Published in final edited form as:

Public Health Nurs. 2017 May ; 34(3): 267–275. doi:10.1111/phn.12307.

Life in Limbo: Latinas' Assessment of Lower Rio Grande Valley Colonias

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The fastest growing population group in the United States (US) and the largest ethnic minority, Hispanics (also referred to as Latinos) are projected to constitute nearly 30% of the nation's population by 2060 (Colby & Ortman, 2014). Despite multiple social, cultural, and economic barriers, Hispanics have better outcomes than other ethnic groups on several health indicators (Campbell, Garcia, Granillo, & Chavez, 2012; Horevitz & Organista, 2012). For example, recent Hispanic immigrants are healthier and have better birth outcomes than US-born Hispanics (Bjornstrom & Kuhl, 2014; Borrell & Lancet, 2012; Teruya & Bazargan-Hejazi, 2013). However, obesity and sedentary lifestyles contribute to higher risk of cardiovascular disease among Mexican-origin Hispanics (Go et al., 2013) and low-income Mexican-origin women have increased risk of type 2 diabetes, hypertension, metabolic syndrome and dyslipidemia (Koniak-Griffin et al, 2015). Comparing recent immigrants to US-born Hispanics, Viruell-Fuentes and colleagues (2013) found immigrants reported fewer social ties and lower levels of social integration, findings that contradict the notion that Hispanic immigrants have broader social networks and higher levels of social support which could contribute to improved health outcomes. Reiningier and colleagues (2015) reported that Hispanics living along the US-Mexico border were less likely than Hispanics nationally to engage in regular physical activity. Better understanding of the health impact of local geographic and social contexts is critical to the design and implementation of effective public health programs and policies.

In this paper we report on the community asset mapping (CAM) activities conducted by *promotoras* in the first phase of an intervention study aimed at increasing physical activity

among Latinas living in the Texas Lower Rio Grande Valley (LRGV) region. We begin with the theoretical framework guiding the CAM approach; provide an overview of the context and setting; then describe the CAM activities, data analysis methods and findings; and conclude with our interpretations of the findings and recommendations for public health nursing research and practice.

Community Asset Mapping: Theoretical Basis

Principles of community empowerment, ownership, and social capital (Kretzmann & McKnight, 1993; Kretzmann, McKnight, Dobrowolski, & Puntenney, 2005) guided the research design and implementation. CAM is a participatory assessment method in which local residents inventory individual and community capacities, assets, and resources that may be mobilized to improve health and social well-being (McKnight & Kretzmann, 2003, 2012). CAM strategies include assessment of physical, social, cultural resources using diverse strategies (e.g., creating visual displays or maps, walking/driving tours, participation in interviews or focus groups). Assets-based community assessment arose as an alternative to traditional problem-focused or needs-based approaches (Minkler & Hancock, 2003). A strengths and assets-based orientation is characteristic of the community-based participatory approach to conducting research in partnership with disadvantaged communities. Although an asset-orientation does not preclude identification and recognition of problems, the aim is to avoid characterizing communities and individuals based solely on needs and deficits. Assessing assets and resources is one step toward mobilizing community resources and capacities to create change (Sharpe, Greaney, Lee, & Royce, 2000). When implemented in conjunction with the design of community health interventions, another intended outcome of CAM is the identification of strategies and opportunities that match the local community context and resources.

Setting, Context, and *Promotoras*

The Texas LRGV is designated a Medically Underserved Area and Health Professional Shortage Area (United States-Mexico Border Health Commission, 2014). The research settings were eight *colonias* in the Texas LRGV (Figure 1; note the border with Mexico in this region is the Rio Grande River). The Spanish word *colonia* refers to a community or neighborhood. Along the US-Mexico border region, *colonia* refers to unincorporated, unregulated settlements dating from the 1950s when Mexican agricultural workers began acquiring small plots from developers selling off idle farmland (The Texas Politics Project, 2009). In Texas, *colonia* refers specifically to communities located within 50 miles of the Mexico border, many of which lack paved roads, water, sewage, and electric services, and have high rates of hepatitis A, salmonellosis, dysentery, cholera and tuberculosis (Texas Secretary of State, n.d.).

Local partners included Community Resource Center (CRC) staff in 8 *colonias*. Established through a 1991 State of Texas Legislative mandate, the CRCs provide services and programs designed to reduce social isolation, increase self-sufficiency, and enhance quality of life among the *colonia* population (Vanegas, 2014). The result of collaborations between Texas A & M University (TAMU) and local communities, the CRCs serve as a centralized access

point to essential services and resources for *colonia* residents. The TAMU *Colonias* Program also includes a *promotora* (the Spanish term for female community health workers) initiative that trains and hires local residents to assist *colonia* residents in accessing health and social services.

Following Institutional Review Board Approval, the TAMU *Colonias* Program recruited eight additional *promotoras* for this community-based research. Chosen for their prior community experience and first-hand knowledge of the local communities, the women were local residents, ranging in age from 21 to 70 years. Three were natives of Mexico and five were US-born; only one was second-generation (i.e., both parents were US-born). Seven had completed 11 or more years of formal schooling; three were US-educated. Self-reported language fluency ranged from speaking and reading Spanish well or very well (N=4); speaking English well or very well (N=4); and reading English well or very well (N=5), to very poor English speaking and reading ability (N=1).

Research Aims and Method

The primary aim was to engage Latina residents from eight Texas LRGV *colonias* in a participatory process of identifying community health and safety assets and concerns and eliciting their perspectives on cultural, social, and geographic factors that either facilitate or create barriers to physical activity. The bilingual, bicultural research team members developed and implemented the *promotora* training, which included a mock CAM session in which *promotoras* experienced both facilitator and participant roles and received feedback and additional instruction from research staff.

Based on a structured project manual with step-by-step, scripted guidelines and instructions, each *promotora* was responsible for recruiting participants from her designated *colonia* to participate in two sequential *promotora*-led CAM sessions in Spanish. The first round of eight CAM sessions involved 89 Latina *colonia* residents (Table 1). Participants ranged in age from 20 to 64; 68 (76 %) were Mexican-born and had resided in the US between three months and 31 years. Years of completed formal education ranged from 1 to 16. The majority (n=56, 63%) spoke Spanish at home; 26 (29%) spoke both English and Spanish at home, and 7 (8%) spoke only English at home.

Each *promotora* conducted the first of the two CAM sessions in a classroom or meeting room at a local CRC. These sessions lasted between two and three hours each (M=2.5 hours). The *promotora* explained the purpose of the research, read the informed consent form aloud, obtained participants' verbal consent, and collected demographic information. Participants sat at tables arranged in a U-format and the *promotora* leading the session stood at the front, where there was an easel with blank flip chart and a map of the local *colonia* representing the area within a three mile radius of the CRC. Following personal introductions and an ice-breaker exercise, the *promotora* initiated the group dialogue by posing a broad question: "What are the major health and safety concerns in this *colonia*?" In the ensuing guided discussion, participants identified the human, organizational and environmental resources available to address these local concerns. The *promotora* listed each resource on the flip chart and then placed an adhesive tag on the community map to indicate

the location of the asset. Each CAM session was audiotaped and a research team member observed the process from the back of the room, recording the pace and sequence of the session according to the CAM protocol and noting group dynamics, interruptions, and the *promotora's* presentation style and level of engagement.

Promotoras scheduled the second round of CAM activities several weeks later, at each site. Of the 89 original participants, 68 (76%) returned for the second CAM session. All *promotoras* conducted follow-up calls or visits with the women who missed the second session to inquire about reasons for not attending. Family and work responsibilities were the most frequently reported reasons for missing the second CAM session. For CAM Session 2, participants met at each CRC and began by reviewing the *colonia* map with the locations of community assets from the previous CAM session. After identifying areas within the community where they could engage in physical activity, teams of 3-4 women conducted an assessment of a specific community location (e.g., a soccer field, playground, gymnasium, park, indoor exercise area). Each team measured the distance of a walking path or trail and conducted an environmental assessment of both assets (i.e., safety, cleanliness) and potential deterrents (i.e., traffic, graffiti, trash). Upon conclusion of the walkability assessments, the teams came together at each CRC to share and discuss their findings. Participants received a \$20 gift card incentive at the conclusion of each CAM session.

Analytic Approach and Process

The data analysis team consisted of a native Spanish speaker with professional and graduate degrees in Social Work (the primary analyst) and three public health researchers, including a public health nurse researcher with expertise in Hispanic health, community-based participatory research, and qualitative research methodologies. The iterative process of coding and analysis was informed by Guba and Lincoln's (2005) criteria of validity as authenticity (e.g., fairness, ontological authenticity and educative authenticity). Data included in this analysis consisted of audio-recordings of the first round of CAM sessions, flip-chart lists, completed community asset maps with flags, and participant observation notes. Audio recordings were uploaded to QSR N-Vivo 10 (QSR International Pty Ltd., 2014) qualitative data management program and the audio recordings were compared with flip-chart notations. The primary analyst conducted the coding directly on the audio recordings in the source language (Spanish) employing grounded theory coding and analysis techniques (Corbin & Strauss, 2008; Patton, 2002; Strauss & Corbin, 1998).

The coding and analysis process began with initial review of each individual CAM session recording to identify salient responses, followed by detailed open coding of each CAM session transcript. Other bilingual research team members subsequently reviewed the transcript data and coding schemes. Following the open coding, salient concepts were grouped together into broader themes. For example, participants across the various mapping sessions highlighted their concerns about gangs, immigration agents, lack of lighting and stray dogs in their neighborhoods. Initially, these concerns were coded as *fears*; subsequently the team created setting categories related to participant fears (i.e., physical setting, neighborhood, or social/community settings). As the analysis team identified recurring issues reflective of these Latinas' social, economic, and environmental

marginalization, we situated these findings within a broader narrative theme, *Living in Limbo*, to reflect the multiple, interconnected challenges of social and cultural isolation, economic marginalization, and lack of citizenship status. In presenting these findings, we strove both to avoid risks of further marginalization and to raise awareness. We purposefully highlighted diverse perspectives and voices, and sought to present a balanced, fair, inclusive representation of the stakeholders' perspectives. To disseminate the findings to English-speaking audiences, the primary analyst translated select data exemplars from Spanish to English, indicated by italics.

Results

Community Assets

CAM participants readily identified a wide range of individuals in their *colonias* as important community assets. These included TAMU *promotoras*, CRC staff and volunteers, local pastors and priests, neighbors who provide informal health care services, foreign trained medical professionals, community leaders, school counselors, psychologists, the sheriff, and firefighters. Participants considered the CRCs and local churches valuable community assets, both in terms of physical space (i.e., rooms to hold community events, safe areas for their children to play, a location for women to exercise) and personnel (i.e., social service providers, pastors, priests). Other organizational resources included schools, adult education classes, fire and police stations, City Hall, Workforce Solutions, *Mujeres Unidas* (a domestic violence shelter), and Women, Infant and Children food assistance. Examples of environmental assets were school gyms where children could exercise; Delta Lake, canals and Rio Grande River for fishing; and neighborhood leaders who offer their homes for meetings or as safe places for children to play. Health resources identified by residents in some *colonias* included folk healers and local dental services; across all sites, participants reported seeking health and dental services in Mexico.

Community Health Concerns

Health concerns identified by participants in all eight *colonias* included physical health (diabetes, obesity, asthma, hypertension, pollution, smoking, and a lack of health education); emotional health (stress, anxiety, depression, feelings of second-class citizenship); diet (access to and excessive consumption of junk food, abandoning traditional foods), and lack of affordable, accessible health care. Common barriers to physical activity included the cost of exercise facilities or programs, the lack of childcare, and time constraints. Safety concerns included environmental hazards (e.g., standing/stagnant water, trash on streets, mosquitos/lack of insect control); limitations of the physical environment (e.g., few parks and green areas; poor maintenance of existing parks); neighborhood threats (e.g., thefts, gangs, vandalism); lack of public transportation; domestic violence; and personal and public safety risks ranging from inadequate public lighting to lack of sidewalks and poor street conditions. Participants reported that in most *colonias* walking was treacherous, due to lack of paved roads and the ubiquitous presence of stray dogs. As a result, residents frequently resorted to using dry irrigation canals as transit paths: “*We walk in the canals. It isn't safe, but people do it!*”

Living in Limbo

Living in limbo was a broad, overarching theme reflecting the challenges of social isolation and cultural marginalization, often associated with both immigration status and poverty. Although not asked to report immigration or citizenship status, many participants self-disclosed that they or family members were undocumented, i.e., without current legal immigration status as a permanent resident or U.S. citizen (Messias, McEwen & Clark, 2015). Mexican-born women noted that immigration status was a major deterrent to many community resources and services. Undocumented women reported living with constant anxiety and preoccupation about being stopped or asked to provide immigration documentation. Others reported a general reluctance to participate in any type of physical activity in public places, noting the frequent presence of border control agents waiting outside the CRCs asking to see immigration papers. Fear of being stopped by border patrol officers was widespread and clearly limited mobility within these *colonias*: “*People don't go out because they are afraid that la migra [immigration officials] are going to say something, that they are going to stop us; that they are going to deport us.*”

Participants also reported feeling discriminated against for being poor or for not having health insurance: “*If you don't have insurance, it's like health discrimination... discrimination against those of us who are poor... What do you call it? Indigent!*” In response to a participant's comment about the lack of health clinics in her *colonia*, the woman seated next to her chimed in, “*They'll let us die.*” Whether because of poverty, undocumented immigration status, language, geography, or a combination of the above, social isolation contributed to these Latinas' feelings of being marginalized, even within their local *colonias*.

Although readily acknowledging the presence of certain community resources, (i.e., schools and CRCs), many participants tellingly noted they did not consider these to be community assets. These Latinas identified various logistic barriers limiting both not only their own but also their children's access to existing resources, such as the fact that some schools, school grounds, and the playgrounds surrounding several CRCs were closed after-hours. One participant noted, “*That [school] closes. That's not a community resource, it's a school resource. It's the kids' during school hours, but it is not a community resource.*” The underlying message was one of lack of belonging and engagement among Latina residents who did not consider the local *colonia* schools as places where they could go to play and exercise with their children or walk on the grounds. *Colonia* residents not only encountered physical and geographic barriers to accessing essential services, they also faced overt discrimination and exclusion. The words of this participant reflected her sense of social marginalization and isolation:

I don't know if it's because we live close to the border. It's as if we lived apart, like there's a difference...I don't feel like we live in the US. We are only divided by a bridge and a border agent that checks my papers when I cross, but it's basically the same as if we were living on the other side.

Due to the unincorporated status of the LRGV *colonias*, city and county officials often disagreed about the jurisdiction and allocation of resources. Participants in all CAM sessions

reported a lack of responsiveness and receptivity to their requests or needs of public services:

I call the sheriff. They say, "Call the police." I call the City. They say, "Call the County." I don't believe in the laws. I don't believe in the police. Everywhere I go I see injustice...As a human being I feel screwed and I say, "So where are we going?" How are we going to respect them [police officers]?

In one CAM session, a participant recounted her sister's recent experience of contacting the local police to report domestic abuse. Although the police answered the call, they refused to take any action. Disclosing her personal distrust and feelings of powerlessness, the participant poignantly recalled, "*The next morning I asked my sister, 'What do you mean they wouldn't do anything? Did they want to see you lying there dead before they did anything?' I felt impotent.*"

These CAM data were replete with examples of the multiple intersections of poverty and Latinas' health and limited access to resources. Restricted financial resources not only limited access to food, health care, and exercise facilities but also impacted the broader community environment and health. In one *colonia*, there was considerable discussion about the frequency with which stray dogs got into garbage on the streets. When one woman suggested that everyone use closed garbage containers rather than leaving trash in bags on the street, another countered, "*But it's because lots of us, we don't have a trash container, because we can't afford it! They charge you a \$120 deposit! I can't afford that!*"

Constrained economic resources limited their access to services more readily available to other residents. The identification of a park as a local resource prompted this comment:

That's private. That belongs to the people that live there. People can play there but you have to pay. It's not like you can go there and play. They charge a dollar. It's not like you can go in if you want to play. No, it doesn't belong to the community.

In response, another participant noted, "*If you have to pay, then it's not really a [community] resource!*" *Colonia* residents noted how poverty limited access to a wide range of available resources, from garbage cans to parks to health care:

There are clinics for low-income people, but you call them and they say they can't see you for five or six months, and then you go in and they see you for five minutes! So those of us who don't have money, we suffer. Because if you have money, then of course the doctor is going to attend to you and be nice, but [not] when I need care...It's an injustice!

Barriers to accessing existing health care resources included lack of transportation, financial constraints, and lack of health insurance. Beyond the health risks of social marginalization, *colonia* residents identified other specific environmental health risks and concerns. Participants' reflections and comments illustrated how legal, linguistic, and geographic isolation had further contributed to social marginalization among *colonia* residents, and in turn, created barriers to engaging in regular physical activity.

Discussion

This analysis of the collective CAM session data highlighted some of the dilemmas and challenges that local Latina residents faced as they went about their daily lives in the LRGV *colonias*. On one hand, these included women's experiences of marginalization, poverty, and poor health; on the other, their resilience in the face of multiple challenges and desire to improve the lives of their family members and children. Both Mexican ethnicity and working class status contribute to the social and economic disenfranchisement of the population of these unincorporated *colonias* along the US/Mexico border (Nuñez-Mchiri, 2009).

As these findings highlighted, *colonias* are marginalized geographically, socially, and politically, and often lack the most basic living necessities (Texas Secretary of State, n.d.). Local schools are a space where such marginalization may be addressed. Engaging parents in local schools contributes to community building and is an important factor in instilling a sense of belonging, especially among non-English speaking families (Green, Walker, Hoover-Dempsey, & Sandler, 2007). Schools and community centers, such as the CRCs where the *promotoras* conducted these CAM sessions, play an important role in building healthy communities. In a prior study with Latinas in the LRGV, Bautista and colleagues (2011) reported perceived personal barriers to physical activity (i.e., lack of time, being tired, lack of self-discipline). The environmental barriers to engaging in physical activity (i.e., limited walkability, dogs, and vehicle traffic, and other safety concerns) identified by these Latina residents of LRGV *colonias* reflect findings from prior research with Hispanics in other settings (Olvera et al., 2012; Tamayo et al., 2016). Increasing access to recreational facilities that already exist in low-income neighborhoods is recognized as one of the most important strategies for increasing physical activity in neighborhoods (Ogilvie & Zimmerman, 2010; Lebron, Stoutenberg, Portacio, & Zollinger, 2016); however, residents must first consider these assets as belonging and available to *all* community members. *Colonia* residents noted a wide range of economic and social barriers to accessing healthcare services, including lack of health insurance and undocumented immigration status. In other communities along the US/Mexico border, seeking transnational healthcare is a common occurrence, given the lower out-of-pocket costs and lack of bureaucratic roadblocks to obtaining health care in Mexico, despite the inconvenience and potential risks of border-crossing among undocumented residents (Miller-Thayer, 2010).

Given the characteristics of these local Rio Grande Valley *colonias*, these findings are not generalizable to other *colonias* along the Rio Grande Valley, nor should they be construed as representative of other communities along the US/Mexico border. For the most part, findings from the eight communities were similar, although there were some site-specific concerns (i.e., presence of an asphalt plant, irrigation canal, or gang activities). To facilitate broader participation, all CAM sessions were conducted in Spanish and bilingual staff members were available to translate into English if necessary; however, a few participants were less fluent in Spanish, which may have impacted their level of contribution.

The broader CAM session goals were to engage the community of interest (i.e., Latina residents in eight LRGV *colonias*) and gather site-specific data in order to design a tailored,

promotora-delivered intervention to enhance participation in regular physical activity that addressed local concerns and was suited to local *colonia* environments and resources. The *promotoras* who led the CAM sessions were local residents with prior knowledge of the *colonias*. Engaging with other women in the context of the CAM sessions allowed the *promotoras* an opportunity to begin establishing more formal relationships, as well as increasing their awareness of *colonia* residents' perspectives on local community resources and assets. These CAM data, which included the enumeration of community assets as well as a wide range of personal and community health and safety concerns, provided the investigators and *promotoras* insights into potential resources and challenges as they moved to the next phase of the randomized community-based intervention trial, in which four *promotoras* implemented a physical activity program in their local *colonia* and in the four communities randomized to the control group, four other *promotoras* conducted a community health and safety intervention.

Implications

This analysis of CAM session data provides a unique view of the social, environmental, and health concerns of Latinas living in some of the most impoverished areas of the country. Given the rapidly increasing Latino population and persistent and increasing health disparities, it is imperative that public health nurses, community leaders, policy makers, educators, and health and social service providers be attentive to the multiple challenges and barriers identified by participants in this community-engaged research. As these findings indicated, although necessary and important, the presence of facilities such as CRCs, parks, and schools may not be sufficient to support and increase physical activity among marginalized groups. Similar to findings from community assessments of Hispanics in other settings (Lebron, Stoutenberg, Portacio, & Zollinger, 2016), local parks were a valued community asset, but traffic and lack of walkability were clear deterrents to community-based physical activity.

In order for Latinas living along the US/Mexico border to feel safe and willing to participate in community-based initiatives promoting physical activity, multiple underlying issues need to be addressed. The Pew Hispanic Center (2010) reported that a majority of all Hispanic adults worried that they, a family member, or a close friend could be deported. Along the US/Mexico border, recently implemented state and federal policies have increased both the angst underlying many immigrants' lives and the concomitant effect on their health (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Community and public health nurses are important partners in the development, implementation, and evaluation of community asset mapping activities and similar collaborative efforts to identify and address the physical, social, and cultural barriers that limit access and participation in regular physical activity among marginalized communities.

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Figure 1. Participating Community Resource Centers

Table 1**CAM Participant Demographics**

Community resource center	Participants	Age (mean)	Foreign born (N)	Years of us residency (mean)	Primary language spoken at home (N)		
					Spanish	English	Both
Alamo	9	32	8	13	7	0	2
Browne	11	36.9	9	15.1	4	0	7
Cameron Park	10	42	8	19.4	7	0	1
Lasara	11	43.9	7	23.9	7	3	1
Monte Alto	13	42.7	7	30.4	4	4	5
Progreso	11	40.9	9	18.3	7	0	3
San Carlos	10	37.2	10	14.5	7	0	4
San Juan	14	40.3	12	17.3	13	0	1
Total/mean	89	39.8	70	19.3	56	7	26