Health, hope, and human development: Building capacity in public housing communities on the U.S. – Mexico border

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Health, Hope, and Human Development: Building Capacity in Public Housing Communities on the U.S.-Mexico Border

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Summary: In this paper we highlight results from our recent survey of public housing residents living in the U.S.-Mexico border region. Our data inform our interdisciplinary (public health, education, environmental engineering, sociology) efforts to improve health and educational equity in our community, and provide ripe opportunities for policy advocacy.

Key words: Health equity, Hispanic health, health disparities, educational equity, public housing.

We are an interdisciplinary team, building a translational research program to develop, implement, and document integrated intervention programs that contribute to health and educational equity among Hispanic populations. Our team includes representatives from the Community Services component of our local Public Housing Authority and faculty from a large, predominantly Hispanic-serving institution (HSI) on the U.S.-Mexico border. We have conducted surveys within four public housing communities and also receive ongoing input from a community advisory board regarding research and program priorities of community members.

The interdisciplinary research (IDR) team has established a collaborative relation-
ship with the Housing Authority of the City of El Paso (HACEP), which manages 54 subsidized housing communities in El Paso, Texas. The IDR team and HACEP residents and staff are working together to improve the quality of life of the HACEP community residents. In this report, we present a brief sociodemographic portrait of community participants, highlighting several health determinants known to contribute to overall health disparities:1,2,3 health insurance coverage, educational attainment, and smoking rates. We highlight these data because of the potential for timely and meaningful practice and policy change given Affordable Care Act (ACA) implementation, community commitment to reducing smoking rates through progressive policy advocacy, and the documented associations between educational attainment and health outcomes. Additionally, these areas present particularly salient opportunities for program implementation and policy advocacy.

Working Together for Health and Educational Equity

El Paso Texas, ranks among the poorest cities in the United States; more than 25% of the population are living below the federal poverty level.4 In El Paso, HACEP manages 54 public residential units comprising multi-family, scattered sites, and elderly communities, which include 5,671 households and 16,513 residents. Fifty-one percent of the HACEP households are led by single women with children. The average HACEP household has three residents, and the average annual household income of HACEP residents is $9,802.5 The residents of the HACEP communities are predominately (98%) of Hispanic background, mostly Mexican immigrants and Mexican Americans.

The overarching goal of our work is to provide a foundation from which to develop programs within the HACEP communities that promote community capacity, facilitate educational attainment, and increase health and well-being. Through an initial survey of 246 adults in four of the 36 communities, we assessed a wide range of sociodemographic factors that included immigrant generational status, ethnic identity and ethnic pride, attitudes about and barriers to educational attainment, community engagement, health status, alcohol and tobacco use, environmental concerns, and perceptions of opportunities for Hispanics compared with non-Hispanic Whites.

Educational Inequities

Hispanics are the largest and fastest-growing minority group in the U.S. and the majority of Hispanics in the U.S. are Mexican American.6 Hispanic youth have significantly higher status dropout rates nationally than their non-Hispanic White (NHW) or Black peers; Hispanics aged 16–24 are twice as likely as Blacks and four times as likely as NHWs to drop out of high school without pursuing alternative education.7 In Texas, recent data indicate that 45% of Hispanic students in Texas leave school between 9th and 12th grades, compared with 20% of NHWs.8 Disparities in educational attainment are significantly linked to health disparities,9 so much so that the Department of Health and Human Services (DHHS) has identified Students who graduate with a regular diploma 4 years after starting 9th grade as a Leading Health Indicator in the Healthy People 2020 national objectives for improving health in America.10
Access to Health Care

Texas has the highest rates of people without health care insurance. Recent data show that among nonelderly adults, 25% of Texans are without any form of health coverage. Hispanics are significantly more likely to be without coverage, with 38% uninsured compared with 26% of Blacks and 17% of NHWs. Moreover, Texas has some of the most restrictive Medicaid eligibility guidelines for adults, leaving many adults with no access to care. Among people living below the federal poverty level, Texas ranks last among all states with 59% of the non-elderly adult population having no insurance. Texans also rank nearly last in access to employer-based health insurance (49%), again with striking disparities by ethnicity: only 34% of Hispanics have employer-based coverage compared with 66% of NHWs.

Tobacco-related Disparities

Smoking and second-hand smoke exposure are significant contributors to environmental health disparities, and a variety of sociodemographic factors such as social context, educational attainment, income, and housing type (e.g., single family vs. multi-unit) contribute to tobacco-related disparities. Regarding housing type, recent policy recommendations regarding the regulation of smoking in public housing have highlighted the critical need for effective policy advocacy to address the implications of differential smoking and second-hand smoke exposure among public housing residents. Specifically, the U.S. Department of Housing and Urban Development (HUD) issued a notice in which Public Housing Authorities (PHAs) are strongly encouraged to “implement nonsmoking policies in some or all of their public housing units.”

Nationally and worldwide, people living in poverty and with low educational attainment continue to have smoking rates that far exceed the norm, and people living in predominantly Black and Hispanic neighborhoods are subject to increased advertising and marketing of alcohol and tobacco products. Significantly, smoking rates among nonelderly adults are much higher among those with no health insurance (32%) or with Medicaid (31%) than among U.S. adults with private health insurance (16%).

Although adult smoking rates have declined significantly in El Paso after a decade of a collaborative and comprehensive tobacco control initiative, little is known about smoking prevalence among local populations that may be at high risk for smoking because of social and contextual factors, including housing type.

Descriptive Data Collection

This was a cross-sectional survey of a volunteer sample of adult HACEP residents. The University of Texas at El Paso Institutional Review Board reviewed and approved the study. Undergraduate students from a research methods course conducted the interviews. Students were trained in interviewing techniques, research methodologies, and research ethics with human participants.

Participants were recruited through community meetings and flyers circulated within four communities by HACEP staff. Participants had to be at least 18 years old...
and reside in the community. Only one individual per household could participate. Following audiotaped verbal informed consent, respondents answered 64 questions that elicited information about a wide range of sociodemographic characteristics and perceived opportunities and concerns. Participants were given a $10 cash incentive for their participation. Interviews were conducted in English or in Spanish as participants preferred, with the majority (70%) preferring Spanish. Interviews were conducted over four days during one week at community centers within the housing communities. In order to reach more people who may have been working during the day, researchers conducted additional interviews during two evenings the following week at two of the original four communities. Because the respondents were not randomly selected, our data are not necessarily representative of the population; however, the high participation rate (22% and 26% of the total community population in the two communities surveyed only in the morning and 37% and 38% in the two communities surveyed in both morning and evening) is a significant strength of the survey. Due to the oral consent procedure and the absence of identifying data on the survey form, we are able to maintain anonymity of participants. Participants always had the option to choose “don’t know” or “prefer not to answer” for each of the questions.

Survey

Data reported here in addition to socio-demographic items include smoking status, health insurance coverage status, and educational attainment (planned, attained or in progress, and planned for children). These items were part of a larger survey developed collaboratively by the research team; the survey reflected community priorities identified by residents through HACEP staff and the interests and expertise of the researchers.

Measures. To determine smoking status we used standard items from the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System regarding tobacco use, asking respondents if they now smoke not at all, some days, or every day. Other items assessed but not reported here included immigrant generational status, ethnic identity and ethnic pride, attitudes about and barriers to educational attainment, community engagement, health status, alcohol use, environmental concerns, perceptions of opportunities for Hispanics compared with NHWs, and questions suggested by HACEP staff to inform program development.

Behavioral and Demographic Characteristics of the Sample

As shown in Table 1, most participants were female, and all were Hispanic or of Mexican origin. The age range of participants was 18–78 ($M = 38.5, SD = 13.92$). Most reported incomes significantly lower than the federal poverty guideline of $19,090 for a family of 3.

Selected health determinants. Current smoking. Compelling evidence shows that a) the burden of smoking and second-hand exposure is “disproportionately borne by the most disadvantaged groups in society”;25 [p:214] b) there is a wide range of effective strategies to reduce tobacco-related disparities including social, political, contextual, and individual approaches; and c) to date, these strategies have not benefited disad-
Building capacity in public housing communities

Table 1.

PARTICIPANT CHARACTERISTICS AND SELECTED HEALTH INDICATORS

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Overall (n=246) M(SD) or %</th>
<th>Men (n=63) M(SD) or %</th>
<th>Women (n=181) M(SD) or %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38.5 (13.92)</td>
<td>35.62 (15.96)</td>
<td>39.4 (13.02)</td>
</tr>
<tr>
<td>Gender (percent female)</td>
<td>74%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Percent Hispanic</td>
<td>100%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Currently Employed</td>
<td>31%</td>
<td>31%</td>
<td>29%</td>
</tr>
<tr>
<td>Total yearly household income all sources b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 0–$1,000</td>
<td>15%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Between $1,000–$5,000</td>
<td>28%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Between $5,000–$10,000</td>
<td>19%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Between $10,000–$20,000</td>
<td>26%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Between $20,000–$30,000</td>
<td>4%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or living as married</td>
<td>41%</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Language of Interview: English</td>
<td>30%</td>
<td>44%</td>
<td>26%</td>
</tr>
<tr>
<td>Selected Health Determinants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke some days or everyday</td>
<td>19%</td>
<td>33%</td>
<td>13%</td>
</tr>
<tr>
<td>No health insurance coverage of any type</td>
<td>62%</td>
<td>48%</td>
<td>73%</td>
</tr>
<tr>
<td>Education level completed or in progress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary or Middle School</td>
<td>19%</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>High School</td>
<td>37%</td>
<td>44%</td>
<td>34%</td>
</tr>
<tr>
<td>GED</td>
<td>18%</td>
<td>6%</td>
<td>22%</td>
</tr>
<tr>
<td>Technical school</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>1–2 years community college</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>5%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>4 yr. college degree</td>
<td>4%</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

a 2 respondents had missing data for gender.
b Categories with fewer than 1% not shown; 12% “don’t know” or “didn’t want to answer”

vantaged groups to the extent that they have benefited the general population, further widening disparities in health and well-being. Smoking rates in our sample are alarmingly high, and access to cessation resources is limited given lack of health care coverage, and recent state-level budget cuts to programs such as telephone quit-line counseling. As shown, 33% of the men and 13% of the women in our sample report current “some day” or “every day” smoking. Significantly, 85% of the men and 83% of the women who smoke said they would like to quit smoking, suggesting the need for tailored and accessible smoking cessation services. We are currently exploring strate-
gies to provide cessation services, and are working with HACEP staff and community residents to develop and implement smoke-free policies to reduce smoking and secondhand smoke exposure.

*Health insurance coverage.* El Paso has one of the highest rates of uninsured residents in the state at 32%. In our sample, 62% reported that they had no medical insurance, highlighting the need for aggressive advocacy efforts related to implementation and promotion of Medicaid expansion and access to services under the ACA.

**Educational attainment.** In terms of educational attainment, most striking is the discrepancy between educational attainment planned, and that achieved or in progress. Although 81% of participants have or are working on at least a high school diploma or equivalent, 73% had planned to earn at least a bachelor’s degree but only 5% have or are currently working on a four-year degree or higher. Almost all (92%) want their children to achieve at least a bachelor’s degree. In response, HACEP and several members of the research team are implementing and evaluating an innovative supplementary educational experience that promotes college and career success among HACEP youth, another faculty member has ongoing activities between teacher education faculty, students, and elementary children to promote interest in science, and others are using these data to inform their research program among homeless people in the border region.

**Promoting Equity**

Our work builds on recent contributions examining health status and health care access among public housing residents in general and among Hispanics in U.S.-Mexico border communities in particular, and provides fertile ground for collaborative efforts to advocate for and affect improved practice and policy. Informed by our research and community input, we are developing and implementing programs to promote health and educational equity, civic engagement, and self-sufficiency among community members. We have recently received funding from an existing National Institutes of Health Center of Excellence and from a local private foundation to work with HACEP residents and other community partners in several health and educational initiatives. Our projects have also received financial and in-kind support from a local health department, our University, and HACEP. We hope to contribute to the rich dialogue on social determinants of health and equity and to evaluate our future work in the tradition of the Promise Neighborhoods initiatives, evaluating ongoing processes as well as long-term health and educational outcomes.

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Notes