ought to be culturally competent," to understand the community's needs, to be known and respected locally and have "automatic" access and influence. The *promotora* is recruited from the community and trained (hopefully) in areas such as specific diseases, listening skills, the organization of the local health care delivery system, client advocacy, public speaking, teaching techniques, and health education materials development.

The primary function of the *promotora* is usually defined as case-finding -- bringing people into the system for screening, education, and/or treatment, or delivering health promotion messages and providing support in the clients' homes and in community settings. As educators, advocates or provider "extenders," *promotora*s provide the critical link between community and clinical provider. There is considerable ongoing discussion among practitioners as to the scope of the model; e.g., whether *promotora*s also should be community change agents, whether their goal is empowerment, whether they are primarily motivators rather than educators, and so on.[9] Nevertheless, the model has been applied and validated in every border state and on both sides of the border.[10] It appears to be effective, efficient, and relatively simple and inexpensive to implement.

One of the challenges presented by the *promotora* model is its potential for acceptance by the providers or managers who supervise the organizations that sponsor these programs; e.g., state and county health departments, community and migrant health centers. This writer has observed that the potential of *promotora* programs to deliver a wide range of educational, psychosocial support, and advocacy services may be limited by the attempt of health professionals and program managers to routinize, bureaucratize, and control these programs in the name of efficiency or in the service of the traditional medical model.[11,12] These authors, as well as other practitioners, have concluded that the truly hard-to-reach (and not only on the border) are not the communities in need, where one discovers not only poverty, ignorance, and disenfranchisement, but intelligence, curiosity, energy, enthusiasm, and "*ganas*" to do the right thing. Rather, the hard-to-reach are frequently the professionals who have difficulty accepting and integrating into their credentialized and highly regulated scheme of things these new "community experts." To succeed, then, *promotora* programs must perform "in-reach" as diligently as they do "out-reach." As experts on their own communities, they have much to teach us.

If *promotora* style outreach programs were combined with community mobilization models, then an expanded definition of the health promoter might make good sense. This is a definition that would acknowledge the political role of the *promotora* and would point toward the synergy of integrating both approaches to improving access to health care. While neither model requires the other, many practitioners have implicitly combined them.[13,14]

Community mobilization models commonly stress high participation rates by community members, broad representation of local interests and "stakeholders," determination of needs, goals and objectives by community members rather than by "outside professionals," development of broad spectrum programs that include economic and political initiatives as well as specific health components, and grassroots control of programs. This is indeed an ambitious vision, which reflects the complexity and systemic nature of health problems along the border and which, therefore, holds promise as a guide for us. Examples of this model include the World Health Organization's (WHO) Healthy Cities Project, the Community Solutions for Rural Health model, and the CDC's PATCH (Planned Approach to Community Health) model. The Healthy Cities Project, for example, seeks to forge political, professional and technical alliances at the local level in order to bring about change, with the ultimate purpose of reaching the WHO goal of "Health for All."[15] A "healthy city" is defined in terms of process and outcome, so that the process of becoming conscious of health issues and striving to improve health status is more important than having achieved a specific level of health. Because this model has been developed by an international organization (WHO) with an international network of cities as one objective, it holds promise for binational implementation along the U.S.-Mexico border.

Most important, the community mobilization model is based on the recognition that health, including access to health care, is a systemic problem that, while reflected in the problems of individuals, is not caused by them. The solutions must also be systemic. Further, it is the community (however defined) that must identify the problems and devise the solutions, thereby claiming ownership of what is done and assuming responsibility for carrying through its initiatives. "Systemic" here means that health problems and health care access problems are not peculiar to random individuals but are shared by identifiable segments of the community (e.g., the young, the elderly, the poor, the monolingual speakers, the illiterate); that they are economic, political, and social in scope, and that, in all likelihood, they have regional, national and, for the border, transnational dimensions.

The community mobilization model is being applied in several border communities, especially with substance abuse prevention programs. The Primary Health Care Review project in Texas and Arizona in the early '90's was an earlier version of the mobilization approach.[16] One of the simpler lessons learned from these experiences is that community mobilization is a long term process requiring long term commitments from funding agencies and participants. There is a hierarchy of actions and results that must be obtained if the mobilization is to reach its ultimate objectives, whether they be decreases in substance abuse, reduction of teen pregnancy rates, or improvement of elders' quality of life.[17] Community mobilization requires that all "stakeholders" be involved in order to build community capacity and develop coalitions. This stage of the process can easily take two years or more, during which time community awareness is also being raised and people are being motivated to act. The systemic health problems of our communities are not amenable to quick fix approaches, and community mobilization is certainly not a quick fix solution.

How and where in the process of improving access to health care might the two models -- community outreach and community mobilization -- be joined? First, outreach is inherent in the mobilization model. It is the mechanism by which community members bring each other into the key interactions -- meetings and conversations and workshops -- that generate collective action. It is also the process by which community members educate themselves about problems and solutions and then bring about changes in community norms and practices. Would it then be reasonable and useful for a community mobilization type of program to include the development of a cadre of outreach specialists, either volunteer or paid or both?

The volunteer leaders of community mobilization programs may be or may act much like community health advisors or *promotoras*. The major difference between them and "outreach specialists" such as prenatal education *promotoras* may be the difference in specificity of their roles and functions, with local community program leaders addressing the broader issues of access to health care, while *promotoras* focus on family-based individual problems. Another difference may

lie in the time and effort devoted to the program or problem; the "outreach specialist" is often a paid worker and may work full-time on a project.

It is not difficult to imagine a community mobilization type of program incorporating into its activities a cadre of paid "outreach specialists" -- *promotoras* -- who would function as community developers/organizers as well as health educators and advocates. Would they work for the community coalition itself or for the local community health center, which of course would be a member of the coalition? They might do either, depending on the local situation Their organizational location and their accountability would be important considerations in designing a program. A *promotora* outreach program that is independent of other health services agencies and contracts with them would have an entirely different relationship with those agencies than would a group of *promotoras* who are employed by the agency. A group of *promotoras* who are employed and/or supervised by a community coalition would also have an unique relationship with other components of the local health care system. Whatever the specific local arrangement might be, the integration of these two models, both focusing on health care access issues, would be a natural development in our attempts to improve the quality of life on the border.
THEMATIC ISSUES

One of my assignments in this paper is to address seven overarching themes within the context of community outreach and mobilization. Several of them have been discussed already, but in order to leave no theme unturned, the remainder of the paper will specifically address these themes.

## Culture of the Border

Given the prior discussion of community-based models for improving access to health services, one might ask how culturally "appropriate" they are in the border region. The community outreach-*promotor/a* model seems to fit many communities, agencies, and health problems very well. It is employed on both sides of the border by governmental and nongovernmental organizations. Building on natural social networks and a high level of face to face interaction, *promotoras* often gain quick acceptance, respect, and authority in their communities.

The community mobilization model may be more closely tied to the U.S. experience of a highly articulated civil society and organized grassroots volunteerism. Apart from the church and perhaps the *ejido* movement, some have argued that post-revolutionary Mexico has had less experience with ongoing, nongovernmental or "secondary" political/social organizations.[18,19] The State of Sonora is currently developing a health program based on WHO's Healthy Cities model, and it will be interesting to follow its course.[20] This development also illustrates the key role of government in promulgating such models. Perhaps the same will one day be said about HRSA in the U.S. HRSA, the federal agency charged with promoting access to primary care throughout the U.S., has now been given the responsibility of coordinating federal health initiatives along the border. Between 1992 and 1994 HRSA awarded more than $214 million in grants, contracts and cooperative agreements to state and local governments and community-based nongovernmental organizations in the U.S. border counties. These funds went to community and migrant health centers, rural health outreach projects, placement of National Health Service Corps providers in underserved areas, and Area Health Education Center (AHEC) programs, among others.[21]

## Professional/Community Interface

Previous comments regarding "inreach" and "outreach" suggest that in many communities there may be a disjunction between the health care professionals and others, due mainly to the professional education and socialization process of health care providers and to social class differences between health professionals and the bulk of the community; e.g., *colonia* residents, migrant and seasonal farm workers, and others. Cultural, ethnic, and language differences, while important, are secondary.

One role of community health advisors is to provide the functional equivalent of the professional-community interface. One role of community health coalitions is to create that interface in the first place. In Columbus, New Mexico, for example, the city government is the grantee and fiscal agent for a *promotora* program, and in Silver City, New Mexico, the grantee is the city hospital.[22]

## Indigenous Leadership

An objective of a community health advisor outreach program is to identify and recruit natural leaders or potential leaders, and then to provide them the tools and skills they need to conduct effective outreach that will result in improved access to services and, ultimately, improved quality of life. One objective of a community health mobilization program is to build leadership capacity at the local level, so that over time more participants take on leadership roles and responsibilities and the impact of the mobilization is increased. Community health advisors are one possible leadership modality of a broad mobilization model.

## Expanding Definition of Health

A definition of health that includes emotional, social, economic and political dimensions was legitimized within the public health profession by the World Health Organization's founding document in 1948 and was expanded upon by the Declaration of Alma Ata in 1978, which provided a comprehensive definition of primary care. However, the public health community has much work to do to promote this broad conception of health in the society as a whole. Fashionable concepts such as "quality of life" and "healthy lifestyle" do not capture the truly systemic and holistic implications of the WHO definition as much as they reflect the merchandising of an affluent, antiseptic, suburban, middle class culture, in which people often suffer the health consequences of abundance, rather than deprivation.

The definition of health is also expanding to encompass and emphasize prevention of illness rather than mere absence of illness. In these ways, personal health increasingly is being understood as a state or condition that is "produced" by other, broader historical, economic and political processes.[23,24] At the same time, various social and physical processes are being medicalized; i.e., being defined as medical and/or public health problems. Violence, including domestic abuse and youth gang violence, is one example; pregnancy is another. Research on pregnancy in the border region suggests that one cause of "inadequate" prenatal care is the lack of medicalization of pregnancy among Latina women and their families.[25] As a result, there may be less interest or perceived need to attend a medical clinic unless the pregnancy becomes obviously endangered.

Given the multiple ways in which the definition of health is expanding, both the community outreach and mobilization models are well suited to respond, because both take, or can take, a holistic, contextual approach to solving health problems. While community health advisor outreach programs are frequently funded to address a specific problem, such as prenatal care, cancer screening, or HIV/AIDS prevention, practitioners universally acknowledge that the *promotora* is dealing not with an isolated problem, but with a person who may have multiple issues and needs, and with that person's family as well. Most practitioners would agree that an effective outreach program de facto assumes and promotes an expanded definition of health.

Community mobilization programs incorporate an expanded definition of health in their basic conceptual model. The rationale of community mobilization requires such a definition. Thus, the WHO Healthy Cities model considers health to be the consequence of interactions among community, economic, and environmental variables: the community must be convivial, that is, supportive; the environment must be viable, and the economy must be adequately prosperous.[26,27]

## Immigration/Migration

The most timely thing to be said about immigration is that current efforts in California (as well as at the federal level) to deny health care to immigrants, whether or not documented, are to be resisted.

What needs to be documented is the actual burden on the health care system of undocumented immigrants, and what needs to be discussed are public policy alternatives to denying health care to anyone.

Migration across and along and on both sides of the border presents unique challenges to the health care system in terms of access to and continuity of care. While many border communities have a relatively stable population base, thousands of migrants may pass through them. Some, like migrant farm workers, do so cyclically, while others are heading to permanent locations like Los Angeles or Phoenix or Chicago. Migrating populations have a notoriously hard time accessing health care services.[28,29] Community outreach programs utilizing the *promotora* model have been used successfully in the four U.S. border states to contact, provide services, and refer migrating workers and families to other services.

## Transborder Utilization

Despite the construction of twelve foot high steel mat walls along the border, the border remains highly permeable. Most families residing on the U.S. side have close relatives on the Mexican side. U.S. border businesses live or die depending on the state of the Mexican economy. *Maquiladoras*, the "twin plants" that utilize cheap Mexican labor to assemble goods for U.S. and other transnational corporations, continue to thrive in the NAFTA era. Numerous studies have documented transborder utilization of health care services.[30,31,32] These studies also document the barriers to transborder utilization, the major one being lack of ability to pay for services. Others include different standards of practice in the two countries, lack of capacity of health care providers to carry large caseloads, and lack of information, such as medical records.

While the models under discussion cannot by themselves solve these problems, they can facilitate their solution. Community health advisors work as client advocates to obtain care for those without the means to pay. They can assist in obtaining medical information for individuals, and they can reduce the burden on providers by offering some services themselves. The medical community tends to appreciate these *promotora*s de salud for their case finding ability and the degree to which they increase patient compliance. They may be less receptive to the *promotora*s' role of giving voice to their client's needs and pursuing care for those who are indigent and who may be undocumented.

A community mobilization initiative can address the issues of transborder utilization if it is itself a binational undertaking. The binational councils established through the U.S.-Mexico Border Health Association and binational coalitions, such as the one in *ambos* Nogales, represent a potential base for such activities, including the development of agreements between state agencies and between insurance carriers to cover certain kinds of care on either side of the border.

## Economic Development

It should be clear by now that economic development plays a crucial role in the health status of individuals as well as in the capacity of border communities to provide adequate health care. But it has to be the right kind of economic development, and that topic is beyond the scope of this paper. Suffice it to say that the "right" kind of development includes investment in social and physical infrastructure (education, housing, health as well as potable water, sewage systems, electricity, and paved streets) and the promotion of locally owned businesses, and not merely the creation of low paying jobs for unskilled workers.

## Conclusion

This paper has attempted to describe how and why two models, community outreach and community mobilization, can be implemented successfully in the U.S.-Mexico border region in order to increase access to health care services. The combination or integration of both models, utilizing community health advisor-advocates, would likely generate desirable synergetic effects.

Both models recognize and incorporate what is special about the border region because their creators, like the border's writers and artists, respect its migrant soul. Starting with these basics may be the best way to achieve what often seems to be the Utopian goal of health for all. But then again, as Oscar Wilde put it, "A map of the world without Utopia on it is not worth looking at."

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