BINATIONAL EXCHANGE PROGRAMS FOR HEALTH PERSONNEL. STRATEGIES TO INCREASE CULTURAL AND LINGUISTIC COMPETENCY[1]

Rosario Alberro, MA
Xóchitl Castañeda, MA
Karyn Ott Smith, MA
Micheal Drake, MD
Roberto Tapia, MD
Javier Cabral Soto, MD

ABSTRACT

The tremendous growth in the number of people of Mexican origin living and working in California and recent research analyzing health care disparities have amplified the call for culturally and linguistically competent health care. This article examines the strengths and challenges of cultural immersion programs as a strategy for improving the cultural sensitivity of health care personnel and, thereby, the quality of health care received by the Mexican origin population in the U.S., especially in California. It describes the three cross-cultural immersion programs currently coordinated by the California-Mexico Health Initiative (CMHI) for current U.S. health care professionals; U.C. medical and nursing students, nurses; and U.S. and Mexican community health outreach workers. The structure of the article replicates the rich and complicated nature of cross-cultural exchanges, demonstrating the necessity of building upon "the knowledge of living experience" and the principles of how adults learn.

INTRODUCTION

*"It is because we are this being—a being of ongoing, curious search, which 'steps back' from life itself and **from the life it leads**—it is because we are this being, given to adventure and the 'passion to know,' for which that freedom becomes indispensable that, constituted in the very struggle for itself, is possible because, though we are 'programmed,' we are nevertheless not determined. It is because 'this is the way we are' that we live the life of a vocation, a calling, to **humanization**…"* Paulo Freire,[1] Brazilian author and political educator

The sheer number of immigrants and migrants from Mexico living and working in California is growing so rapidly that their needs for quality health care are also growing in volume and importance. These immigrants and migrants are no longer simply *Mexicanos*. Their experiences of leaving Mexico and coming to the U.S. have changed them, creating a new context within which to interpret their physical and mental health needs. The public and private health care systems can no longer ignore them. Providing effective preventive care and early intervention today will save millions in terms of the cost of acute and catastrophic care of this population in the future. But how can health care professionals understand the context of the lives and health of their Mexican-origin patients in order to accurately translate their symptoms and communicate effective treatments?

[1] Working document. Not for citing or for formal publication.

The number, as well as the proportion of the population of Californians, who speak Spanish, is substantial and will continue to increase significantly in the future due to both immigration and birth rates among Latinos in the United States. The total number of Latinos in the United States is 39 million, of which more than 67% are of Mexican-origin.[2] This Mexican-origin group represents 24% of California's population, which means that of California's 35 million residents, 9.7 million are of Mexican descent and, of them, 3.8 million were born in Mexico.[3] According to a new analysis of birth certificates by UCLA scholars, by fall 2006, the majority of children entering the state's kindergartens will be Latino, and in fall 2014, the majority of children entering high schools will be Latino. The majority of new workers entering the state's labor force in fall 2017 will be Latino, and the majority of young adults eligible to vote in fall 2019 will be Latino.[4]

"The immigration phenomenon is something that neither the U.S. nor the Mexican government can ignore. We must recognize it and work on new solutions." Dr. Juan Genaro Flores, Director of Epidemiology, Guanjuato

The lack of Latino providers creates barriers to health care for the Mexican-origin population, many of whom speak no or only limited English. Only about 1 in 20 licensed doctors in California is Latino. Thus, there are 335 White patients for every White physician, and 2,893 Latino patients for every Latino physician.[5] In addition, the shortage of clinics or hospitals in rural areas where agricultural workers live and work also limits the access of those who possess neither the time nor money to travel in order to receive health care. While it is very necessary to recruit and educate more Latino physicians, it is also imperative to train non-Latino health care providers to be more culturally aware and effective with Latino patients.

This article examines the strengths and challenges of cultural immersion programs as a strategy for improving the cultural sensitivity of health care personnel and, thereby, the quality of health care received by the Mexican origin population in the U.S., especially in California. It begins by reviewing the theoretical foundation of how one's personal history, gender, political, class, race, and personal experiences influence one's "voice" and one's ability to understand an "other." It then uses the concept of "intersectionality" as a tool for analyzing the overlapping systems of subordination facing migrants of Mexican origin in the U.S. It provides a brief overview of the strategies of the California-Mexico Health Initiative (CMHI) to address the health needs of this population by describing the three cross-cultural immersion programs currently coordinated by CMHI:

1. *Jornadas Informativas de Salud Sobre México* (Informative Health Journeys about Mexico) — a week-long cultural immersion for U.S. health care professionals in Mexico
2. Medical Exchanges — a month or longer linguistic and cultural immersion for U.S. and Mexican medical students, nurses and physicians

3. *Promotoras/es*[2] Exchanges — a week long cultural immersion for U.S. and Mexican community health outreach workers

This article seeks to alternately layer the voices of migrants[3] of Mexican origin, policy makers, and program participants with the descriptions of the exchanges and an analysis and discussion of their quantitative and qualitative results and weaknesses. The structure replicates the rich and complicated nature of cross-cultural exchanges, demonstrating the necessity of building upon "the knowledge of living experience" and the principles of andragogy.[4] However, the difficulty in measuring the effectiveness of cultural immersion programs lies in the complex nature of people's motivation and behavior and the need for long-term tracking.

THEORETICAL BACKGROUND

Spanish philosopher José Ortega y Gasset described one's life as an intense dialogue between oneself and one's environment: *"yo soy yo y mi circunstancia"* - I am I and my circumstances.[6] Considerable research has focused on the power relations set up by the social scientist or institution when designing and conducting research.[7] Like social scientists, health care providers, too, are in the powerful position of gathering information, interpreting symptoms, and defining the health of their patients. Asking questions about health-related topics (especially substance abuse, sexuality and reproduction) and getting authentic answers are hard tasks. Yet these are crucial health issues – especially in the increasingly youthful Latino population – that will have a long-term affect on the health of individuals, families and the whole community. The challenge is to be aware of the process of negotiation where one's personal, social and economic history "speaks" and "listens" to the "other's" perceived reality.

"The most challenging health problems are among the agricultural workers. There are people who work two or three seasons here without visiting a doctor. They prefer to wait to return to Mexico because it is cheaper there. Here, they don't have enough support or information to get the services they need." María Islas, Lideres Campesinas, Salinas, CA

Despite differences in place of origin, class, and education, the Spanish language and culture are probably the main common symbols among Latinos living in California, of which 70% are of Mexican origin.[8] In fact, 80% of Latino households are Spanish-speaking.[9] For the health care provider of patients of Mexican origin, this means that the main "conceptualizations of health or illness (experienced, observed, or perceived) are accomplished through language,"[10] which, in this case, is primarily Spanish [although

[2] Promotoras/es are community health outreach workers and advocates who generally share their community's socio-economic characteristics and cultural norms, conduct home visits and serve at community events. Some are volunteers and others are the paid staff of clinics, public programs, or community-based organizations.

[3] Using Rouse's formulation, the term "migrants" rather than "immigrants" will be used throughout this article. The term immigrants suggests an unidirectional movement, which does not portray the reality of millions of Latinos going back and forth between their countries of origin and the United States, as well as between geographical locations within the United States. Instead the term migrant implies a continuum in the migration process of individuals who spend varying amounts of time in multiple communities across borders, often following seasonal growing patterns and economic cycles. R. Rouse, Questions of Identity. Personhood and Collectivity in Transnational Migration to the US, *Critique of Anthropology*, 15:4, pp. 351-380, 1995.

[4] The study and principles of how adults learn.

some may speak an indigenous language, such as Maya or Mixteco]. However, as other researchers have cautioned:

> *Translatio*n is not a matter of literally translating from English *into* Spanish or back translation *from* Spanish into English. Translation without contextualization can lead to miscommunication, particularly when working with people from different countries of origin. Interpretation and translation are inherently tied. When dimensions and subtleties of the word are contextualized, clarified and thus, interpreted, translation becomes possible.[11]

As the number of Spanish-speaking and "Spanish-conceptualizing" patients increases, it becomes more imperative for health care systems and professionals likewise to increase not only their linguistic competency, but also their cultural awareness and sensitivity.

"We cannot remain invisible and silent. We are working so hard for this country. We are human beings with needs, dreams, fears—just like everyone else." Reymundo Martínez, 63 year old farmworker from Mexico

Words are usually framed in both rational and emotional spheres, and can be elliptic because they go back and forth between norms, desires and myths. We are polyphonic beings and words can have different meanings depending on the context, the topic, or the moments of life we are passing through. These tasks are further complicated when the health care provider and patient do not share the same language and/or culture. For example, in addition to the common fears of most patients (of the unknown, of dying, of not being able to provide for their families), many migrants of Mexican origin must also struggle with the specific fears of not knowing how to access care, of the cost of treatment without health insurance, of not understanding and/or being understood, of racism and discrimination, and of increasing vulnerability for themselves or others to the Immigration and Naturalization Service (INS). These fears greatly influence how patients perceive symptoms, when they seek care and from whom, whether they feel comfortable enough to ask questions, and how effectively they are able to follow treatment plans.

"Illness and sickness have no borders. It's not fair for health care to have borders." Roberto Tapia-Conyer, Undersecretary of Health, Mexico

The concept of intersectionality used by feminists of color to denote the ways in which race and gender interact to shape how women of color experience discrimination offers a tool for analyzing the overlapping systems of subordination facing both women and men of Mexican origin in the U.S.[12] Intersectionality allows us to examine the ways in which the patterns of subordination currently attached to certain categories of race, gender, class, immigration status, and language within our society overlap or intersect to create experiences that are frequently marginalized — even within the organizations that are committed to helping the migrant population. Kimberlé Williams Crenshaw[13] cites numerous examples of the ineffectiveness and even harm done by "adopting policies, priorities, or strategies of empowerment that either elide or wholly disregard the particular intersectional needs" of people of color. For the health care providers working in the U.S. with Mexican migrants, an awareness of the binational nature of their

particular intersectionality is crucial. If we are to effectively increase the quality and access to health care for this population, health care providers must be aware of how illness and injury are treated in Mexico, how the stress of leaving their families and homes to come to the U.S. may affect their health, and how the high cost of medical care and the fear of the INS hinders many from seeking care before conditions become serious.

THE IMMERSION PROGRAMS

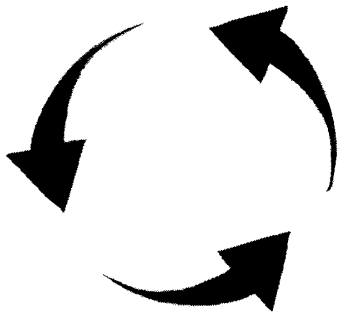
The cultural immersion of health care professionals through exchanges is one of the programs of the California-Mexico Health Initiative (CMHI),[5] targeting both the systems' and community health domains. Its goal is raise awareness and improve workforce training in order to improve the delivery and effectiveness of health care for the population of Mexican-origin.

[5] The California-Mexico Health Initiative (CMHI) was created in January 2001 under the auspices of the California Policy Research Center to realize a future of health across borders for the Mexican-origin population in the United States through binational strategies and cooperation. To attain their vision and mission, CMHI's strategic plan focuses on three distinct yet interdependent domains: systems, community health, and population health. The concept of leveraging existing and potential resources is fundamental to their approach and the key to their effectiveness. Working in partnership with key public and private organizations, CMHI oversees twelve ongoing programs throughout the year, developing and strengthening simultaneous and complementary activities in California and Mexico.

Interrelationship of Exchange Program Goals among Systems, Community Health, and Population Health Domains

Systems

Goals: Educate U.S. medical students, nurses, physicians, and other health care professionals to increase their cultural and linguistic competency. Increase the number of competent health providers to the Latino communities. Make both U.S. and Mexican health care systems aware of migrant-population health care issues and more responsive to them.



Population Health

Goal: Use effective workforce training to develop the bilateral capacity to reduce health disparities and improve health outcomes among the migrant population.

Community Health

Goals: Improve the quality of training for promotoras/es regarding the Mexican health care delivery system and migration and its affect on physical and mental health. Increase the number of trained promotoras/es. Increase the interorganizational referrals of migrants serviced by programs that employ promotoras/es.

THE METHODOLGY OF THE EXCHANGE PROGRAMS

Recognizing the complex infrastructures of the health care systems of the U.S. and Mexico, CMHI has designed and implemented three cultural immersion exchange programs that address the myriad levels of health care professionals, from the high level decision-makers, such as the CEOs of the National Association of Community Health Centers, to the medical students in the midst of their education, to the *promotoras/es* living in the communities.

While each program varies in its target audience, length of stay and areas of emphasis, all three programs work to achieve the same goal of increasing access to culturally relevant health care for migrants of Mexican origin in the U.S and especially in California. All three programs also share certain characteristics, such as:

- presentations by health care experts from both the U.S. and Mexican governments and health care systems to learn and ask questions about:
    - demographics and health patterns of migrant populations
    - traditional herbal remedies and practices
    - binational health insurance
    - the differences between the U.S. and Mexican health care systems
    - the role of community health centers in serving minority groups
    - current binational programs
    - potential binational efforts, initiatives and implications

- visits to both urban hospitals and rural medical clinics to experience firsthand the context of Mexican migrants' health care needs and expectations
- opportunities to meet with both Mexican and U.S. peers and colleagues to discuss, share resources and plan future collaborative projects
- a written evaluation, asking participants to reflect on their experiences as well as to comment on the strengths and weaknesses of the exchange program
- follow-up contact to encourage participants' continued involvement with CMHI and/or other agencies through participation in planning committees and events, such as the next Binational Health Week. (Binational Health Week is an intensive, week-long political and educational *fiesta* that provides health services and health promotion activities throughout California and other states in the U.S. and Mexico, culminating in a binational policy forum on migrant and immigrant health.)
- CMHI's arrangement of logistics (funding for air fare, room and board, local transportation and cultural activities for all participants to travel to Mexico and spend time fully immersed in Mexican culture).

"It is very important for us to receive an orientation about what to do and where to go if we get sick or injured on the job. Obviously, we can't work if we get sick and if we do, we could be risking our lives." Chano Medina, 30 year old farmworker

The content of each exchange is tailored to the specific needs and interests of that particular group of participants, specifically:

1. The *Jornadas Informativas de Salud Sobre México* (Informative Health Journeys about Mexico) are week-long cultural immersions for U.S. health care professionals in Mexico. Participants range from the heads of community health centers, to the heads of departments of education of community health clinics, to the health care providers in the clinics. The program focuses more on the politics of migrant health care and on the health care systems themselves, offering both up-to-date information as well as the opportunity to reflect on current practices and envision new ways to meet the needs of this underserved population.

2. The medical exchanges, which last a month or longer, offer linguistic and cultural immersion for University of California (UC) medical and nursing students in Mexico. Medical students are generally in their second year and must demonstrate that they have contact with Spanish-speaking patients, are sensitive to the needs and challenges of this population, and already speak an intermediate level of Spanish.

   The month-long program for UC medical students includes: being assigned to shadow a Mexican physician/mentor in both a rural clinic and a city hospital, receiving daily formal language instruction in a Mexican college, and living with a Mexican family for their entire stay. The students' Spanish coursework focuses on medical terminology and their stay culminates in taking a patient's health history and giving a physical exam in Spanish. This exchange fosters medical students' understanding of the linguistic and cultural health needs of Mexican-

origin patients early in their careers, encouraging them to consider focusing their future practice on this population.

3. The *promotoras/es* exchanges are week long cultural immersions for both U.S. and Mexican community health outreach workers. *Promotoras/es* play key liaison and educator roles within lower-income Latino communities, both in the cities and rural areas. They are members of the community themselves, which means they are generally already linguistically and culturally competent. However, to maximize their effectiveness within their communities, they need to be familiar with local resources as well as binational health issues and the ways in which both California and Mexico address them.

   The U.S. exchange program is a week-long experience for paid and volunteer *promotora/es* who visit Mexican *promotoras/es* training sites and meet with their Mexican counterparts to discuss migrant health issues, available resources, and program implementation issues. They also participate in field visits with their Mexican peers to experience firsthand the context in which they operate and from which their service communities come. Mexican *promotoras/es* have comparable experiences in California, where CMHI and partner organizations host them and facilitate their exchange experiences.

RESULTS AND DISCUSSION

"The educator needs to know that his or her 'here' and 'now' are nearly always the educands' 'there' and 'then.' Even though the educator's dream is not only to rend his or her 'here-and-now' accessible to educands, but to get beyond their own 'here-and-now' with them, or to understand and rejoice that educands have gotten beyond their 'here' so that this dream is realized, she or he must begin with the educands' 'here,' and not with her or his own. At the very least, the educator must keep account of the existence of his or her educands' 'here' and respect it. Let me put it this way: you never get ***there*** *by starting from* ***there****, you get* ***there*** *by starting from some* ***here****. This means, ultimately, that the educator must not be ignorant of, underestimate, or reject any of the 'knowledge of living experience' with which educands come to school."* Paulo Freire[14]

Freire admonishes progressive educators that before they can teach effectively, they must learn about, value and accept "the knowledge of living experience" that their students bring with them. Making "the knowledge of living experience" the foundation upon which education builds has direct implications for both the necessity of health care providers to become more culturally sensitive — as well as the effectiveness of cultural immersion programs in adult learning.

Malcolm Knowles's theory of andragogy, which describes effective methodologies for adult learning, stresses the importance of adult learners' need to know the reasons why they should learn something and how it will apply to their lives.[15] Again this can be applied to both the participants and their patients of Mexican origin. The application process for CMHI's immersion programs requires candidates to describe their current

work with Spanish-speaking patients and to explain their need for greater cultural training. Correspondingly, health care decisions and treatments will only be effective if health care providers can communicate the reasons behind the recommendations.

The principle of the effectiveness of building upon the learner's past experiences for motivation as well as for understanding content is also fundamental to the immersion program model. Health care providers who are familiar with Mexican health practices can design treatment programs that are more familiar and, therefore, more meaningful to their patients.

Most importantly, it is the association of past learning experiences with self-identity that provides participants in immersion programs with the opportunity of engaging in what Jack Mezirow calls "reflective learning." Reflective learning "involves assessment or reassessment of assumptions" and "becomes transformative whenever assumptions or premises are found to be distorting, inauthentic or otherwise invalid."[16] By providing health care professionals with the opportunity to experience Mexican health care firsthand, outside of the context of their usual work environment, they can gain an external perspective on their own practice, discover the assumptions underlying their current practice, become motivated to develop new skills and knowledge, and consider alternative ways of improving the health care provided to patients of Mexican origin. By targeting health care professionals, medical and nursing students, and promotoras/es, CMHI seeks to transform each link and thereby the whole chain of health care professionals serving the Mexican-origin community.

The *Jornadas Informativas de Salud Sobre México* (Informative Health Journeys about Mexico)

CMHI has sponsored four *Jornadas Informativas de Salud*, affecting a total of 142 key decison makers in current U.S. health care systems.

Dates	Participants
February 2001	47 health care providers from California, Arizona and Texas – all levels
February 2002	32 health care providers from health clinics in California – all levels
February 2003	23 National Association of Community Health Centers (NACHC) from U.S.
June 2004	40 Health Education Heads of Community Health Clinics from U.S. in collaboration with Institute of Mexicans Abroad (IME)

Through these four *jornadas*, CMHI learned that grouping participants together by their positions allowed presenters to tailor information more appropriately and participants to relate to one another more easily, improving the effectiveness of the program.

"These exchanges are very important to the Mexican government. We have a very good national epidemiological survey system, but once Mexicanos cross the border, we lose track of them. Meeting the health care providers who come to Mexico completes the picture of what happens in migration and helps us get to know each other better so we can work together. We need to help the Mexican migrants learn how to access health care in the U.S. before they migrate and to encourage them to think about preventive

health care before they get sick or injured." Hilda Davila, Director of Migrant Programs, Secretary of Health, Mexico

While the inter-agency and intra-agency challenges of working within the systems domains are substantial, CMHI recognizes the value of bringing the two mega bureaucracies (the U.S. and Mexican governments and their health care systems and medical schools) together in order to foster better dialogue, greater understanding and respect, and more effective collaboration.

"The jornada I attended last year gave me the opportunity to make some indispensable ties with colleagues in Mexico and in the U.S. These qualitative exchanges of ideas and culture are just as important as the political and economic exchanges. When you work with people who cross the border, you have to be able to cross the border yourself – at least mentally. And our involvement in Binational Health Week has shown how a relatively small investment can yield tremendous benefits to the community." Joel Jose Garcia, CEO Tiburcio Vasquez Health Center

The Medical Exchanges

CMHI has facilitated six medical exchanges, affecting 45 current or future health care providers:

Dates	**Participants**	**Number Attending**	**Length of Program**
July 2002/2003/2004	UC Medical Students from U.S. to Mexico	2002: 10 (2 from each UC medical school) 2003: 11 (2 from each UC medical school and 1 from joint program of Public Health at UCB & medical school at UCSF) 2004: 17 (UC medical & nursing students)	1 month
July 2003	Doctors from Mexico to U.S.	4 (2 at UCSF and 2 at UC Irvine College of Medicine)	
September 2003/ February 2004	Medical Students from Mexico to U.S.	2003: 2 at UC Irvine College of Medicine 2004: 2 at UC Davis 1 at UC Irvine College of Medicine	8 weeks

"The most rewarding benefit I have noted since the program has been evident during one-on-one patient contact. Even in my young career, I recognize that one of the most difficult tasks as a physician is to establish a positive relationship with patients often in a short amount of time. Compounded by barriers of language and culture with Latino patients, I have found that this is often an area of misconnect between an American physician and a Latino patient. Whether it is surprising my patients with my Spanish language skills, using a slang vocabulary word that they better understand (my favorite is 'pancita' for 'little stomach'), inquiring about their cultural views of medicine or even frankly talking about my experience in Cuernava and Mexico City, I cannot express the benefit of being able to connect with my patients on a unique and essential level—this has been my most treasured reward." Brian Dennis, 3rd year medical student at UCSF

***Promotoras/es* Exchanges**

"Promotoras/es are a vital health workforce in both Mexico and California that helps provide essential health education and information and serves as a link between the community and health care access." Dr. Javier Cabral Soto, Coordinator General, *IMSS* (Mexican Social Security Institute) *Opportunidades* Program

CMHI has facilitated three *promotoras/es* exchanges, affecting 150 community health workers:

Dates	Participants	Number Attending	Length of Program
October 2003	***Promotoras/es* from Mexico visited communities in Bay Area, Central Valley and Los Angeles**	**23 (plus 125 promotoras/es from U.S. for day-long conference)**	**1 week culminating in the First Binational *Promotoras/es* Conference on 10/15/03 in Vallejo, CA.**
March 2004	***Promotoras/es* from U.S. and Mexico visited McAllen, Texas**	**50 from U.S. and 50 from Mexico**	**3 days focused on HIV/AIDS outreach prevention services**
April 2004	***Promotoras/es* from U.S. to Mexico**	**27**	**1 week**

"Hosting a Mexican promotora gives the women in our community here the chance to see that we're trying to organize our community health workers just like they do in Mexico. We are not alone. We can learn from them. We just wish they could stay longer, two or three weeks would be even more worthwhile." Laura Caballero-Conle, Coordinator for Lideres Campesinas

An example of the effectiveness of building upon the promotora model from Mexico is Oralia Maceda Méndez, who was born in Paxtlahuaca, Oaxaca, a community in which she was trained and worked as a health promoter in the community clinic. She has resided in California's Central Valley for the past seven years, where she has worked promoting health education and access to health services for indigenous Oaxacan migrants. Oralia has focused her work on going to rural areas in Fresno County to offer HIV exams and education on HIV and sexually transmitted diseases. Her labor has not been easy because this topic is still taboo amongst indigenous communities and because there is still great need for mechanisms to accomplish an effective binational reference of patients.

"Upon coming to the United States I had the opportunity to continue working in health related subjects with a large community, not only with the families from my town but with all of the rest of the people from my state (the ones whom we have been able to reach). Although the media has passed along informative announcements on this issue, people have refused to take reality into account and it is still difficult to speak about this even though we have found more informative resources and exams are offered through county health departments. Despite this difficulty, we have at least accomplished that some

people receive the information and get the test done on time." Oralia Maceda Méndez: Promotora in Fresno, California, originally from Oaxaca

OVERALL CHALLENGES

CMHI faces several important challenges to maintain and expand these exchanges programs, including:

- Selecting the most appropriate candidates who will, in turn, have the greatest impact on the health of Mexican-origin population. It is difficult to gauge people's commitment based on applications and interviews and their potential for the future.
- Measuring the effectiveness of the exchanges requires long-term follow up. A Binational Exchange Directory has been created, listing the contact information and organizational affiliation for each participant. CMHI has a coordinator to follow up with participants in order to assess their current work with the Mexican-origin population, to determine the ripple effects of their participation, and to encourage their involvement in collaborative projects.
- Securing funding in order to sustain and expand the programs.

CONCLUSION

"An understanding of the world, which conditioned by the concrete reality that in part explains that understanding, can begin to change through a change in that concrete reality. In fact, that understanding of the world can begin to change the moment the unmasking of concrete reality begins to lay bare the 'whys' of what the actual understanding had been up until then." Paulo Freire[17]

The tremendous growth in the number of people of Mexican origin living and working in California and recent research analyzing health care disparities have amplified the call for culturally and linguistically competent health care. To address both the complexities of current U.S. health care systems and the particular characteristics and health needs of immigrants and migrants of Mexican origin, strategies must be developed, implemented and monitored to target the many interconnected, yet distinct, areas of health care, including legislature, health care system design and administration, health education of current and future health care professionals, health care delivery, and public awareness. An innovative approach that acknowledges the realities of our current health care systems and looks to influence them at every level is the linguistic and cultural immersion of health care personnel designed and implemented by the California-Mexico Health Initiative (CMHI) with its many partners in the U.S. and in Mexico.

"What's missing for migrants is a sense of dignity and a fair living wage. And by connecting our work with Mexico now, we believe we'll be able to make a big difference over time." Marío Gutierrez, Binational & Agricultural Workers' Programs, The California Endowment

It is the binational perspective of CMHI and these exchange programs that is the key to their success. The health care professionals who have participated in an exchange have

overwhelmingly appreciated their value, but the challenge remains to leverage the investment made in them to yield high gains in the health of migrants from Mexico.

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[7] Gramasci, 1975, Stacy, 1988, Rosaldo, 1993, Fine, 1994. The ability to determine the focus of the research, the subjects to interview, and the questions to ask resides in the political, economic and social power of researchers and their relations within their historical context. As a result, the age, race, gender, class, and religious and educational background of the researcher greatly influence the kind of information gathered and the relationship established with participants. [Amuchástegui,1998]. Social scientists can no longer view themselves as objective, neutral and universal observers, but must now "grapple with the realization that [their] objects of analysis are also analyzing subjects" [Rosaldo, 1993:21] like themselves but also different from themselves.
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