

2004 Border Summit

White Paper

**A Disease Without Borders: the Impact of HIV and
Migration on Families Living along the U.S.- Mexico Border**

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Texas/Oklahoma AIDS Education & Training Center

I. BACKGROUND

In a continuing effort to address HIV/AIDS needs along the U.S.-Mexico Border, the Texas/Oklahoma AIDS Education & Training Center sponsored policy forums in El Paso, Texas and the Lower Rio Grande Valley, in order to set priorities and outline strategies for enhancing care and prevention services. This White Paper draws upon data and input from the cross-cultural, interdisciplinary, and binational exchanges that transpired during the Border Summits held October 14-16, 2004. A total of 78 individuals from both sides of the Border attended the two summit events, including public health officials, community leaders, program administrators, HIV specialists, and consumers.

History of Summit efforts

The Texas/Oklahoma AIDS Education and Training Center (TX/OK AETC) hosted the first Border Summit in San Antonio in 2002, which was attended by representatives from the Texas Department of Health (now known as the Department of State Health Services), Centro de Salud Familiar La Fe, University of Texas Southwestern Medical Center, American Lung Association, Special Health Resources of Texas, Valley AIDS Council, the Binational TB Prevention & Control Project, the University of Oklahoma Health Science Center, University of Texas Health Science Center in San Antonio, US-Mexico Border Health Association, and the Pan American Health Organization, among others. The content of the summit included presentations on current grant funded programs, current collaborations on the Border, target populations and services and the identification of areas for future collaborations.

In 2003, TX/OK AETC hosted a second Border Summit as the last day of the HIV Clinical Update Conference in Austin, Texas. At this summit, participants developed a list of issues and strategies. Participants ranked the priority of each issue and strategy. The number one concern that emerged was the need for culturally competent and linguistically appropriate Prevention with Positives (PWP) Training. TX/OK AETC responded by holding the first PWP training in early December of 2003 with Border providers, utilizing a Train-the-trainer model. Two subsequent trainings have been held for these trainers. The trainers, in addition to using PWP in their own clinical care settings, now are presenting PWP workshops for other Border providers and agencies.

The third Border Summit was held in October of 2004 in two locations—El Paso and South Padre Island—as part of Border Health Week sponsored by the US-Mexico Border Health Commission, in partnership with HRSA, CDC, Office of Minority Health, and their Mexican counterparts across the Border. The purpose of the forum was to

identify cross-border HIV/AIDS policy issues and gaps in prevention, care, and treatment, and factors that cut across prevention and care. Staff from TX/OK AETC and the POLICY project collaborated with local stakeholders to plan and implement the forums. HIV specialists and NGOs from the Mexican side of the Border also participated.

Based on the findings of the first three Summits, as well as a review of the literature, a logic model was developed as the basis for the work of the 4th Summit (see page 6 below). Speakers were selected based on their expertise on a particular aspect of Border health, or HIV/AIDS. Attendees participated in discussions of the topics, adding their own content to the Logic Model. From these discussions, priority lists of problems and strategies emerged.

Epidemiology Issues

One way to address the significance of a health problem is to count the numbers of cases. Epidemiology of the HIV epidemic, however, is limited by stigma and the systems used to diagnose and report the infection. For example, in Mexico, authorities believe that 160,000 persons are infected with HIV, but 60% do not know they are infected. The areas of Mexico contiguous with the United States have the largest population of persons living with HIV/AIDS. Persons living in Mexico may get tested in the United States and vice versa. On the United States side of the Border, access to HIV testing may be limited by immigration status, lack of health insurance, fear of government agencies, language barriers, and poverty.

HIV and AIDS prevalence in the Border counties of Texas is lower than in other parts of the state. It is not clear, however, to what extent these lower prevalences may reflect lower rates of testing, the transient nature of Border residents and binational patients, or possibly a lack of effective case-finding and outreach strategies for HIV counseling and testing services along the Border.

Testing on both sides of the Border is more readily available for women and children. In Mexico, women comprise a small proportion of the population with HIV/AIDS (14%), but receive more attention due to the potential for mother to child transmission (MTCT). Texas has mandatory HIV testing for women who seek health care during pregnancy or labor, and the state health department has been making concerted efforts to improve access for HIV screening, testing, and treatment—including the development of capacity among providers for HIV rapid testing.

Numbers also do not capture the implications of HIV/AIDS on the economy of the Border regions of Mexico and the United States. In Mexico, among the cases of AIDS, 76,311 are 15 to 44 years of age, the most productive working years. In the United States, over 80% of HIV/AIDS cases in the Border region are between the ages of 15 and 44 years of age.

A major epidemiological trend that inspired the main focus of the 2004 Border Summit was that new cases of HIV/AIDS have increased among women in the Border region. On the Texas side, there was a 57% increase in AIDS cases among women from 1999 to 2003 (21 cases to 33 cases). HIV cases had increased 80% among women during the same time and in the same region (31 to 56 cases). Furthermore, the impact of this increase in HIV/AIDS among women on mother to child transmission (MTCT) is largely unexplored and unknown.

Numbers can provide a quantification of a problem, but behind each number, there is a living human being with dreams, aspirations, and responsibilities to family and community.

Training Needs

Assessments conducted during annual Border Summits 2001-2004, clinical conferences by Valley AIDS Council (Harlingen) and La Fe CARE Center (El Paso), and a Rural Minority ASO Capacity Building Project sponsored by TX/OK AETC, have all provided information on education/training needs and gaps for providers serving Border communities. Chief among the needs identified in early assessments were case management training, counseling and testing, and prevention. In more recent assessments, prevention with positives and prevention case management have been expressed priorities. Culturally competent and bilingual trainers, along with patient education and resource materials in Spanish, English, and low-literacy (both languages) are a constant need.

The HIV epidemic in this region is made more complex by many factors, including Hispanic cultural norms regarding sexuality and gender roles, the rural nature of the border, geographic isolation, enduring poverty, and the lack of access to culturally appropriate, high quality health care. Migration and transborder populations compound the ability to get people into care and provide continuity of primary care. Health professional training and education agencies should take these types of factors into consideration when attempting to design and offer capacity-building and clinical skill-building programs on the Border.

A discussion of the training and capacity-building needs of the Border region would be incomplete without acknowledgement of the dire shortage of healthcare professionals. Frankly put, the few providers in the area—particularly those working in publicly funded health centers—are greatly overtaxed by a tremendous chronic disease burden and an overall lack of systematic prevention and health promotion efforts. Through a series of privately funded meetings with Mexican providers, discussions with the Secretaria de Salud [Secretariat of Health], and other ethnographic data collection, Parkland and UT Southwestern Medical Center staff have documented similar observations from the Mexican side of the Border. Organized efforts such as the “Border Binational Health Week” discussed below can help ameliorate this situation, but the long-term solution is to continue to develop the threadbare healthcare and public health infrastructure presently found on the Border.

II. 2004 SUMMIT PROCESS

The 2004 Border Summit process involved holding two separate, but parallel, events at South Padre Island (hosted by Valley AIDS Council) and in El Paso (hosted by La Fe CARE Center). The October summits were held in conjunction with, and as a part of the border-wide celebrations of the “2004 Border Binational Health Week” (BHW). The BHW, held October 11-17, was a major initiative of the US-Mexico Border Health Commission, with sponsorship and technical support from HRSA, as well as CDC, the California-Mexico Health Initiative, the Administration on Aging, Office of Minority Health, National Head Start Bureau, Pan American Health Organization, and the US Environmental Protection Agency. The major Mexican counterparts participating in the BHW were the Mexico Secretariat of Health, the Secretaria de Relaciones Exteriores [Secretariat of External Relations], and the Instituto de los Mexicanos en el Exterior [Institute of Mexicans Abroad].

More than 300 organizations and educational institutions in 14 pairs of sister cities from 10 border states in two nations, joined together at national, regional, and local levels to plan, promote, and carry out the BHW initiative. In the U.S., there were 126 events held in 17 border counties, plus Washington D.C. with an estimated 35,000 participants. In Mexico, nearly half a million immunizations were administered at health fairs, hundreds of health promotion talks were offered to communities, and more than 400,000 health guides and pamphlets were distributed.

Embedded within this overall Border Binational Health Week international initiative, the two 2004 Summit events featured a structured process to elicit, through policy forums, input from Border practitioners, policy-makers, residents, and consumers. Specifically, the policy forums utilized a “Theory of Change Logic Model” (adapted from the Kellogg Foundation Planning Model) as a tool to synthesize input regarding “Influential Factors,” “Community Needs/Assets,” “Problems or Issues,” “Desired Results,” Assumptions,” and “Strategies.”

The table below illustrates the Logic Model as it was initially conceived by TX/OK AETC staff and faculty, drawing upon their broad experience working with Border issues and Border providers since the year 2000. The tool was presented in the packet provided to all Summit attendees, and was reviewed during the policy forum in El Paso by the TX/OK AETC Evaluator, Dr. Jennifer Gray, and in South Padre by an evaluation consultant, Dr. Carole Veach.

The Logic Model framework provided initial starting points for discussion and analysis of issues and problems, as well as proposed solutions and policies/strategies to address these needs. When used in conjunction with an automated Audience Response System, the Logic Model yielded prioritized issues and strategies, detailed below in Section III.

Theory-of-Change Logic Model

A. INFLUENTIAL FACTORS	B. COMMUNITY NEEDS/ASSETS	C. PROBLEM OR ISSUE
<ul style="list-style-type: none"> • Increase of TB/HIV co-infections and drug-resistant strains of TB • Poverty • Migration and immigration policies • Bi-national patients • Rural nature of the Border • Stigma against HIV/AIDS • High unemployment- less employer support for health care. • Multiple definitions of Border region • HIV only one of numerous health and environmental problems on the Border • Uninsured/ under-insured • Culture and communication • Status of women • Decreased funding for Children’s Health Insurance Program • Evolving values related to childbearing • Policy differences between Mexico and Texas • “Digital Divide”--lack of computers and information technology on Border 	<ul style="list-style-type: none"> • Border SPNS project is scheduled to phase out in 2005, resulting in the loss of \$2.5Million of funding. • Loss of infrastructure, including TOAETC’s two local performance sites, Valley AIDS Council in Harlingen and LaFe CARE Center in El Paso • Loss of HIV primary care services • Service structures are needed to prevent Maternal To Child Transmission (MTCT) • Border Resource Guide now available. 	<ul style="list-style-type: none"> • New cases of HIV/AIDS have increased among women • 57% increase in AIDS cases among women 1999-2003 (21 cases to 33 cases) on TX side of Border • 80% increase in HIV cases among women 1999-2003 (31 to 56 cases) on TX side of Border • Impact on mother to child transmission (MTCT) unknown • There is limited information on new HIV cases among adolescents • Limited access to care due to distance and lack of public transportation • Despite increased attention and funding for Border Health, health care disparities are still prevalent. • HIV/AIDS care and services are inadequate to meet Border needs. • Health professional shortages, particularly for specialty care.
D. DESIRED RESULTS	E. ASSUMPTIONS	F. STRATEGIES (What can we do to eliminate the gap between the Problem/Issue [C] and the Outcomes and Desired Impact [D]?)
<ul style="list-style-type: none"> • Outputs: <ul style="list-style-type: none"> - New collaborations and binational efforts are designed to address TB/HIV co-epidemic -Distribution of a white paper prioritizing HIV/AIDS issues for the Border, especially related to women and children • Outcomes: <ul style="list-style-type: none"> - MTCT training and capacity building are enhanced and institutionalized among Border providers - Continuity of care through SPNS sites and on both sides of the Border - “Twinning” projects to develop clinical capacity for Border providers on TB, HIV, MTCT - Strategies to preserve service infrastructure are identified/communicated to policy makers - Individual participants in Summit report increased clarity of how he/she can contribute to HIV/AIDS prevention and care goals. - Agencies along Border identify projects/intervention to reach Healthy Border 2010 initiative goals. • Impact: <ul style="list-style-type: none"> - Decline in new cases of HIV on both sides of the Border, especially among women. - Efficient and effective use of HIV and TB treatment services. - Culturally appropriate prevention and care are available for persons with HIV/AIDS. 	<ul style="list-style-type: none"> * Community-based, culturally congruent health care systems are more likely to be sustained over time. * Collaborative relationships among agencies and individuals are based on mutual respect and acknowledgement of differences. * Capacity development of prevention and treatment services along the Border will have a far-ranging impact on public health in both countries. 	

III. INPUT FROM SUMMIT PARTICIPANTS

Influential Factors

In the "Influential Factors" section of the Logic Model, the staff identified contextual conditions that are more difficult to change. Poverty is one example. The national poverty rate in the United States is 12.4% while in the US Border region the rate is 23%. In contrast, the Mexico Border region has a lower poverty rate than the rest of the country. Many persons on both sides of the Border are uninsured or underinsured which limits their access to health care. While geopolitically divided by a border, communities on the Border have fluid movement, with routine Border crossings to work, shop, visit family and friends, and seek health care. Strategies to address the problems related to HIV/AIDS must be tailored to be effective in the context created by these influential factors.

Communities Assets and Needs

Assets

The "Healthy Border 2010" Report, written in 2001, noted that HIV infection and AIDS occurs across age groups and economic levels in all the large cities along the Border. The report clearly identified prevalence objectives related to HIV/AIDS. Within the United States Border Region, the prevalence rate of AIDS was 13.8 cases per 100,000 people. In the six Border states in Mexico, the rate was about a third of the US Border rate or 4.6/100,000. The HB2010 objectives are to decrease the US Border prevalence rate by 50% and prevent any increase in the Mexican Border prevalence rate.

Through work spearheaded by the TX/OK AETC, a Border Resource Guide is now available describing care providers and support services available to persons living with HIV/AIDS on both sides of the Border. This resource is currently available online at www.aetcBorderHealth.org. Persons needing hard copies can contact TX/OK AETC at 1-888-892-5481.

Needs

The Border Special Projects of National Significance (SPNS) projects in Texas have provided health care around El Paso, Eagle Pass, and Harlingen. With SPNS funding scheduled to phase out in 2005, resulting in an estimated loss of \$2.5 million of funding, there will be a loss of HIV primary care services for nearly 1100 Texas clients. As recently reported by the Border SPNS evaluator, 65 percent of this population has no US health insurance, only 36% are working, and 43% have co-morbid mental health issues.

The two Border SPNS grantees in Texas (La Fe CARE Center and Valley AIDS Council) are also local performance sites (LPS) for TX/OK AETC, providing HIV/AIDS education for health care professionals. The Healthy Border 2010 report identified the lack of HIV trained providers as a barrier to care.

The system structures are especially lacking to prevent maternal to child transmission (MTCT). For instance, the Healthy Borders 2010 Report indicates that one-quarter of U.S. Border women who gave birth—about 48,000 women in 1998—did not initiate prenatal care in the first trimester of care, and some had no prenatal care at all.

Problems and Issues

A major trend that instigated the Border Summit was that new cases of HIV/AIDS had increased among women. On the Texas side of the Border, there was a 57% increase in AIDS cases among women from 1999 to 2003 (21 cases to 33 cases). HIV cases had increased 80% among women during the same time and in the same region (31 to 56 cases). The impact of this increase in HIV/AIDS among women on mother to child transmission (MTCT) was unknown.

Other problems of concern were increases among adolescents, limited access to care, and health professional shortages. Health care professionals in the region believe that cases of HIV among adolescents are increasing, but the increases have not been seen yet statistically due to delays in testing and reporting. Access to care is limited due to distance and lack of public transportation. One of the reasons for limited health care facilities is the lack of health care professionals in the region.

Embedded in the lists of problems and priority issues set forth below, are the overarching issues of migration, culture, and language differences.

Migration, both legal and illegal, involves a vast and complex set of policy issues far beyond the scope of this paper. In the realm of health care policy and HIV prevention, however, migration is most often considered in terms of the vectors for HIV viral transmission. U.S. and Mexican Border providers and advocates are quick to point out that the arrow of the HIV vector mostly points south, rather than north. That is, migrant workers come to the U.S., are infected here, and then return to spread HIV in their hometowns and villages of origin. Time after time, Mexican officials have noted this phenomenon to help account for local outbreaks of HIV infection, particularly in relatively remote settings. In addition, the international tourism trade, and “sex tourists” have been linked to the spread of HIV and STIs in border areas as well as tourism centers in the interior of Mexico; this disease vector has not been adequately studied.

The impact of culture, in the broadest sense, is immeasurable. Not only does the region represent the intersection of the cultures of the two nations, but the Border has also been characterized as having its own unique and dynamic culture. HIV treatment and prevention efforts must acknowledge this cultural richness and the differences in worldviews found here, in order to build upon the insights and experiences of individuals and organizations that are able to successfully operate in this multifaceted binational setting.

Language is perhaps the most concrete expression of this cultural dynamic. In developing communications strategies and educational approaches, providers and

advocates must realize that language preference/usage is not a simple dichotomy between Spanish and English. Rather, there are complex social forces at play that may, for instance, lead an individual to express a preference for English language health services and information—even when that person is predominantly Spanish speaking. Alternately, class and social differences can often serve as barriers that outweigh the shared language between a provider and a patient/client. Additionally, regional differences in dialect, e.g. the distinctions between “Tex Mex” and “Californio” Spanish speakers, must be taken into account.

A final consideration, both in terms of language and culture, is the terminology used to describe sexual behaviors—in particular the terms used to describe the behaviors of men who engage in sex with other men. Beyond the fact that many health providers feel reluctant to engage in extensive sexual history-taking and risk assessment, there are epistemological and regional variances in the understanding of Spanish language terms for these behaviors which have not been fully explored. The English language terminology cannot be simply translated and applied with any degree of validity or reliability. As an example, the Spanish term “mayate” is used by some Mexicans to refer to a man who has sexual relations with other men, but who considers himself to be heterosexual. In other idioms, the word means a “drunk,” or is a pejorative term equivalent to “faggot,” or can be used as a derogatory term for a black person. A great deal of work still needs to be done to adequately address these language and cultural issues.

Problems

- The Texas side of the Border has seen a 57% increase in AIDS cases among women from 1999-2003.
- During the same period, there has been an 80% increase in HIV cases among women along the Texas Border.
- The impact on mother to child transmission (MTCT) is unknown.
- There is only limited information on new HIV cases among adolescents.
- Families have limited access to care due to distance, the rural nature of much of the Border, and limited public transportation.
- Health care disparities and extensive healthcare professional shortages still exist along the Border.
- The number and preparation of health professionals, particularly for specialty care and HIV primary care, are inadequate.

Priority issues

- The rate of new cases of HIV among women is especially concerning when coupled with the pending loss of HIV primary care funding along the Border.
- Stigma and homophobia, even among medical providers, and a lack of community awareness, pose major barriers to the implementation of effective strategies.

- Cultural and structural barriers to HIV testing exist on both sides of the Border; a special concern is the prohibitive expense of HIV tests on the Mexican side of the Border. Pre- and post-test counseling are frequently not available in Mexico.
- The lack of continuity of care for binational patients; information is not shared between public health or medical care systems.
- Community based organizations and non-governmental organizations lack expertise in HIV care and prevention. Sometimes the efforts of CBOs and NGOs to help PLWHA are seen as competitive with or even counter-productive to the delivery of care to PLWHA by larger health systems.
- The chronic nature of HIV disease (once treatment has been initiated) presents daily challenges that are not well understood by Border residents and PLWHA in the Border region.
- Access to condoms is a barrier, particularly in Mexico.
- The easy access to illicit drugs contributes to increased risk-taking behaviors. A special concern is noted for correctional facilities with high incidence rates of Hepatitis C.

Proposed Strategies and Desired Results

Proposed strategies

- Increase political will to address HIV/AIDS along the Border, in light of the pending loss of HIV primary care funds.
- Find mechanisms to preserve the Border SPNS (HRSA) infrastructure that has been developed over a 5-yr. period, and serves over 1,100 HIV/AIDS patients per year in Texas.
- Promote continuity of care by strengthening coordination among in-country and cross-border providers. An example would be a trans-border network of case managers as a support system for transient and migrant patients.
- Use public-private collaborations to support “twinning projects,” capacity-building, and HIV prevention and care education for Mexican providers. Begin with a focus on the prevention of mother-to-child-transmission, and rapid-testing linked to prenatal care.
- Develop culturally appropriate education for low-literacy persons; build on existing Spanish-language materials and materials developed in Mexico/Central/South America.
- Standardize and integrate HIV testing into primary care settings, and as part of perinatal care services. Expand the availability of HIV rapid testing.
- Adapt and tailor “Prevention with Positives” curricula for culturally appropriate interventions along the Border.
- Develop information technology capabilities, including telemedicine, in order to facilitate access to specialty care and HIV primary care consultations. Concomitantly, increase technology training for providers.
- Continue to feature HIV/AIDS issues and networking within the context of the annual “Border Binational Health Week.”

Desired Results

Outputs:

- New collaborative binational efforts will be designed to address the TB/HIV co-Epidemic along the U.S.-Mexico Border.
- A white paper prioritizing HIV/AIDS issues for the Border, especially related to women and children, will be distributed to policy-makers, providers, and community leaders.

Outcomes:

- Agencies along the Border identify specific interventions to reach “Healthy Border 2010” initiative goals.
- Training and capacity-building for MTCT and continuity of care are enhanced among Border providers.
- “Twinning” projects for Border providers are developed to increase clinical capacity for TB, HIV, MTCT, and specialty care.
- Strategies to preserve/re-align service infrastructure are identified and communicated to policy makers.
- Individual participants in Border Summits report increased clarity on how they can contribute to HIV/AIDS prevention and care goals in their respective Border communities.

Impact:

The number of new cases of HIV on both sides of the Border, especially among women, will be monitored. Efficient and effective use of HIV and TB treatment services and the availability of culturally appropriate prevention and treatment will be assessed. Successful collaborations and binational efforts will be promoted.

Assumptions

- 1) To develop sustainable programs, communities must develop health care systems that are community-based and culturally congruent.
- 2) Collaborative relationships among agencies and individuals are based on mutual respect and acknowledgement of differences.
- 3) Capacity development of prevention and treatment services along the Border will have a far-ranging impact on public health in both countries.

IV. ANALYSIS AND RECOMMENDATIONS

Strategies

Priority setting was facilitated by the use of an electronic response system that allowed participants to key in individual votes for strategies. This system was supplemented by small group discussions and consensus building. The participants identified over 40 strategies that have been synthesized and categorized into five themes: collaboration, capacity building, funding sustainability, advocacy, and policy.

Collaboration

Strengthen mechanisms for coordination of care through collaboration within each country as well as across state and national borders.

Several participants described instances in which care was interrupted and/or duplicated, resulting in increased costs and lower quality care. The goal is to identify undiagnosed HIV cases and move them into systems of care. A case management network that spans the Border is needed to provide referrals and serve as a safety net for persons with HIV/AIDS. Trainings that included information about the differences between healthcare systems and collection of health information on both sides of the Border would facilitate the operation of this case management network. Care could also be facilitated by a Binational health card that provides individual treatment history.

Enhanced collaboration between the two countries at the federal level would provide an infrastructure to support care. The need for collaboration, however, goes across traditional lines of health care and public health. Private and public hospitals need to collaborate with each other as well as with community based organizations in the US and Mexico. Model agreements of care are needed that capitalize on the strengths of all partners. For example, medical care could be managed by clinics/hospitals and support services provided by community-based organizations in a coordinated fashion.

Twinning agreements between health care organizations should be designed to emphasize a mutual exchange of expertise, information, and skills. Health care providers and expertise should travel in both directions. For example, Mexican organizations could serve as immersion sites for US health care professionals who will be working with Spanish clients. US organizations could link local health care providers with Mexican health care professionals for enhanced HIV/AIDS clinical training.

Capacity Building

Provide organizations with the training and resources to provide enhanced care for persons with HIV/AIDS in the areas of HIV testing, health care professionals training, and culturally appropriate education for low-literacy persons.

Capacity building and training for Border providers is needed to increase the availability of HIV testing, in particular rapid tests. Rapid testing is seen as especially valuable for use with transient/migratory populations, and in prenatal care or delivery room settings.

Mexican hospitals, such as the Hospital General in Juarez are beginning to implement rapid test protocols with donated test kits.

Two recent studies published in *The New England Journal of Medicine* have advanced the notion that voluntary HIV testing should be part of routine medical care, and that early detection of HIV infection can lengthen lifespan and help to prevent the spread of the virus. These sentiments were echoed in the Border Summits. An additional finding of the new studies is that the benefits of routine testing should outweigh the costs for additional testing. For the Border region, in the context of MTCT and a large population of medically underserved women of child-bearing age, the benefits should be even more pronounced.

The American Academy of HIV Medicine recently surveyed 300 doctors in private practice in 10 U.S. states with high rates of HIV infection; only 5% of the surveyed general practitioners reported use of HIV rapid tests. In Border regions, particularly on the Mexican side, it is not uncommon for providers who work in the governmental healthcare system to also maintain busy private offices, or *consultorios*. These medical providers would be prime targets for capacity-building on rapid test protocols.

Providers and agencies on both sides of the Border have expressed interest in capacity-building and training on “Prevention with Positives” (PWP) and the CDC principles of the “Advancing HIV Prevention ” (AHP) initiative.

CDC Advancing HIV Prevention Initiative

- Strategy 1: To make voluntary HIV and hepatitis C testing a routine part of medical care.
- Strategy 2: To implement new models for diagnosing HIV infections outside medical settings.
- Strategy 3: To prevent new infections by working with persons diagnosed with HIV and their partners.
- Strategy 4: To further decrease perinatal transmission.

PWP and AHP curricula and materials need to be further developed to ensure their cultural and linguistic appropriateness for Border populations and providers. Whenever possible, Spanish and bilingual HIV prevention materials from Mexico and other Spanish speaking countries should be integrated into PWP and AHP trainings.

Similarly, culturally appropriate general HIV prevention education materials and programs for low literacy individuals should be more fully developed for use on the Border. A clearinghouse or resource center should be established to develop a systematic process to screen materials for accuracy and cultural suitability for Border applications.

Sustainable Funding

Develop a strategic plan for funding HIV care and related services on both sides of the Border.

The HRSA HIV AIDS Bureau's Border SPNS projects were widely hailed as effective and worthwhile investments in HIV primary care infrastructure. One Mexican official attending the El Paso Summit was surprised by the news that the Border SPNS projects were reaching the end of their five-year funding period in 2005. She expressed great alarm at the prospect of losing this vital healthcare infrastructure, and noted that the repercussions for her health program and her patients would be very negative.

Funding for the continuation, or revamping of the SPNS Border projects was given high priority by Summit participants. Such continued support could take the form of new Bureau of Primary Health Care funding, or a "new spin" SPNS Border program that retains a much-needed focus on HIV primary care, while demonstrating new approaches for integrating care and evidence-based prevention programs in a continuum of culturally competent services. The SPNS Border grantees would also be ideal sites for formal "international twinning" projects.

The indelible link between healthcare providers on both sides of the international border, and the binational patients that move back and forth between health systems, require that policy and funding decisions be made in light of the impact on the entire region.

Advocacy

Develop work-based and media-delivered educational programs using culturally appropriate methods with the goal of decreasing HIV stigma and discrimination.

Communities need information about HIV/AIDS as a basis for health choices and collective action. This information must be presented in a way that is culturally and linguistically appropriate. Border Summit participants proposed selective use of media, primarily in the development and broadcast of radio soap operas (*novelas*) and short stories featuring sex, condoms, and safe behaviors.

Another area of need for community advocacy is employment-based training programs that address stigma and discrimination of employers against infected employees. In the context of the Border, migrant workers, in particular, are considered at very high risk for HIV infection, and workplace programs may be one of the few venues available for prevention interventions and outreach for HIV testing.

Policy

Provide effective and congruent messages to policy makers who make decisions that impact HIV/AIDS care.

The U.S.-Mexico Border region is beset by a complex and turbulent mixture of policies and conventions relative to immigration, healthcare, substance abuse, drug trafficking, homeland security, economic development, education, public health, the environment, agriculture, water rights, workforce development, and international relations. In this

setting, it may be difficult to maintain a focus on HIV/AIDS prevention and care issues. Consumers and providers concerned with the impact of the HIV epidemic therefore need to continue articulating policy consensus and messages that convey the stark dangers that imperil women, children, and families living on the Border. Equally as important, advocates must highlight the promising opportunities, and seek support for the proven programs, such as the Border SPNS initiative.

V. Conclusions

The U.S.- Mexico Border region is arguably one of the least-well understood and most complex areas in North America. Finding policy consensus in this type of setting for such a controversial topic as HIV/AIDS is a daunting challenge. In an attempt to lay the groundwork for such consensus, the Texas/Oklahoma AETC organized the cross-cultural, interdisciplinary, and binational exchanges that transpired during the Border Summits held October 14-16, 2004 in El Paso and South Padre Island. The participants in these summits promulgated a list of policy and advocacy issues, along with the outlines of suggested strategies to pursue. The Texas/Oklahoma AETC, along with its sponsoring organization, Parkland Health & Hospital System, is committed to collaborating with Mexican and U.S. agencies, Border organizations and providers, and consumers to highlight these issues and advance these strategies.

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