U.S. MEXICO BINATIONAL HEALTH
PROFESSIONAL EXCHANGE PROGRAM

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1998 Binational Health Professional Exchange:
Evaluation Report

1998
Binational Health
Professional Exchange
Evaluation Report

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U.S. – MEXICO BINATIONAL HEALTH PROFESSIONAL EXCHANGE PROGRAM

1998 Binational Health Professional Exchange Evaluation Report

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1998 BINATIONAL HEALTH PROFESSIONAL EXCHANGE SUMMARY

I. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Background:

In the early 1980's U.S. President Reagan and Mexico's President Lopez Portillo established the Binational Commission (BNC) as a venue for binational high level discussions. In 1996, U.S. Secretary of Health and Human Services Donna E. Shalala and Mexico's Secretary of Health Juan Ramón de la Fuente signed a memorandum of cooperation that created the BNC Health Working Group, with the purpose of strengthening and improving the coordination of public health efforts between the U.S. and Mexico. The BNC Health Working Group formed five Core Groups in order to satisfy its purpose: Women's Health, Smoking Prevention (with emphasis on adolescents), Immunizations, Aging, and Migrant Health.

The Migrant Health Core Group is co-chaired by Antonio Durán, former Director of the Migrant Health Branch of the Bureau of Primary Care, and Dra. Lourdes Quintanilla, Secretary of Health and Community Development, State of Coahuila, Mexico. Members of the Migrant Health Core Group represent federal, state, and local health care agencies from Mexico and the United States, as well as representatives from non-governmental organizations and academia.

The Migrant Health Core Group agreed to focus its initial efforts on issues affecting migrant agricultural workers and their families. The Migrant Health Core Group pursues activities aimed at identifying successful preventive health measures and policies, as well as in improving the effectiveness of health care available in both countries for migrant populations that work in rural and agricultural environments in the U.S. and return to their native lands.

Migrant Health Core Group Action Plan:

Based on the 1996 BNC Health Working Group agreements and subsequent annual affirmations, a Migrant Health Action Plan was developed by the Migrant Health Core Group. The action plan was designed to explore opportunities to broaden bilateral collaborative efforts aimed at better meeting the health care needs of agricultural workers who migrate to the U.S. from Mexico on a regular basis.

The action plan focuses efforts on building collaborative relationships that will assist health professionals identify risk factors and prevent illness among migrant agricultural workers and their families.

Primary Areas of Collaboration:

The action plan identifies two primary areas for collaboration: the exchange of information and materials, and the promotion of learning experiences. The goals for these two areas of collaboration are:

Exchange of Information and Materials

- Reinforce dialogue on key issues through meetings between the Core Groups;
- Establish joint health initiatives with the other Core Groups;
- Develop and distribute an inventory of agreements and existing health education programs;
- Exchange and review health education materials on HIV/AIDS, sexually transmitted diseases, tuberculosis, rabies, and others;
- Strengthen binational collaboration concerning development of health education materials.

Promotion of Learning Experiences

- Raise the level of awareness among health officials regarding the importance of migrant health problems and needs in both Mexico and the U.S.;
- Share information and promote migrant related conferences and forums;
- Develop substantive courses for health professionals in topics such as: addictions, HIV/AIDS, tuberculosis, reproductive health, and other relevant topics;
- Develop a U.S.-Mexico health professional exchange program that allows health professionals to gain a better understanding of the socio-cultural background of their patients, care-giving strategies, and the health care systems of each country and improve access to

care. Selected health professionals will participate in the exchange in the capacity of observers only in order to ensure that licensure laws in both the U.S. and Mexico are complied with.

- Promote ongoing collaborative projects and programs between health providers and their institutions in the U.S. and Mexico, as well as identify and develop potential policy initiatives that could improve care for migrants.

This report examines the Migrant Health Core Group's efforts in developing the professional exchange program during the 1998 calendar year. Specifically, this report highlights the lessons learned from the exchange experiences of the U.S. and Mexican health professionals who participated in the pilot orientation sessions and team visits.

U.S.-Mexico Health Professional Exchange Program:

The exchange program has been designed to provide participants with an opportunity to understand the U.S. and Mexican health care systems, and how health care is provided to migratory populations in both countries. It was also designed to develop ongoing relationships with providers who share common patient populations, in order to improve access to care.

Recognizing the unique role Migrant Health Centers in the U.S. play as a key source of personal health services available to Mexican migrant farmworkers, the Core Group developed the professional exchange program. This program gives U.S. and Mexican health professionals the opportunity to learn about the health and social services available to Mexican migrant farmworkers in both Mexico and in the U.S. The professional exchange also provides U.S. and Mexican health professionals with the opportunity to experience first hand the cultural environment in which migrant farmworkers live when in each country.

Concerns about continuity of, and access to, care as Mexican agricultural workers moved to other parts of the U.S. and on their return to their home states in Mexico gave rise to a strategy that linked sending and receiving communities. Given this initial focus on health care provided to agricultural workers the exchange program has been developed in several phases linking Migrant Health Centers and their professionals with the health care providers in the Mexican states

where the majority of participating immigrant Center's patients originate.

The exchange program has been developed with the following objectives in mind:

- Relationship building - strengthen U.S.-Mexico relationships in migrant health with opportunities for informing the larger public about migrant health concerns, information sharing, and development of international communications networks for continuity of and improving accessibility to care;

- Better understanding the U.S. and Mexican health care systems – to acquire increased knowledge of the structure and function of the population-based service and personal health services available in the two countries. Identify care models that may be workable in both environments;

- Increase understanding of cultural differences in illness, health, care giving strategies - develop a connection between communities that strengthens the bond of family, individuals and community support systems, increasing awareness and cultural competency among individuals and institutions;

- Better understanding of clinical priorities - increase knowledge of the key health care issues and successful clinical and non-clinical approaches used, for example, regarding child health, immunizations, reproductive health, HIV/AIDS, tuberculosis, and dental care;

- Expand learning experiences - develop community to community relationships for future collaborative health care projects and additional learning experiences, including expansion beyond the initial exchanges.

The exchange program experience has been developed in several phases: the *"Baby Piloto"*, the U.S. team visits to Mexico, and finally the Mexican team visits to the U.S., including pre-exchange orientation sessions in each country.

Phase I: The "Baby Piloto"

The first phase focused on the general planning and implementation of the initial pilot exchange experiences between the health officials from

the Mexican State of Coahuila and Plan de Salud del Valle, Inc. in Ft. Lupton, Colorado, as well as the Mexican State of Jalisco and Columbia Valley Community Health Services in Wenatchee, Washington. Each of the visiting Mexican delegations was composed of three health care officials that visited U.S. counterparts based at migrant health centers.

The main goal of this phase of development was to test basic issues regarding physical accommodations, types of experiences that might prove useful for visitors in understanding how the U.S. health care system works, and experiences that allow for a better understanding of what migrants experience in the U.S. with regards to work environment, housing, social services, and medical care.

The findings from this phase were used to design the experiences for the U.S. and Mexican team visits in phase two of the exchange program development. Both Mexican and U.S. participants in this small pilot effort reported the visits as successfully instructive and that they had begun initial discussions regarding ongoing educational and research activities. These early efforts suggested the need to consider a more structured team visits approach rather than an individualized visit approach. It also alerted organizers to the potential difficulties in housing and transportation logistics.

Phase II: "Piloto"

The second phase of the exchange program development consisted of a formal exchange of health care professionals between five U.S. Migrant Health Centers and their Mexican State counterparts. Migrant Health Centers were matched with the Mexican State from which their patient population predominantly originated. Given the current migration patterns of agricultural workers Migrant Health Centers determined through an informal survey of patients the following matches:

Kalamazoo, Michigan	-	Jalisco
Hudson Valley, New York	-	Puebla
Wenatchee, Washington	-	Michoacán
Ft. Lupton, Colorado	-	Guanajuato
Eagle Pass, Texas	-	Coahuila

The phase two U.S. visits took place January 22-30, 1998. This phase consisted of two parts: a two day orientation on the Mexican health care system held in Guadalajara, Jalisco and a week-long

resident experience in assigned Mexican states. In the second part of Phase II, the Mexican contingency participated in a two-day orientation on the U.S. health care system held in Dallas, Texas during September 10-12. Immediately following the orientation teams made their visits to U.S. host sites from September 13-20, 1998.

Phase two activities were supported in part by funds provided from the Bureau of Primary Health Care, Migrant Health Branch; the University of California's MEXUS Program; the UCLA School of Public Health's Department of Health Services; the Pan American Health Organization; the State of Jalisco Department of Health; the National Center for Farmworker Health; the participating Mexican states' Department of Health; and the participating Migrant Health Centers.

Phase II Pilot Goals

The U.S. Team visits to Mexico and Mexican Team visits to the U.S. were evaluated so as to:

- Gain understanding about ways participants benefit from a structured visit experience;
- Enhance future exchanges by building on what works and modifying what did not work as well as expected;
- Document the lessons learned and identify opportunities for additional learning experiences that could be supported by various funding sources as the exchanges are expanded to include additional participants and sites.

Phase II Professional Exchanges

The professional exchanges were organized as a centralized two-day orientation program and a weeklong (five to seven days) visit by teams of health care professionals to designated communities. The U.S. teams were composed of health care professionals from different disciplines and training (e.g., physicians, nurses, dentists, and community outreach workers) who serve agricultural migrant workers at Migrant Health Centers. The Mexican teams were composed of health care professionals who provide care through State health care programs especially in rural communities.

Prior to their visits, teams were brought together for an orientation program designed to enhance their understanding of the health care

delivery systems and communities they would be visiting. The orientation for the U.S. teams was held in Guadalajara in January 1998 and hosted by the State of Jalisco. The orientation for the Mexican team was held in Dallas and hosted by the National Center for Farmworker Health. The orientations provided visiting teams with presentations by researchers and scholars of the structure and function of the U.S. and Mexican health systems, the health and health care issues affecting migrant farmworkers both in the U.S. and in Mexico. In addition participants learned about the patterns and magnitude of migration between the two countries.

Following the orientation program, teams traveled to their host communities for a weeklong series of opportunities to learn how care and prevention programs operate in the host community. Teams were scheduled throughout their visit to see local primary care programs, visit medical facilities and related social service and education programs, as well as meet with local public health officials and migrant farmworkers and their families.

Several key themes standout among successful accomplishments of the professional exchange visits. These are best summarized through the impressions and insights provided by the visiting teams and their hosts.

Health professionals greatly benefited professionally and personally

The orientations and local visits profoundly affected participants in the exchange, both visiting and hosting organizations. Individual visitors indicated that the experience affected them both personally and professionally.

For example, one participant said, "I learned that, in some ways the similarities are more evident and important than the differences....I have a better understanding of what kind of messages we need to give patients – simple, clear, and consistent." Another participant echoed these observations; "I learned that there is a commonality of purpose between Colorado and Guanajuato, and that we both are interested in an ongoing relationship to improve the health of our common population."

In general, the participants developed a better sense of how the two health care systems were designed to serve different populations in each of the countries. Mexico, in fact, operates several different primary care delivery mechanisms. Health care in Mexico was found

to be inexpensive and in many cases free of out-of-pocket patient charges. One system, Instituto de Seguridad y Servicio Social para los Trabajadores del Estado (ISSTE) is designed to serve government employees and teachers. Instituto Mexicano del Seguro Social (IMSS) serves all those who are employed in non-professional positions such as general laborers, carpenters, masonry workers, and others. The Department of Health offers services to the unemployed, the indigent and rural communities. Private sector physicians and hospitals tend those persons in higher socio-economic strata of society or those who are insured by programs like IMSS. Thus, like the United States different delivery systems exist for different populations. However, most clinics are government owned, financed, and operated.

In the United States, we have delivery systems that serve the poor and uninsured (including some public health departments that provide primary care similar to the Mexican State's Health Departments) and other delivery systems that serve the middle income insured populations. We have systems designed to serve veterans of military service and systems designed to serve members of the military. Each system is financed and operated by a mix of sources with most care provided in the United States by non-governmental organizations and providers.

Mexican participants highly valued the opportunity to learn about the living and working conditions of migrants in the United States as well as how their medical needs are attended to by the migrant health centers and other related migrant agricultural programs. Several teams indicated that they found it personally and professionally important to understand the migratory process and how it affects a specific local U.S. community and health service delivery system.

Participants emphasized the opportunities the professional exchange provides for building a sense of trust. Individual participants commented on the building of trust through personal knowledge or observation of Mexican and U.S. approaches to caring for patients. Participants also acknowledge that much of the trust building was through the personal connections and relationships they developed with their hosts. Mexican participants expressed amazement of and appreciation for the dedication and efforts by U.S. health care professionals to care for Mexican farmworkers through the migrant health centers.

Participants expressed a broadened understanding of the people and the systems that provide care in each nation. For example, one U.S.

participant says, I have "an improved understanding for the level and the type of health provisions our patients are accustomed to as well as how these are provided (in Mexico)." Similarly, another U.S. participant indicates "this understanding allows me to see how migrants may respond to the health systems they encounter in the United States." Mexican visitors learned more about the working and living hazards that farmworkers are exposed to in the United States and how these issues are addressed by the U.S. health system.

Mexican visitors similarly learned about the network of federally and state subsidized migrant and community health centers located across the U.S. designed to provide access to care for any in need. They expressed a deeper understanding of how the U.S. market based system operated and role of community health centers and public health departments in caring for Mexican migrant farmworkers.

One team summarized the experience in the following way: "We found the trip extremely beneficial in its capacity to deepen and enrich our cultural awareness of our Mexican neighbors. We learned a great deal not only about their healthcare system, but also about their lives and daily existence. It was professionally gratifying to be given a close-up, inside view, of the Mexican health system, to meet the committed competent people who make it work, and to participate in the process of building a collegial and institutional bridge between our two countries that will enable us to better serve the farmworkers in our care."

Better Information Exchange is the Key

A general consensus developed among participants of the exchanges with regard to opportunities in the areas of illness prevention and health promotion that lend themselves for ongoing relationships. It is clear that the exchange of health promotion materials project, identified as a goal of the Migrant Health Workgroup, can be a superb starting point for much other illness prevention and health promotion activities binationally.

Teams gained a better understanding of the health issues affecting rural communities. "Having the opportunity to visit many communities within three health jurisdictions of the state of Puebla left us with a clear impression of Mexican health disparities and the proactive campaign taken by the Secretary of Health of Puebla to reduce these disparities and produce healthy outcomes. Problems such as overpopulation, cholera, scorpions, dengue, rabies, diarrhea, dog

control, TB, HIV, and homelessness are being addressed by all municipalities, from urban to rural."

Mexican states spend a great deal of time and energy in prevention and education for all population age groups. Mexican television frequently airs public service announcements addressing primary health care issues and videotapes for public viewing at health centers are prevalent. Spanish-language television and radio could be better used in the United States to promote health and prevent illness. Many of the messages have already been developed and could be used by migrant health centers and their communities.

A U.S. participant observes that the exchanges help "identify how we can better work with our Mexican counterparts to prevent health problems, in particular communicable diseases such as HIV, tuberculosis, hepatitis, rabies epidemics, STDs, etc." The participant goes on to observe that the exchanges provide the "greatest benefit for both sides ...to establish who the key players are, and identify strengths, weaknesses, and resources....improving communication and identifying ... resources we can share."

U.S. participants observed that the Mexican focus on childhood immunizations, breastfeeding, and environmental control could be reinforced better in U.S. programs. A U.S. participant comments, "We improved our understanding about...the health information people in Mexico receive and how we can build and complement this, e.g., dietary suggestions, importance of [childhood] immunizations, and prenatal recommendations." Mexican primary care programs could learn from the U.S. about the need to focus on women's health screenings, such as cervical and breast cancer screening.

Both U.S. and Mexican participants observed that addictions, depression, and stress should receive more prevention and primary care attention. Both groups see limited resources in these areas for agricultural communities in both countries.

The exchange visits have provided the Migrant Health Centers with an opportunity to develop relationships with the Mexican consulates serving their area. Mexican consulates through the Ministry of Foreign Affairs' Asuntos Comunitarios program are playing an active role in outreach to the Mexican communities who live and work in the United States. The opportunities for working together in illness prevention and health promotion activities are considerable. The Consulates in Denver and New York City are already developing plans for health

conferences and health outreach activities with the participating Migrant Health Centers in their areas as a result of these initial contacts through the exchange program.

Quality of care may be improved for migrants as a result of better understanding

The exchange visits challenged clinical participants to reconsider how they serve migrants at Migrant Health Centers and what migrants are told in Mexico with regards to seeking health care in the United States. In large part, participants believe that what they have learned will improve the quality of care and patient compliance.

One U.S. participant observes that "we need to boost our emphasis on breastfeeding [and] our health promotion and prevention programs almost don't exist" compared to the efforts in Mexico. Another makes a similar observation, "we need more emphasis on prevention and health education."

Farmworkers, particularly those living in rural Mexican communities, are used to having a local medical clinic in each of their communities. They generally get "free" medical consultations as well as "free" medications. They are asked to give a donation for the services they receive. Recent graduates of the medical and nursing schools doing their mandatory national service generally staff the clinics. Yet, even these rudimentary clinics emphasize health promotion practices and illness prevention activities, including childhood immunizations administered by local health outreach workers.

The participants' assumptions about their patients needs and level of understanding were challenged by the exchanges. These assumptions play an important role in the way provider's approach care for patients. A participant observes that I gained a sense of "who my patients are, and how they think. Also [I learned] what's important to them." This change in perspective "forces me to thoughtfully [re]consider how ...health center staff can best work with our migrant clients."

The New York team learned that Mexican hospitals have outpatient services for episodic illnesses, and that community is encouraged to go to the hospital for primary care services, particularly in areas where there are no clinics. When in the U.S., Mexican nationals follow this trained behavior of going to the hospital for primary care needs, which is perceived as inappropriate health seeking behavior in the U.S.

One health center has begun to examine how to expand on the training and use of health promoters given their observation of the extensive and successful use of community-based health auxiliaries in Mexico. One clinic says, "We now have a better idea of how to locate immunization records if a child comes from Mexico, preventing unnecessary duplicative shots. We are also more aware of the person who can be called upon for any medical question regarding our patients and theirs."

Another participant says, "As a dentist, I was able to see what materials are currently being used to restore teeth. I was able to observe what preventive steps are being taken to arrest tooth decay. Understanding the diet of the average farmworker family will help me provide better caries-preventive health education."

The sentiment of the exchange participants perhaps is best expressed in the following words, "I have gained a deeper understanding of the cultural history and milieu of Mexico. This allows me to interact with and serve the Mexican farmworker in a more humane and respectful manner."

Opportunities for Collaboration:

The professional exchanges have pointed out numerous areas in which immediate governmental actions could be taken to improve care for migrant farmworkers. For example, HRSA and CDC could clarify standards for TB screening particularly among migrants from Mexico and other parts of Latin America.

HRSA collects much patient-related data from federally qualified health centers but does not identify migrant or seasonal farmworker specific data. These data if appropriately coded and analyzed could be useful in resource and care planning.

The BHPE program has impacted both the U.S. participating health centers and Mexican State Secretarías de Salud, and most importantly has led to the identification of areas of collaboration between matched states. The program has opened communication between the matched sites, and has and continues to produce collaborative outcomes. Below please find a summary of the impact and collaboration that has resulted from the BNPE program.

Colorado – Guanajuato:

Plan de Salud del Valle, Inc., the Colorado center, has signed an agreement which identifies three areas they plan to develop collaborations in with their Guanajuato counterparts. First, they hope to establish a better line of communication to improve continuity of care. They are working out a FAX communication system so that health clinics and Salud clinics can exchange patient information as necessary. In addition, Plan de Salud del Valle will be hiring an outreach worker from Guanajuato for 16 weeks to assist in reviewing outreach activities and health promotion materials. Second, they are developing a student/resident exchange between the University of Guanajuato and the University of Colorado with students rotating for this elective from the two Universities. Third, they are developing collaborative investigations studies focused on migrant farmworker illnesses and accidents that require collection of data on both sides of the border.

The research effort will begin with a study of traffic accidents due to long work hours and late night driving. The project has been funded for a three-year study. Lastly, the center has engaged in ongoing discussions and planning with the Mexican consulate in Denver to do more extensive health education and illness prevention activities in Colorado. The center is developing letters of agreement with Guanajuato and other participating institutions.

New York – Puebla:

As a result of the exchange program Peekskill Area Health Center (PAHC) and the Secretaría de Salud de Puebla have made a significant connection that has created a bridge between New York and Puebla. PAHC and the Secretaría have ensured to keep the Mexican Consulate in New York informed and involved in their joint efforts. PAHC is developing health education opportunities through the Mexican Consulate's GOAL (sporting events) program.

PAHC and Puebla are exchanging information on health risks in both countries, and have begun providing binational case management to HIV patients. PAHC and Puebla are currently collaborating on two binational case management HIV cases. As a result of this exchange program Health Jurisdictions 7, 8 and 9 in Puebla have developed a health education video on HIV.

Another outcome of the exchange experience has been the one-year internship of a health educator from Puebla at PAHC. This intern is working with the PAHC to develop patient education materials for their migrant patients, and to assist in PAHC in putting together health profiles that can be shared with Puebla.

TB related issues is another collaboration area identified by this match. Some of these issues include: the use of the Mexican health card for TB treatment continuation in the U.S., as it is the same as the 10 steps card used in the U.S. They are also looking at the BCG–PPD incompatibility issue in an effort to seek a solution to TB screening issues.

Other areas that PAHC and Puebla are planning to collaborate on are the areas of: chronic degenerative illnesses; immunizations; nutrition and its link to hypertension and diabetes; expanding the role of nursing; replication of the Casa de Salud and Comités de Salud models in New York to improve effectiveness of outreach services and increase accessibility to care; and the development of a behavioral health component in New York. PAHC participants were humbled by Puebla's data system analysis and, as a result of their visit to Puebla, will make changes in order to produce more complete data and analysis that can be shared with their Puebla counterparts.

Washington – Michoacán:

Columbia Valley Community Health Services, the Washington center, is using the professional exchange program to educate community leaders, growers, and public health officials about the Mexican health care system and migrant and seasonal farmworkers to develop more culturally sensitive community programs, and improve accessibility of health care and social services. In particular, they are working on ways to incorporate the local health districts into their exchange related activities, in order to include culturally sensitive health education materials and efforts into these districts.

Michoacán officials learned that they have significant numbers of people in the State of Washington contrary to their earlier notions. Michoacán participants, that visited Wenatchee in September 1998, developed a document regarding their experience in Wenatchee. As a result the state has initiated new outreach efforts to serve their compatriots in collaboration with the Wenatchee center. Washington and Michoacán are developing a joint work plan which will consist of four main components: the exchange of documented information

regarding the health of migrants and their families living in Michoacán, which will be obtained through statistical epidemiological information sources. This objective will also include the development of computer programs for listing of migrants with obligatory and immediate surveillance illnesses such as DM, TB, Leprosy, etc.; the dissemination of preventive and assistance related activities in both Washington and Michoacán; the strengthening of health services and development of health education materials regarding mental health, chronic degenerative and infectious diseases such as DM, HTA and Neoplasm, and the elaboration of a health card for the migrant population and their families; and training, to include the continuation of the exchange of professionals and the involvement of Washington and Michoacán universities in the program.

Michigan – Jalisco:

InterCare Community Health Network, the Michigan center, and the Sate of Jalisco found that the teams shared a lot of common concerns with regard to continuity of care, prescription formulary, TB follow-up, mental health, domestic violence, and prevalence of child abuse. InterCare and the State of Jalisco are focusing their joint efforts in developing patient education materials that will be incorporated into the center's outreach program, and on the exchange of patient records and data to improve continuity and consistency of care. InterCare will include Western Michigan University in the 1999 exchange, through the joint efforts in their Rural Health Interdisciplinary Training Grant. Through this grant, nursing, social work, speech pathology, occupational therapy, physician assistant, and dietician students will be completing a rotation at InterCare, and as a part of this rotation students will be involved in the professional exchange program.

InterCare and Jalisco are also planning to collaborate on the development of permanent health prevention campaigns that would be coordinated in both countries; the development of specific preventive programs for HIV/AIDS, STDs, addictions, mental health, etc.; the development of audiovisual and printed education materials directed towards the migrant population; and the training and formation of volunteer health promoters to include farm and packing supervisors.

Texas – Coahuila:

As a border match, United Medical Centers, the Eagle Pass center, and their counterparts are most concerned about the prevention and treatment of communicable and infectious diseases. They are

developing regular lines of communication with health officials in the neighboring border communities. They are also exploring the opportunities for shared outreach and education efforts along their border. As a result of this exchange program, and the shared initiatives, two members of the Coahuila team received a high ranking community award for their services to the community.

Conclusions:

The pilot exchange and future exchanges hold great promise for improving the care of migrant farmworkers in the United States. The exchanges point to opportunities to strengthening the health promotion and illness prevention activities of migrant and community health centers. More importantly they illustrate the potential for improving health professionals understanding of the structural barriers to care in the U.S. and Mexico, as well as their patient's needs and expectations with regard to health, illness and treatment.

The federal governments of Mexico and the United States can play several roles supporting the improvement of primary care to farmworkers. For example, there exists a great need by clinicians for clarification of treatment and immunization protocols for communicable diseases. Similarly clarifying prescription drug formulary issues remains a major concern of the participating clinicians. The U.S. and Mexican governments could also establish protocols for cases addressing issues of when Mexican migrants suffer trauma resulting in long term incapacitation including dismemberment, paralysis, coma or death while in the U.S.

There appears to be a consensus among providers for increasing investment in HIV/AIDS, mental health and alcohol and substance abuse programs for farmworkers. Subsidizing development and implementation of improved health promotion and illness prevention activities and materials appears to be another wise investment opportunity.

Because the Mexican health care system is largely a government operated system, the U.S. federal government should continue various efforts aimed at creating better lines of communication between state and local health officials in both countries, as well as with non-governmental organizations such as migrant and community health centers.

Recommendations:

Based on the experiences of the professional exchange coordinating agents, and that of the five participating U.S. health centers during the pilot phases, two distinct sets of recommendations are suggested. The first set of recommendations is general and program related. The second set of recommendations reflects the professional exchange as one of the Core Group priorities, these suggestions are for the U.S. Migrant Health Core Group. Below please find a summary of these recommendations:

General Recommendations for the Migrant Health Binational Health Professional Exchange

1. Maintain a centralized U.S. coordinating agent in order to sustain the following activities:

   a. Liaison with planning partners;
   b. Organize and host U.S Orientation Sessions
   c. Grant writing and fund raising;
   d. Coordination among U.S. participants;
   e. Coordination with Mexican coordinating agent;
   f. Program documentation and evaluation;
   g. Abstracts preparation and submission to sponsor workshops for promotion of project awareness and sharing of learning experiences.

2. Establish two year formal agreements between the coordinating agent and participating Migrant/Community Health Centers (MCHC) Teams with specification of each participating center's commitment to invest and target outcomes. Each center to be responsible for the development of an individualized work plan for the program period for which they participate. The work plan should include measurable outcomes and commitments such as: breakdown of UDS data, migration patterns, documentation of health profiles, sharing of formal and informal collaboration agreements with the Migrant Health Core Group, sharing of patient education materials developed as a result of the Binational Health Professional Exchange Program, etc.

3. Each Professional Exchange Phase should consist of a two-year partnership (previously projected at three years), informing MCHC's that this is a two year "nurturing" period in which they responsible for building an infrastructure. MCHC's and Mexican states (Binational Teams) will develop a work plan and begin its implementation by the

end of Year 1. Participating Binational Teams will be expected to sustain their partnerships on an ongoing basis through the implementation of the work plan developed and implemented in the two year "nurturing" period.

4. BHPE Planning Committee should divide the two year "nurturing" period as follows:

   a. *Year 1:* January Orientation for U.S. Participants in México, followed by a five to seven day exchange experience. September Orientation for Mexican Participants in the U.S., followed by a five to seven day exchange experience. By the last quarter of Year 1, Binational Teams should present a formal work plan for Year 2 and beyond.

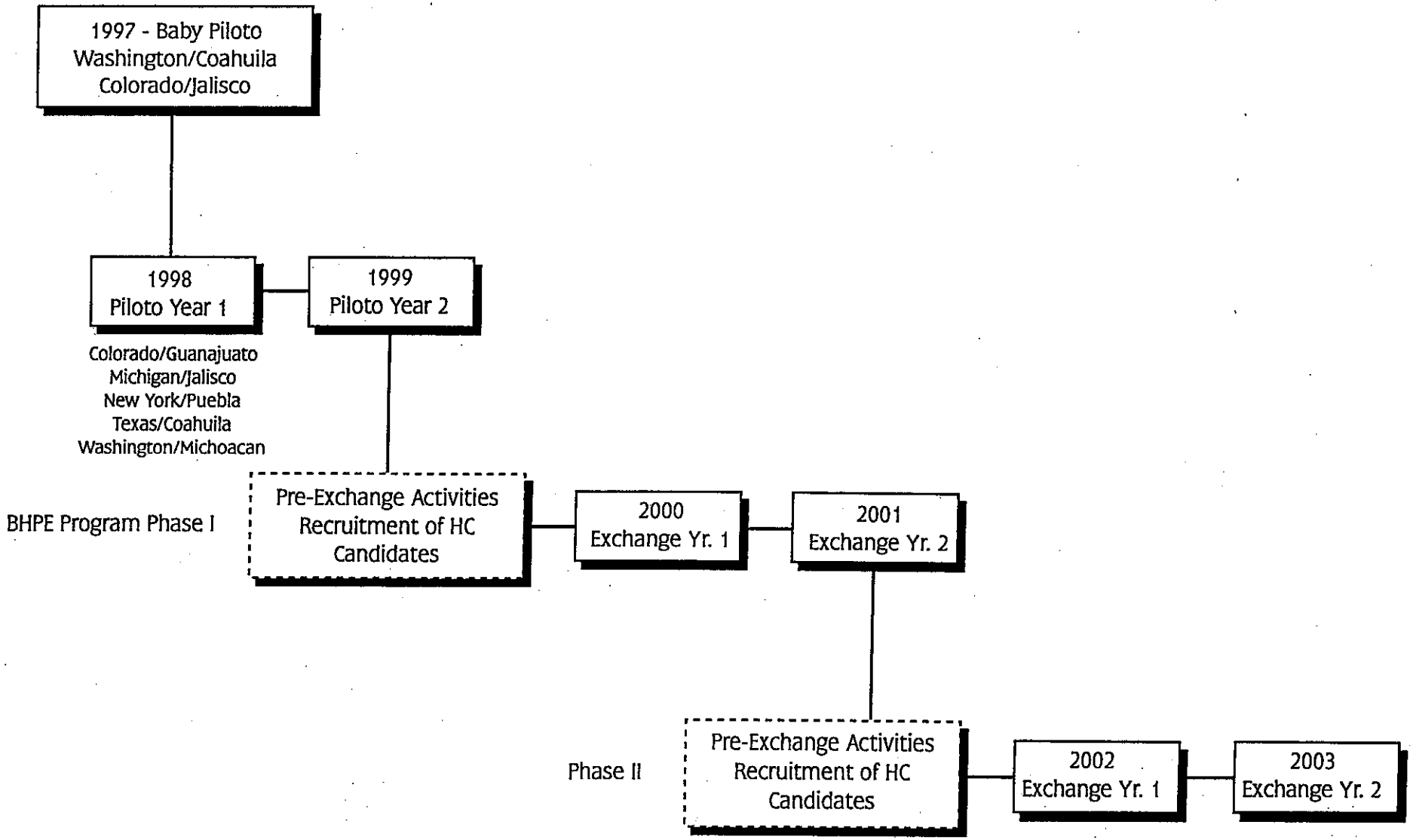
   b. *Year 2:* Repetition of *Year 1* activities to solidify commitments between the MCHC's and Mexican states, as well as strengthen infrastructures developed in Year 1. Ensure that all parties understand how the U.S. and Mexican health care systems operate in order to ensure realistic outcomes from each match.

      During *Year 2* the BHPE Planning Committee will identify and prepare the U.S. and Mexican State teams to participate in the next cycle of exchanges.

   c. At the conclusion of the two-year period the exchange cycle is complete. U.S. MCHC teams are on their own to continue the work they started during the "nurturing" period. At the conclusion of *Year 2* the next group of U.S. MCHC teams and Mexican States will begin their *Year 1* experiences.

Please see ***Binational Health Professional Exchange Proposed Implementation Schedule*** on the following page, for a graphic representation of the above described model.

Binational Health Professional Exchange
Proposed Implementation Schedule



BHPE - Binational Health Professional Exchange HC - Health Center

Recommendations to the Migrant Health Core Group:

1. In keeping with the bilateral desire to sustain and expand this program, it is recommended that both Secretaries recognize the Binational Health Professional Exchange as primary and permanent, and seek the political and financial support for its viability, given the impact that it already has had on the improvement of migrant health services.

2. Given the fact that this activities supported by this demonstration project in the US have been funded almost exclusively with monies from the HRSA Migrant Health Program, future replication and expansion in the US should be fully supported by other appropriate agencies within HHS.

3. Recognize that the Binational Commission's U.S. – Mexico Migrant Health Core Groups have implemented the Binational Health Professional Exchange according to the U.S. definition of *migrant* as a *farmworker*.

4. Recognize that the Mexican definition of *migrant* as a *Mexican emigrant* is much broader in scope and embraces a greater population of medically under served residing in the U.S., *performing a wide variety of labors*.

5. Recognize that the Migrant Health Core Group's Binational Health Professional Exchange, which focused on migrant and seasonal farmworkers, is a model which can be successfully applied to the growing Mexican immigrant labor force in the U.S. through Community Health Centers.

6. Seek broader financial and political support for the Migrant Health Core Group in order to begin addressing this large issue.

7. Recognize the Binational Health Professional Exchange as one component of the Core Group priorities, and its capability of yielding program specific results only.

8. Develop other priorities, or components to Core Group priorities, to address the process and technical expectations of the Binational Commission.

9. Strengthen linkages with all Core Groups to create mechanisms for information sharing and dissemination regarding Migrant Health

Core Group activities to include the professional exchange experience.

10. Establish a minimum of one face to face meeting per year to review the general progress of the Core Group, conduct future planning, etc.

II. DESCRIPTION OF EXCHANGE PARTICIPANTS

Eighty-three (83) health care professionals, from five U.S. migrant community health centers (MCHC's), and five Mexican States including government officials and orientation presenters from private and public agencies participated in the U.S./Mexico Binational Health Professional Exchange program. Numerous other health care workers from both countries were involved in a variety of educational and supportive roles.

U.S./Mexico Binational Commission co-chairs Antonio Durán and Dra. Lourdes Quintanilla provided leadership for the exchange activities, as did the chief evaluator for the project, Dr. Robert Burciaga Valdéz of UCLA. The National Center for Farmworker Health coordinated U.S. participation, while the Mexican Communities Abroad Program of the Secretariat of Foreign Relations and Dra. Quintanilla managed the Mexican involvement.

Fifty-seven percent (57%) of the participants who traveled and hosted teams were from the Mexican States and 43% were from the U.S. Forty-one (41) of fifty-six (56) health professionals traveled to their matched state while the other 14 played a critical role in "hosting" the team in either the U.S. or Mexico. (See Chart I below.)

Chart I

All U.S./Mexico Participants by Profession (Discipline)

Profession/Title	**All U.S. Participants**	U.S. Hosted Only	U.S. Traveled	**All Mex. Participants**	Mex. Hosted Only	Mex. Traveled	**All Participants**
Administrators	**6**	3	3	**1**	0	1	**7**
CHW/Health Ed.	**2**	0	2	**3**	0	2	**5**
Coordinator	**2**	1	1	**2**	1	1	**4**
Dentist	**2**	0	2	**1**	0	1	**3**
Government	**0**	0	0	**4**	2	2	**4**
Nurse	**3**	0	3	**3**	0	3	**6**
PA/NP	**3**	0	3	**0**	0	0	**3**
Physician	**2**	0	2	**8**	4	4	**10**
Physician/Admin.	**2**	0	2	**6**	2	4	**8**
Physician/Epid.	**0**	0	0	**3**	1	2	**3**
Psychologist	**0**	0	0	**1**	0	1	**1**
University	**1**	0	1	**0**	0	0	**1**
Journalist	**1**	0	1	**0**	0	0	**1**
Total	**24**	4	20	**32**	10	21	**56**
	43%			**57%**			**100%**

Multi-Disciplinary Teams:

In order to augment the primary goals of the Exchange ... "increasing the understanding of how health care is delivered to MSFW's in both countries and to improve the cultural environment of the patients seen in the MCHC's"... multi-disciplinary teams were selected so that a diverse perspective, interpretation and learning could be achieved. Of all participants, 11 (20%) were administrators / coordinators and an additional 8 (14%) were physician / administrators, six of whom were Mexican State Jurisdiction chiefs and two U.S. CHC Medical Directors. Five (5) of the participants were community health workers with outreach and health education experience. Four (4) of the participants represented the Mexican States Secretary of Health offices. A University of Colorado faculty member and a photojournalist were among the U.S. travelers. Twenty-six (46%) of the participants were clinicians represented by ten physicians, three physician / epidemiologists, two physician assistants, one nurse practitioner, three dentists including one CHC dental director, six nurses and a psychologist. (Chart II.)

Chart II

Team Members by Discipline				
Profession	**U.S. Part.**	**Mex Part.**	**All Participants (%)**	
Administrator/Coord.	8	3	**11**	**(20%)**
Physician/Admin.	2	6	**8**	**(14%)**
CHW/Health Ed.	2	3	**5**	**(9%)**
Clinical	10	16	**26**	**(46%)**
Government		4	**4**	**(7%)**
Journalist	1		**1**	**(2%)**
University	1		**1**	**(2%)**
Total	24	32	**56**	**(100%)**

Clinical Participation:

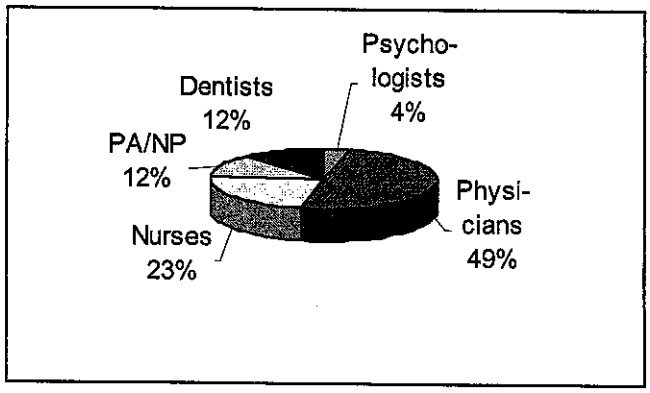
The clinical expertise among the participants was well rounded and diverse. Physicians dominated the teams with 49% of the clinicians being physician trained and 23% being nurses. (See Chart III & IIIA)

Chart III

Participants by Clinical Training

Clinical Expertise	US	Mex.	Total	%
Dentist	2	1	3	12%
Nurse	3	3	6	23%
PA/NP	3	0	3	12%
Physician	2	8	10	49%
Physician/Epid.	0	3	3	
Psychologist	0	1	1	4%
Total	10	16	26	100%

Chart IIIA
Orientation Presenters



Twenty-seven (27) leading individuals presented at the orientations in Guadalajara and Dallas, 18 from Mexico and nine from the U.S. (In addition to these nine, there were four CEO's and one medical director involved in the orientation.) Fifty-four percent (54%) of the presenters were representing the federal government, 26% state and local government, 12% from private NGO's and 8% were university faculty. The Secretary of Health's Office participants included five Secretaries of Health from each participating Mexican State and the U.S. had the Texas Commissioner of Health participating in the Dallas orientation. (See Chart IV and V.)

Chat IV

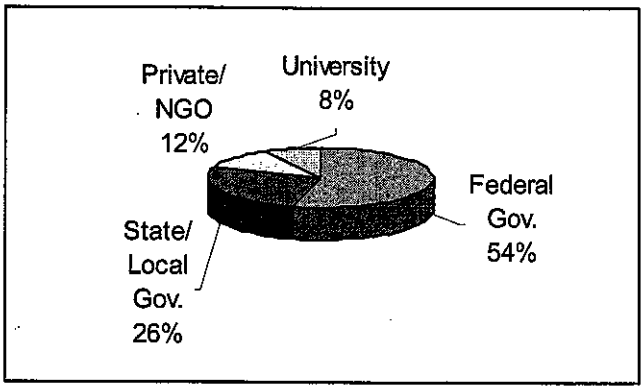


Chart V

Presenters by Country, Affiliation & Orientation			
	Orientation Presenters	**Affiliation**	**Orientation Event**
1	Mary Lou Anderson BPHC Deputy Dir.	Fed. Gov./US	D
2	Dr. William Archer Texas Health Commissioner	State/Local /US	D
3	Guadalupe Bello Mexico social Security Inst.	Fed. Gov. /Mx	G
4	Gov. Alberto Cardenas Jimenez/State of Jalisco	State/Local /Mx	G
5	Dr. Antonio Duran US Chair Migrant Health Core Group	Fed. Gov./US	G & D
6	Ambassador Leonardo Ffrench / Fed. Gen. Director/ Oficina de la Secretaría de Relaciones Exteriores	Fed. Gov./Mx	D
7	Dr. Hector J. Gallardo Rincón Gen. Dir. of Public Health/Jalisco	State/Local /Mx	G
8	Carlos Gonzalez Gutierrez Dir. Community Affairs, Mexicans Abroad/Fed.	Fed. Gov./Mx	G & D
9	Fernando Guerra, MPH Dir. of Health, San Antonio Metropolitan Health District.	State/Local /US	D
10	David Hayes-Bautista, Ph.D. Professor of Medicine, UCLA	University /US	D
11	Dra. Midori Kato Subdirector TB/Epidemiology / SSA Federal	SSA /Mx	G
12	Dr. Alejandro Morales del Olmo Reproductive Health/SSA Federal	SSA /Mx	G
13	Dr. Eduardo Morales Andrade Disease Prevention & Control/SSA Federal	SSA /Mx	G
14	Dra. Melba Muñiz M. Dir. Financial Support/ SSA Federal	Fed. Gov./Mx	G
15	Dr. Arturo Muzquiz Pena Dir. of Planning, Jalisco	State/Local /Mx	G

Presenters by Country, Affiliation & Orientation			
	Orientation Presenters	**Affiliation**	**Orientation Event**
16	Dr. Miguel Angel Nakamura Lopez Dir. Coordination and Programming/Federal	Fed. Gov./Mx	G
17	Dr. Federico Ortíz Quesada Secretary of Health, Fed. Mexico	Fed. Gov./Mx	G
18	Dra. Lourdes Quintanilla Program Coord. US Binational Exchange	State/Local/Mx	G & D
19	Refugio "Wil" Rochin, Ph.D. Dir. Latino Initiatives Office/ Smithsonian Inst.	Private /US	D
20	Cuahtemoc Ruíz Matus Tech. Coord. Office of the Undersecretary for Prevention & Control	Fed. Gov./Mx	D
21	Dr. Cristóbal Ruíz Gaytan Lopez Secretary of Health, Jalisco	State/Local /Mx	G
22	Roberta Ryder CEO, National Center for Farmworker Health	Private /US	G & D
23	Dra. Nelly Salgado Snyder Mexican Psychiatric Institute	Private /Mx	G
24	Dr. Gustavo Sanchez Tejedo Subdirector Transmittable Diseases	SSA /Mx	G
25	Mary Lou Valdez Off. Of International & Refugee Health	Fed. Gov./US	D
26	Dr. Robert Valdez Public Health School UCLA	University /US	G & D
27	Dr. Eduardo Vasquez Valdez Former Secretary of Health/Puebla	State/Local /Mx	G & D
	Presenting but Not Included in Count		
	Tillman Farley, MD Plan de Salud del Valle, Colorado	US	D
	Ben Flores, MPH Columbia Valley Community Health Services, Washington	US	D
	Velma Hendershott CEO, InterCare Community Health Network	US	D
	George Kypuros CEO, United Medical Centers, Inc., Texas	US	D
	Anne K. Nolon, MPH CEO / Peekskill Area Health Center	US	D
*G = Guadalajara D = Dallas			

Chart VI is a listing of all U.S./Mexican participants.

Chart VI

All U.S./Mex. Participants by Name & Profession					
	Traveled to:	**Name**	**Profession**	**HOME STATE**	**Event**
1	Host	Hilda Chacón	Administrator	Colorado	Sep-97
2	Host	Velma Hendershott	Administrator	Michigan	Sep-98
3	Mexico	Anne Nolon	Administrator	New York	Jan-98
4	Mexico	George Kypuros	Administrator	Texas	Jan-98
5	Mexico	James O'Barr	Administrator	New York	Jan-98
6	Host	Benjamin Flores	Administrator	Washington	Sep-98
7	U.S.	Samuel Rodriguez Villalpando	Administrator	Guanajuato	Sep-98
8	Mexico	Hector Jasso	CHW/Health Ed.	New York	Jan-98
9	Mexico	Vi Rios	CHW/Health Ed.	Colorado	Jan-98
10	U.S.	Javier de Lara Serrato	CHW/Health Ed.	Coahuila	Sep-98
11	U.S.	Teresa de Jesus Vazquez	CHW/Health Ed.	Coahuila	Sep-98
12	U.S.	Hugo Dominguez	CHW/Health Ed.	Puebla	Sep-98
13	Host	Gelasio Ruíz	Coordinator	Michoacán	Jan-98
14	Host	Jose Castro	Coordinator	Texas	Sep-98
15	U.S.	Anabel Floria Bernardo	Coordinator	Guanajuato	Sep-98
16	U.S.	Elizabeth Arendale	Coordinator	Texas	Sep-98
17	Mexico	Cecilia Fors	Dentist	Colorado	Jan-98
18	Mexico	Clifford Hames	Dentist	New York	Jan-98
19	U.S.	Ricardo Hugo Aguilar	Dentist	Coahuila	Sep-97
20	Host	Carlos Tena Tamayo	Government	Guanajuato	Jan-98
21	Host	Eduardo Vasques Valdes	Government	Puebla	
22	U.S.	Alejandro Molina Garcia	Government	Michoacán	Sep-98
23	U.S.	Gabriel Alejo Batalla	Government	Michoacán	Sep-98
24	Mexico	Dora Frausto	Nurse	Texas	Jan-98
25	Mexico	Maria Benancia Solis	Nurse	New York	Jan-98
26	Mexico	Rebecca Shimelfenig	Nurse	Washington	Jan-98
27	U.S.	Marisela Ochoa Sebastian	Nurse	Puebla	Sep-98
28	U.S.	Sandra Luz Rodriguez	Nurse	Coahuila	Sep-97
29	U.S.	Virginia Almanza	Nurse	Guanajuato	Sep-98
30	Mexico	Susan Wade Murphy	PA/NP	Michigan	Jan-98
31	Mexico	Carolyn Johnson	PA/NP	Washington	Jan-98
32	Mexico	Ed Hendrickson	PA/NP	Colorado	Jan-98
33	Host	Dora Marlene Nava Huerta	Physician	Coahuila	Jan-98
34	Host	Eduardo Samuel Garballo Triana	Physician	Jalisco	Jan-98
35	Host	Luis Cervantes Garcia	Physician	Michoacán	Jan-98
36	Host	Salvador Garcia Uvence	Physician	Jalisco	Jan-98
37	Mexico	David Collins	Physician	Michigan	Jan-98
38	Mexico	Eric Dant	Physician	Washington	Jan-98
39	U.S.	Luis Alfonso Navarro	Physician	Jalisco	Sep-98
40	U.S.	Mario Marquez	Physician	Jalisco	Sep-97
41	U.S.	Patricia Isabel Campos	Physician	Jalisco	Sep-97
42	U.S.	Salvador Villasenor	Physician	Jalisco	Sep-98
43	Host	Cristina Rodriguez Morales	Physician/Administrator	Puebla	Jan-98

All U.S./Mex. Participants by Name & Profession					
44	Host	Jose Eduardo Quintero	Physician/Administrator	Puebla	Jan-98
45	Mexico	Beverly Gutierrez	Physician/Administrator	Texas	Jan-98
46	Mexico	Tillman Farley	Physician/Administrator	Colorado	Jan-98
47	U.S.	Jorge Luis Chávez	Physician/Administrator	Coahuila	Sep-98
48	U.S.	Luis Barajas	Physician/Administrator	Guanajuato	Sep-98
49	U.S.	Rey David Guerrero	Physician/Administrator	Puebla	Sep-98
50	U.S.	Rodolfo Martinez	Physician/Administrator	Coahuila	Sep-97
51	Host	Armando Perez	Physician/Epidemiologist	Michoacán	Jan-98
52	U.S.	Norma Perez Contreras	Physician/Epidemiologist	Puebla	Sep-98
53	U.S.	Narciso Lucero Huerta	Physician/Epidemiologist	Puebla	Sep-98
54	U.S.	Ma. Cristina Santascoy	Psychologist	Jalisco	Sep-97
55	Mexico	Julie Paranka	University	Colorado	Jan-98

III. DESCRIPTION OF EXCHANGE ACTIVITIES

The *"Baby Piloto"*, conducted in September of 1997, was comprised of six Mexican health professionals and two U.S. migrant/community health centers. The matches were between three health professionals from the Mexican State of Jalisco and the staff at Columbia Valley Community Health Services in Wenatchee, WA, and three health professionals from the Mexican State of Coahuila and the staff at Plan de Salud del Valle in Ft. Lupton, CO.

The success of these two exchanges resulted in the expansion of the BHPE from two sites to five, and the request that selected U.S. health centers identify the origin of their migrant population in order to be properly matched with a Mexican State. In order to maximize and enhance the community to community exchange experiences, the BHPE Planning Committee agreed that providing an Orientation on the Mexican health care system would be beneficial for U.S. BHPE participants participating in the January 1998 Exchange. The Migrant Health Core Group was in agreement. The Orientation provided an opportunity to build cohesiveness between the assigned U.S. and Mexican teams prior to the on-site exchange experiences. The two-day orientation took place in Guadalajara, México. The January orientation in Guadalajara was funded by the University of California at Los Angeles (UCLA), and The Pan American Health Organization (PAHO). Below please find participant comments regarding the January orientation:

- "Extremely beneficial! The value of convening such an Orientation as this pilot is launched, I think will definitely make it ever more so successful."

- "Excellent, and repeat it and let the exchange continue."

- "I believe that the proposed objectives were met. The participants obtained a general view of the Mexican health system.

Based on participant feedback and U.S. and Mexican Migrant Health Core Group Co-Chair guidance, in June of 1998 the BHPE Planning Committee made the decision to host an Orientation for the Mexican teams coming to the U.S. in September. The September Orientation focused on the U.S. health care system, and was hosted by NCFH in Dallas, Texas. The BHPE Planning Committee extended invitations to BNPE participants, Migrant Health Core Group Members and to Chairs of the other Core Groups. The Smoking Cessation Core Group sent Ms. Stephanie Maya as their representative, the other Core Groups were unable to attend. The Agenda was well received by all orientation participants. Comments recorded on evaluation forms at the Dallas Orientation include:

- "It is very valuable to have a general vision of the [BHPE exchange] experience, of the health care system, and to see the movement in migratory patterns."

- "A) [I learned] that health care in the U.S. is a privilege and not a constitutional right. B) [I learned about] the difference in patient care in Mexico and U.S. C) [I learned the most from] the presentations made by Professor Hayes-Bautista and Professor Refugio Rochin."

- "It [the Orientation] helped us to better understand the U.S. health care system, that by its diversity makes it more complex for us [to understand] because we are still so centralized."

Itineraries:

BHPE experience itineraries were formulated based on the goals of the BHPE Program. Actual exchanges between matched communities were five to seven days in length. Communities were matched based on U.S. migrant/community health center identification of the state of origin of their migrant patients. Matches were as follows:

- Colorado (Plan de Salud del Valle, Inc.) – Guanajuato
- Michigan (InterCare Community Health Network) – Jalisco
- New York (Peekskill Area Health Centers)– Puebla
- Texas (United Medical Centers)– Coahuila
- Washington (Columbia Valley Community Health Services)– Michoacán

Both the January and September experiences included not only rotation of health facilities in the U.S. and Mexican communities visited by participants, but also included but were not limited to:

- Visits to organizations and agencies such as schools, state and/or county health departments, local government officials, etc., and meetings with organization/agency leaders and governmental officials.

- Visits to labor camps and farmworker housing facilities.

- Opportunities to meet and speak with farmworkers.

- Meetings between participants to provide clarification regarding health care structures, access to care.

- Sharing of information regarding epidemiological issues and concerns.
- Meetings between participants to share information and discuss each other's programs to identify areas of collaboration.
- Exposure to community culture.