
# Enlaces Por La Salud

## Intervention Implementation Guide

HRSA
Ryan White HIV/AIDS Program

## Acknowledgements

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This publication lists non-federal resources in order to provide additional information to those considering replication. The views and content in these resources have not been formally approved by HHS or HRSA. Neither HHS nor HRSA endorses the products or services of the listed resources.



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# Enlaces Por La Salud

This guide examines the Enlaces Por La Salud: Finding, Linking, and Retaining Men and Transgender Women in HIV Care intervention, which uses a transnational framework to provide intensive services, including one-on-one educational sessions to help Latino men and Latina transgender women link to and stay engaged in care and treatment.

***Ending the HIV Epidemic in the U.S. Pillar:*** Treat

***HIV Care Continuum Stage:*** Linkage to Care and Retention

***Priority Population:*** Latino Men Who Have Sex with Men (MSM)* and Latina Transgender Women of Mexican Origin

***Setting:*** CBO/ASO

*The priority population was broadened to include all Latino men, due to low levels of MSM self-identification

The Enlaces Por La Salud intervention, launched by the University of North Carolina at Chapel Hill (UNC), was funded through the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program "Culturally Appropriate Interventions of Outreach, Access and Retention Among Latino/a Populations" initiative.

Enlaces Por La Salud is an HIV linkage, navigation, and education program for Mexican men and transgender women. The intervention is grounded in a transnational framework for providing cultural context to support the delivery of one-on-one educational sessions to people with a new HIV diagnosis as well as for people with HIV but not yet retained in care.

This guide includes key components of the Enlaces Por La Salud intervention, outlines the capacity required by organizations/clinics to conduct this work, and includes replication steps to support others in their implementation efforts. Finding replicable interventions that meet Ending the HIV Epidemic in the U.S. (EHE) initiative goals and support clients along the stages of the HIV care continuum are key to future programmatic and client success in HIV care.[1]

## Achievements

Enlaces Por La Salud served a total of 91 participants. Of the 91 intervention participants, 50 were new to care and 41 were re-engaging in care. At 12-months, 81.3 percent had completed all six intervention sessions; 73.6 percent were retained in care. Additionally, at 12-months, 90.5 percent of intervention participants were virally suppressed (had fewer than 200 copies of HIV per mililiter of blood) and 85.7 percent had undetectable viral loads (so few copies of HIV in the blood that it cannot be detected on an HIV test).[2]

## About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving healthcare to people who are geographically isolated, economically or medically vulnerable. The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program is administered by the HRSA HIV/AIDS Bureau (HAB). The RWHAP SPNS Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by the RWHAP. RWHAP SPNS advances knowledge and skills in the delivery of healthcare and support services for people with HIV who have not been successfully maintained in care. Through its demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

### About the Culturally Appropriate Interventions of Outreach, Access and Retention Among Latino/a Populations Initiative

The featured intervention was part of the RWHAP Part F: SPNS Program "Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations" initiative, a multi-site demonstration and evaluation of culturally specific service delivery models focused on improving health outcomes among Latinos/as with HIV. The initiative funded 10 demonstration sites for up to five years to design, implement, and evaluate innovative methods to identify Latinos/as with HIV and improve their access, timely entry, and retention in quality HIV primary care. This initiative is one of the first public health adaptations of the transnational approach, with interventions prioritizing Latino/a subpopulations with HIV living in the U.S. that are specific to their country or place of origin.

To learn more about this initiative, visit:
**https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-spns/previous-spns-initiatives/culturally-appropriate-interventions-outreach**

# Getting Started

This table provides a general overview of the Enlaces Por La Salud intervention so readers can assess the necessary steps required for replication. This intervention facilitates linkage to HIV care and supportive services for Mexican men and transgender women through the provision of intensive, one-on-one counseling and education applied within a transnational framework.

| INTERVENTION AT-A-GLANCE | |
|---|---|
| **Step 1**  | **Identify and Partner with Community-based Organizations**<br>Identify community-based organizations (CBOs) that have a history of working with people of Mexican descent and people with HIV and have developed trust within that community. Partner with organizations with the capacity to expand their HIV testing within the Mexican population and to identify men who have sex with men (MSM) and transgender women and to include a personal health navigator (PHN) on their staff. Intervention PHNs will be embedded into each of the CBO partners and will be co-located at partner locations. CBO partners engaged in the original implementation of the intervention were in a high HIV prevalence county with the largest Latino/a populations in North Carolina (NC). The organizations included a grassroots Latino/a organization dedicated to strengthening the Latino/a community and an HIV non-profit organization. |
| **Step 2**  | **Hire and Train Staff**<br>Hire staff with the ability to connect with Mexican men and transgender women and treat them with dignity and respect. Staff members do not have to be of Mexican descent. However, they should be able to address issues of relevance to the target population through a transnational framework. The core staff for the intervention are the project coordinator, bilingual PHNs and outreach staff. Train the PHNs and outreach staff on:<br>• PHN role and responsibilities<br>• Skills-based case management<br>• Cultural context of HIV<br>• HIV healthcare system in your jurisdiction<br>• How to interact with clients and people of diverse backgrounds<br>• Principles of client-centered and client-driven approaches<br>• Goal setting with clients<br>• Connecting clients to social services<br>• Establishing effective community collaborations and relationships for seamless linkage and referrals to care |

## INTERVENTION AT-A-GLANCE

| | |
|---|---|
| **Step 3**  | **Conduct Outreach and Establish Referral Relationships**<br>Conduct outreach to area clinics, health care providers, state HIV personnel, and social service agencies to inform them about the intervention and how it can help keep their clients engaged in care. Conduct outreach by implementing visibility campaigns, appearing on radio shows, delivering presentations to providers, and presenting during regional conferences. During these outreach events, the outreach staff, project coordinator, and PHNs should describe the intervention and explain the benefits of making referrals to the intervention for the client and the provider and the process by which the PHN will receive referrals. |
| **Step 4**  | **Receive Referrals**<br>PHNs receive referrals from state HIV personnel, such as the NC Department of Public Health's Disease Intervention Specialists (DIS) and State Bridge Counselors (SBCs). The DIS' primary role is to assure early linkage to care for all individuals receiving a new diagnosis. SBCs supplement the DIS work by locating individuals who are identified as out of care, per their clinic, and addressing barriers to care to facilitate the client's reengagement in care. After assessing a client's eligibility for the intervention and receiving the client's consent, the DIS and SBCs directly refer each client to PHNs. |
| **Step 5**  | **Enroll Clients**<br>During enrollment, PHNs explain the intervention and expectations for the client. They also assess the client's strengths, needs, and barriers to accessing HIV medical care. |
| **Step 6**  | **Develop a Service and Care Plan**<br>After the client is enrolled in the intervention, the PHN in collaboration with the client, develops a service and care plan that outlines goals, action steps, and a timeline. The PHN monitors and updates the plan as necessary. |
| **Step 7**  | **Provide Intensive and Ongoing Client Support**<br>The PHN provides intensive and ongoing support for a period of six to 12 months to help clients reach a place of health self-management. Over the course of the intervention, the PHN delivers six one-on-one educational sessions; helps with medical appointments; builds rapport, provides emotional support, and establishes a relationship with each client; provides an enhanced level of medical case management; and provides one-on-one adherence support. Throughout service provision, the PHN assesses client engagement in care and treatment. |
| **Step 8**  | **Transition the Client to Traditional Long-term Case Management with an Established Partner**<br>At the end of the intervention, the PHN transitions the client to case management services provided by an established partner. The PHN begins preparing the client for the transition at the beginning of the intervention by delivering services that are intended to be an enhancement to routine Medical Case Management (MCM). Throughout the intervention, PHNs should provide/coordinate as many MCM service components as possible including linkage to healthcare, psychosocial, and other services. In addition, the PHN introduces the client to the case manager several months prior to the transition. |

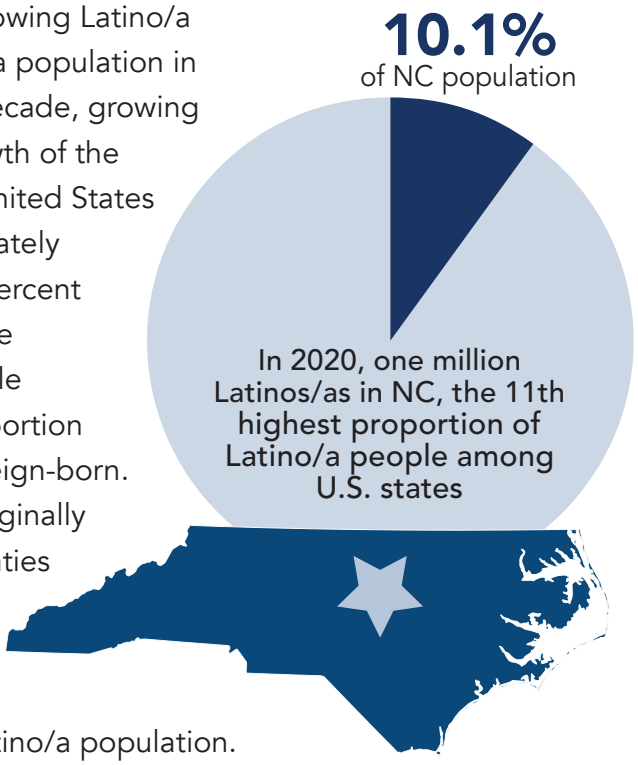
## RESOURCE ASSESSMENT CHECKLIST

Prior to implementing the Enlaces Por La Salud intervention, organizations should walk through a Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have the recommended readiness, they are encouraged to develop their capacity so that they can successfully implement this intervention. Questions to consider include:

- ❑ Does your organization have a history of serving Mexican MSM or transgender women? If not, can you establish a relationship with an organization that does?
- ❑ Do you have bilingual staff or the resources to hire bilingual staff?
- ❑ Are staff knowledgeable about case management, the cultural context of HIV, your jurisdiction's healthcare environment, motivational interviewing,* how to interact with people and clients of diverse backgrounds, connecting clients to social services, principles of client-driven and client-centered approaches, goal setting, and establishing effective community collaborations and relationships for linkage and referral to care? If not, do you have the resources to train them on these topics?
- ❑ Does your staff have mobile phones for reaching clients when they are in the field?

*To learn more about motivational interviewing, visit the Motivational Interviewing Network of Trainers at: **http://www.motivationalinterviewing.org**.

# Setting the Stage




North Carolina (NC) has one of the fastest growing Latino/a populations in the United States. The Latino/a population in the state grew by 40 percent over the past decade, growing nearly two times faster than the average growth of the Latino/a population nationwide.[3] The 2020 United States Census data indicate that there are approximately one million Latinos/as in NC, equaling 10.1 percent of the state's population.[4] In 2010, NC had the eleventh highest proportion of Latino/a people among U.S. states, and the sixth highest proportion of Latino/a community members who are foreign-born. The Enlaces Por La Salud intervention was originally implemented in Wake and Mecklenburg counties in 2013, the two counties that had the highest total Latino/a population in NC at the time, and still in 2020. In 2020, Mexicans made up the majority (54 percent) of NC's Latino/a population. As a new destination state, NC is part of a larger trend in which Mexican and other Latin American migrants are traveling to regions outside of longstanding receiving areas such as New York and California.[5] The rapid growth of the Mexican population in NC reflects a demographic shift in response to: 1) employment opportunities in the construction, meatpacking, and service industries; and 2) lower cost of living than in traditional receiving states.[4]

The number of HIV cases among the Latino/a community in NC have significantly increased. In 1995, they accounted for only one percent of newly reported HIV cases in NC compared to 8.5 percent in 2020.[6] As of 2020, the population of Latino/a people with HIV in NC who are virally suppressed remained the lowest of all racial and ethnic groups.[7] From 2016 to 2020, the percentage of late diagnosis among the Latino/a population in NC increased from 10.7 percent to 12.9 percent. Late diagnosis is defined as receiving an AIDS diagnosis within six months of testing positive. Late diagnosis among the Latino/a community may be attributed to language barriers, HIV stigma, and limited access to

testing and health care. Latino men and transgender women have been particularly affected by the HIV epidemic. Members of the Latino/a transgender community are disproportionately affected, accounting for 14.3 percent of all people diagnosed with HIV in the state.[5] In 2019, the rate of Latino men with HIV was 2.6 times that of White men.[8] Traditional HIV testing strategies may not effectively reach Latino MSM and Latina transgender women, who may be mobile, socially isolated, and reluctant to use health services. These same barriers also make this population vulnerable to HIV acquisition. In addition, Latino MSM and Latina transgender women with HIV are heavily stigmatized because of their sexual orientation, gender identity, ethnic minority status, and their HIV status.[4]

# Description of Intervention Model

**CHALLENGE ACCEPTED**

***The Challenge:*** Increase the number of Mexican men and transgender women with HIV who are engaged in consistent care.

Enlaces Por La Salud is a six- to 12-month intervention. PHNs trained in strengths-based counseling work one-on-one with Mexican men and transgender women clients to connect or reconnect them to care and link them to support services. A key component of the intervention is the delivery of six one-on-one educational sessions by the PHN, focused on the client's migration story.

## Theoretical Framework:

The intervention uses three theoretical concepts to understand the experiences of sexual minority Mexicans and to inform that impact of cross-cultural influences on the health and well-being of clients engaged in the intervention.

1. *Parker and Aggleton's HIV and AIDS-related stigma and discrimination conceptual framework*—Reflecting the intersectionality framework, this concept provides a way to understand HIV and AIDS-related stigma and the way it feeds upon, strengthens, and reproduces class, race, gender, and sexual inequality.[9] The intervention developers drew upon this approach to inform their use of a holistic and integrated response to HIV that recognized the intersectionality of each individual's identity.[4]

2. *Migratory Process Framework (MPF)*—A rights-based, policy-oriented approach that considers migration to be cyclical and multi-staged. The MPF divides this process of migration into five phases: 1) Pre-departure, 2) Travel, 3) Destination, 4) Interception, and 5) Return. The framework outlines the health impacts, intervention opportunities, and policy needs associated with each stage of the

migratory process.[10] The intervention developers utilized the MPF to understand how the stages of migration and migration experiences may influence HIV testing behaviors and engagement with care.

3. *Transnationalism*—The foundation from which intervention PHNs explore the impact of cross-cultural influences on health and well-being and inform their approach to the provision of services and support for transnational migrants with HIV.[4]

When implementing the intervention, the PHN should understand the client's migration story and use it to inform the session structure throughout the intervention. Important questions for understanding client migration stories include:

- How are clients still connected to their home country?
- How does their migration story continue to affect their current life situation?
- What has been their experience in the US/their current place of settlement?

By centering the client's migration story, sessions can focus on the migratory and cultural influences of the client's life upon their HIV care management.

## Intervention Steps:

1. *Train staff:* Provide PHNs and outreach staff with training in the following topic areas: skills-based case management, the cultural context of HIV, the HIV healthcare system in your jurisdiction, how to interact with clients and people of diverse backgrounds, connecting clients to social services, and establishing community collaborations and relationships for seamless linkage and referrals to care. Training should include demonstrations and role-play activities to demonstrate PHN roles and responsibilities, the principles of client-centered care and client-driven approaches, and goal setting activities with clients.

2. *Co-locate staff at local community-based organizations:* Assign a PHN to work at each of the partner community-based organizations. Embedding staff within each of the organizations allows for more seamless referral and linkage processes.

3. *Provide intensive support services:* PHN services are intended to be an enhancement to routine medical case management (MCM). Therefore, the PHNs adhere to the same requirements as MCM interdisciplinary teams with respect to the MCM service components. This enhanced MCM includes the following activities:

a) *Conduct client intake and assessment:* The PHN conducts a standardized intake interview with the client to identify barriers that have prevented the client from linking to and engaging in HIV medical care, identify immediate barriers to care, and identify high risk behaviors to inform risk reduction strategies.

b) *Develop and implement a service plan:* The PHN works with each client to develop, implement, and evaluate a personalized service plan. The service plan outlines specific steps for overcoming the client's barriers identified during the assessment. The PHN monitors and revises the service plan as needed.

c) *Support clients with medical appointments:* The PHN helps each client by scheduling their HIV medical appointment. After scheduling the HIV medical appointment, the PHN:

- Explains what the client can expect during that appointment
- Identifies and helps mitigate potential barriers, such as transportation
- Answers questions
- Helps the client complete paperwork
- Offers to accompany the client to the appointment

To provide emotional support, the PHN contacts each client once a week before the first appointment, and on the day before the appointment. Some clients benefitted from the PHN calling or texting them on the morning of the first appointment.

It was helpful for some clients to have the PHN meet them in the hospital or clinic lobby to help them find the doctor's office on the day of their appointment. The PHN accompanies the client throughout the appointment or remains in the lobby or waiting room, depending on the client's preference. After the appointment, the PHN and the client discuss the client's experiences and review and clarify information shared by the provider. The PHN also answers questions the client may have.

The PHN also supports clients with scheduling appointments with specialty and primary care providers.

d) *Monitor missed appointments:* An important element of the PHN service provision is monitoring missed appointments and following up with clients who miss appointments. Missed appointments are a sign that a client is at risk of falling out of care. Therefore, the PHN contacts a client after a missed appointment to check in, help reschedule the appointment, and help manage barriers to attending appointments.

e) *Communicate with clients:* PHNs contact clients no less than bi-weekly and more frequently as necessary for the first three months

of the intervention. The frequent communication helps the PHN build rapport, provide emotional support, and establish a relationship with the client. At the end of the three months, the PHN and the client reassess the frequency of contact. Based on the client's needs, the frequency can be maintained or reduced to monthly. PHNs use several means for maintaining client contact, including telephone calls, text messages, and in-person visits at locations most convenient for the client.

f) *Provide medication adherence support:* The PHN provides individual one-on-one medication adherence support by collaborating with the client's healthcare provider to understand the client's medication regimen. The PHN develops personalized tips and practices to encourage medication adherence for each client, as needed. In addition, the PHN discusses actual and potential adherence challenges with clients, collaborates with the client to develop practical plans for addressing challenges, and engages in skills-building activities to help the client address the potential and actual challenges. Lastly, the PHN stays abreast of adherence methods, including types of medication reminders, scheduling strategies, and methods for maintaining privacy and confidentiality.

g) *Facilitate one-on-one education sessions:* The PHN delivers six one-on-one educational sessions that focus on the client's migration history and addresses a transnational goal. Each session is designed to last between one and two hours, depending upon the client's availability and comfort discussing the topic. The PHN has the flexibility to deliver the sessions in the order that works best for the client. Ideally, the PHN delivers the sessions in-person but they can be delivered over the phone.

h) *Collaborate with care team and participate in case conferencing:* The PHN has regular and ongoing communication with each client's medical providers and other service providers to ensure the client is engaged in care and receiving the necessary support services. The PHNs participate in weekly case conferences with the project coordinator to discuss cases and associated challenges.

i) *Develop and implement a transition plan:* Prior to transitioning a client from the intervention to a traditional case manager, the PHN develops a transition plan that will support the client with maintaining engagement in HIV medical care. The transition plan identifies barriers that were resolved during engagement in the intervention as well as any unresolved matters that require action after the transition.

## List of sessions, the discussion topics, and transnational goals:

| Session Number and Title | Discussion Topics | Transnational Goal |
|---|---|---|
| Sessions 1: Life and Migration History | • Diagnosis<br>• Mexico<br>• Barriers to care | Migration history and identification of relevant events or experiences (highlighting strengths) that may shape the HIV care and treatment experience |
| Session 2: Medical Visits | • Health history<br>• Visits<br>• Emotions | Healthcare history prior to, during, and following migration to provide context for initiation or reengagement with care |
| Session 3: Social Networks | • Social support<br>• Inventory<br>• Types of support | Elicit a social network and support inventory (both local and transnational) to understand the social context in which the client currently lives<br><br>Identify messages clients are receiving from their community about HIV status and how this affects them |
| Session 4: Stigma and Discrimination | • Stigma<br>• Coping<br>• Support | Identify individuals in the client's social support networks to whom they would like to disclose their status, and practice how they want to talk about their HIV diagnosis |
| Session 5: Healthy Living | • Type of health<br>• Mental health<br>• Stress | To discuss the client's responsibilities as a migrant to improve the understanding of external pressures that may impact healthy living, HIV care, and treatment behaviors and outcomes |
| Session 6: Transition Plan | • Self-management<br>• Readiness<br>• Support | Define future plans with regard to migration and relations with country of origin and current community of residence |

## Cost of Intervention:

While the cost of implementing the intervention may vary, the table below reflects approximate costs of key intervention elements across two sites with the use of RWHAP SPNS funds. The costs listed exclude evaluation costs, staff salaries, and office space. Travel costs are dependent on the geographic location and the need and ability of clients to meet in-person at clinics, offices, and/or a client's residence.

**Approximate annual intervention costs:**

| Intervention | Cost |
|---|---|
| PHN Phone Plan | $1,320 |
| Program and Office Supplies* | $2,136 |
| Staff Travel | $2,088 |
| PHN Computers** | $2,500 |
| **Estimated Annual Total** | **$8,044** |

*Program and office supplies—Includes costs of printing for brochures, flyers, posters, condoms and lubricant, and general office supply needs.

**The cost associated with purchasing computers for the PHNs reflects a one-time purchase and does not need to be included in the annual cost after the first year of implementation.

## STAFFING REQUIREMENTS & CONSIDERATIONS FOR REPLICATION

### Staffing/Organizational Capacity

Based on the Enlaces Por La Salud intervention, the following staff requirements and competencies are necessary to successfully replicate this intervention.

- *Project Coordinator (50 percent FTE):* Oversees day-to-day intervention activities; meets with PHNs weekly; visits community partner sites bi-weekly to assess progress and help staff address challenges; and holds case conferences to facilitate the discussion of specific cases, insights, and difficulties among PHNs and ways to address client recruitment and retention with the team.
- *Personal Health Navigator (2 PHN, 100 percent FTE each):* Builds a trusting and effective relationship with clients, identifies clients' needs, and barriers to accessing HIV medical care; provides appropriate interventions dependent upon clients' needs; facilitates the six one-on-one educational sessions with clients; and empowers clients through identification of their strengths. The PHN provides referrals and aids in consistent engagement of HIV care; assists clients in building positive communication with their medical providers; develops individualized care plans for clients, which include training clients to use medical adherence tools; provides referrals for social support services; accompanies clients to medical and other appointments; and follows-up with clients after medical care visits. The PHN collaborates with the regional DIS and SBC and local HIV primary care providers and support service agencies to assist Mexican men and transgender women to enter and remain in care.
- *Outreach staff (2 outreach staff, 50 percent FTE each):* Establishes referral relationships with area clinics, health care providers, and social service agencies. Staff conduct outreach via visibility campaigns, radio shows, conference attendance, presentations to health care providers, and in-person meetings with health care and social services staff.

### Staff Characteristics

Core competencies include:

- Spanish/English proficiency
- Excellent verbal and written communication skills
- Excellent interpersonal skills
- Experience working with the target population
- Strong HIV knowledge base
- Ability to communicate well with medical providers and support staff
- Ability to multitask
- Ability to work well with organizational structure
- Ability to meet clients where they are and treat them with dignity and respect
- Two years of HIV or case management work experience
- Cultural and linguistic competency.

# Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, examples for further context. Successful replication of the intervention involves the following:


*Partner with a case management organization.* This is a high need population. Therefore, clients need to be linked to a range of services, which is most effectively done by a case management organization.


*Create a system for regular communication.* Ensure that staff are not working in silos by creating a system for communicating across locations. For example, the project coordinator spoke with each PHN weekly and also held a weekly case conference for the PHNs and outreach staff to discuss and strategize around cases and discuss challenges with outreach and recruitment. Additionally, the project team held a biannual meeting to review project progress.


*Hire the right staff.* Staff do not have to be Mexican, but they should be bilingual and able to connect with and relate to clients and treat them with dignity and respect.

# Securing Buy-in

Securing the support of leadership, staff, and other relevant stakeholders is important when implementing a novel intervention. The following strategies may help to secure buy-in for the Enlaces Por La Salud intervention:

- ***Discuss the Enlaces Por La Salud goals with partner organizations*** in the context of their priorities, needs, and goals. Securing buy-in from local agencies and clinics requires staff to invest considerable time delivering presentations and attending meetings to explain how the clinics' clients could benefit by participating in the intervention.

- ***Demonstrate the value of the intervention with data.*** As intervention data becomes available, outreach staff should translate that data into a compelling story to communicate the benefits that the clinics and providers can expect for their clients.

# Overcoming Implementation Challenges

Implementing a new intervention comes with its challenges. The following are some challenges UNC experienced while implementing the intervention and their tips to help you avoid them.

- ***Difficulty building referral networks.*** Local agencies and clinics had a number of concerns regarding serving as a referral source for the intervention. Some believed the intervention to be a duplication of their efforts, whereas others believed it would increase their workloads, and possibly impact their funding. To address these concerns, staff invested considerable time continuously delivering presentations and meeting with agencies and clinics to share how their clients were benefitting from their engagement in the intervention.
- ***Staff turnover at area clinics.*** Staff turnover also required the continuous delivery of presentations about the intervention. To anticipate gaps in staffing due to turnover, UNC ensured that organizational staff had prior knowledge of the intervention and established relationships with the intervention team.
- ***PHNs were unable to meet with all clients in-person.*** Because clients often spent long spans of time working out of state and had little free time due to work schedules, PHNs had difficulty meeting with clients in-person. To address this challenge, PHNs contacted clients by phone, text messages, including the use of WhatsApp, and delivered the one-on-one educational sessions via phone.
- ***Low recruitment of Mexican MSM.*** Mexican MSM were initially one of the intervention's priority populations; however, the study team recognized that some Mexican men may not identify as MSM or only do so after a period of trust has been established. To ensure MSM clients were not being excluded based on a low level of MSM self-identification, the priority population was broadened to target the wider Latino male population in order to achieve maximal uptake.

# Promoting Sustainability

When planning for and promoting sustainability, assess organizational capacity to roll intervention activities and roles into existing structures, services, and programs. While implementing the intervention, the study team found that both community-based organizations were assessing which intervention elements could be sustained. The HIV nonprofit organization maintained the PHN position and is using a transnational framework and content from the one-on-one educational sessions to engage with clients. They were equipped to sustain parts of the intervention because they were already offering case management services.

## BY THE NUMBERS

**91** clients served by Enlaces Por La Salud

**41** were reengaged in care | **50** were new to care.

The mean age of these participants when they arrived in the U.S. was **21.1** years.

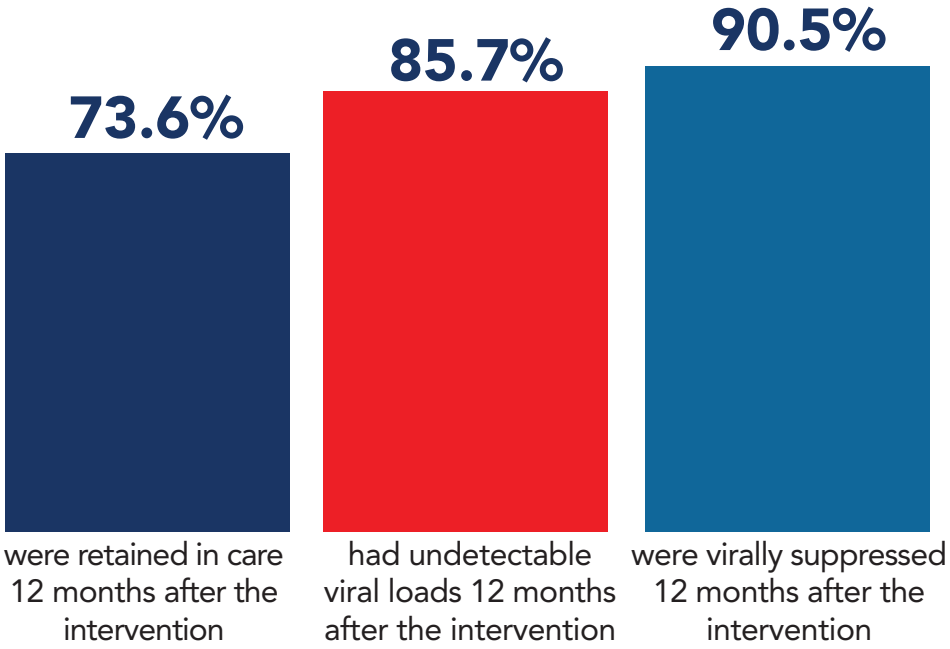
**64%** occasionally or often send money to their country of origin

**79%** born in Mexico

**85%** Spanish speakers

**88%** never or rarely travel back to their country of origin

**Client outcomes for the project reporting period of October 2014 through October 2017:**




**81.3** percent of clients completed all sessions.

Source: University of North Carolina at Chapel Hill.

# Conclusion

The Latino/a community is disproportionately affected by the HIV epidemic. Social and structural issues, some unique to the transnational experience, make it more difficult for Latino/a people to find, engage with, and be retained in high-quality HIV care. Utilizing the one-on-one, transnational model of HIV education and care coordination outlined in the Enlaces Por La Salud intervention can help Latino/a individuals, particularly those of Mexican origin, achieve better health outcomes. Ninety-one clients participated in Enlaces Por La Salud, fifty of which were new to care. Overall, participants strongly identify with Mexican culture. The majority (79 percent) were born in Mexico and speak Spanish (85 percent). The majority (81.3 percent) of participants completed the intervention by attending all six sessions.

## OTHER AVAILABLE RESOURCES

### Enlaces Por La Salud & Initiative Resources

Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations Initiative: Intervention Monographs:
**https://targethiv.org/sites/default/files/file-upload/resources/Latino-SPNS-Intervention-Monograph-508_0.pdf**

Building Effective Interventions for Latino Clients:
**https://targethiv.org/ihip/webinar-building-effective-interventions**

Empodérate: A Model for Addressing Social Determinants of health Among LGBTQ Latinx Young Adults:
**https://targethiv.org/library/empoderate-model-addressing-social-determinants-health-among-lgbtq-latinx-young-adults**

Replicating Innovative HIV Care Strategies to Priority Populations:
**https://targethiv.org/library/replicating-innovative-hiv-care-strategies-priority-populations**

HRSA IHIP Viviendo Valiente Intervention Implementation Guide:
**https://targethiv.org/ihip/viviendovaliente**

### Additional Replication Resources

Integrating HIV Innovative Practices:
**https://targethiv.org/ihip**

Best Practices Compilation:
**https://targethiv.org/bestpractices/search**

HIV Care Innovations:
**https://targethiv.org/library/hiv-care-innovations-replication-resources**

## Need Help Getting Started?

If you are interested in learning more about this intervention or other interventions featured through the Integrating HIV Innovative Practices project or want to request technical assistance, please email: **ihiphelpdesk@mayatech.com**

## Subscribe to our Listserv

To receive notifications of when other evidence-informed and evidence-based intervention materials, trainings, webinars, and TA are available through the Integrating HIV Innovative Practices project, subscribe to our listserv at: **https://targethiv.org/ihip**

## Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

## Endnotes

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