

Binational Health Week:

**Mobilizing Existing Networks and
Resources to Focus on
Migrant Health Care Issues**

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ABSTRACT

The California-Mexico Health Initiative, a program of the California Policy Research Center, University of California Office of the President, endorsed by the Mexican government and funded primarily by The California Endowment, has been the sponsor of a highly focused annual effort that seeks to reduce health disparities and improve access to care for the low income population of Mexican origin in the U.S. as well as in their places of origin. This innovative strategy, called Binational Health Week (BHW), seeks to mobilize existing networks and resources in a highly-organized, synergistic effort that result in significant and concrete improvements that do not require major infrastructural changes. The strength of BHW — as well as its weakness — is that it relies on volunteer contributions of more than 300 organizations that all come together once a year to provide services to this highly underserved population. During BHW this year, these organizations provided services to over 70,000 people throughout 22 counties of California and 8 states of Mexico with high migration rates.

Keywords: community health; binational programs; migrants; immigrants; Mexicans; program planning; networks

INTRODUCTION TO BINATIONAL HEALTH WEEK

Since its inception in October 2001, Binational Health Week (BHW) has been instrumental in developing programs aimed at improving the health and well-being of migrant workers and their families.¹ Although the California-Mexico Health Initiative (CMHI) focuses on the health needs of Mexican-origin and other Latino migrants and their families (including permanent and temporary residents in both rural and urban areas), this week-long event benefits underserved Latinos² regardless of their national origin.

BHW's concept was built upon Mexico's highly successful immunization crusades. Since 1993, the Mexican Ministry of Health (SSA) has implemented three nationwide health weeks a year designed to improve the health of underserved populations through festive social mobilization.³ A large part of BHW's success is due to the CMHI's reliance on existing partnerships and networks including clinics, county based organizations, university resources, Mexican home town associations, and the involvement of Mexico's Ministry of Health and Foreign Affairs. Binational Health Week has been a catalyst in facilitating dialogue among Mexican-origin migrants and immigrants, Latino legislators, philanthropic organizations, Mexican and California government officials, Mexican-Americans, and Chicanos.

¹ 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 (Rouse, 1995).

² "Latinos" is a political term used to designate a heterogeneous Caribbean and Latin American population sharing a historical background and cultural perspectives (Clayson, Casteñada, Sanchez, and Brindis, 1999-2000).

³ SSA uses 59,000 temporary stations across Mexico to provide health services during these weeks.

Using the terminology of network theorists, CMHI is fulfilling the role of a network weaver, first creating new interactions between groups and then helping these groups work together and eventually begin weaving their own networks. In “Building Sustainable Communities through Network Building,” Valdis Krebs and June Holley describe the two parts of network weaving:

One is relationship building, particularly across traditional divides, so that people have access to innovation and important information. The second is learning how to facilitate collaborations for mutual benefit... This culture of collaboration creates a state of emergence, where the outcome—a health community—is more than the sum of the many collaborations. The local interactions create a global outcome that no one could accomplish alone (Krebs & Holley, 2002).

Through BHW, CMHI not only enables connections to form between different groups interested in migrants and/or health issues, but it also provides them with a collaborative project that shows the effectiveness of working together to improve the health of migrants. In addition, CMHI demonstrates how the communication technologies available today can empower these networks through the development of databases and on-line directories, increasing the depth and reach of these networks’ efforts.

CMHI has identified six priority health topics for BHW, based on disease incidence levels among the Latino population⁴ in California, data available from Mexico, and input from CMHI’s advisory board. These are:

⁴ Note: In California, disease incidence and prevalence data are generally available for the Latino/Hispanic population rather than specifically categorized by country of origin.

- mental health, including issues related to domestic violence, alcohol, and substance abuse
- nutrition, including the relationship between diet and diabetes, hypertension, high cholesterol, and obesity
- infectious diseases, including HIV/AIDS, tuberculosis, hepatitis, and STDs
- occupational health and injury prevention, especially issues relevant to adolescent agricultural workers
- women's health, including issues related to cervical and breast cancer, gender issues, and reproductive health
- oral health, especially dental care and prevention of tooth decay.

To address these specific health needs within the migrant population, CMHI organizes BHW around three main components:

1. ***Health service provision and health promotion activities*** conducted in both countries, which include: health information and screening fairs; workshops and other cultural approaches to health promotion (e.g. theater presentations, radio soap operas, interviews, public service announcements, television programs, and newspaper articles); distribution of health education materials such as posters, brochures, and videos; and outreach activities to enroll eligible population on existing health insurance programs such as Medi-Cal and Healthy Families.
2. ***Binational Policy Forum on Migrant and Immigrant Health Issues*** to convene legislative representatives (including the leadership, committee chairs, and members of all key health committees); university officials; members of county

boards of supervisors; union leaders; heads of major media organizations; state agencies directors; community health center leaders, and other key stakeholders from both countries — to discuss the challenges and unique opportunities of working collaboratively to improve the health and well-being of people crossing the Mexico-U.S. border. Officials are targeted from selected Mexican States, including Baja California, Guanajuato, Guerrero, Jalisco, Michoacán, Morelos, Oaxaca, Puebla, and Zacatecas.

3. *Press events* to open and close BHW events, including a press conference during the Binational Policy Forum on Migrant and Immigrant Health Issues with high-level government officials from Mexico and the United States, University of California representatives, foundation directors, legislators, and community leaders. A comprehensive press strategy also covers the main local events in each of the counties and airs media messages culturally and linguistically appropriate, to increase awareness of illness and disease among target communities.

BACKGROUND ON THE CALIFORNIA-MEXICO HEALTH INITIATIVE

CMHI was created in January 2001 under the auspices of the California Policy Research Center to facilitate the development of complementary and coordinated projects involving key stakeholders in Mexico and the United States. A binational advisory board ensures that the efforts of CMHI are bilateral, synchronized, and complementary.

The overarching vision of CMHI is to realize a future of health across borders for the Mexican-origin population in the United States through binational strategies and cooperation. To attain this vision, CMHI's mission is to coordinate resources in the United States and complement resources in Mexico to increase access to and use of health services, expand health insurance coverage, improve health outcomes, reduce health disparities, enhance the cultural competency of health care personnel, and implement innovative strategies to address unmet health needs of the Mexican-origin population living and working in the United States.

Through funding from the University of California, The California Endowment (TCE), and the California HealthCare Foundation, CMHI has completed three successful years of operation. Working collaboratively with other organizations, CMHI has launched eleven programs in addition to BHW, including: creation of health stations (ventanillas de salud) within Mexican consulates; development of a binational epidemiological surveillance system pilot project; release of a special call for research proposals on migration and health; development of a database and on-line directory on migrant health services and programs; creation of a clearinghouse of health education materials in both Spanish and English; and coordination of training for health care professionals and medical students. While CMHI's initial activities have focused on California, the strategies described here could be replicated in other states with migrant populations.

BACKGROUND ON MIGRANT HEALTH

It is important to recognize that the Mexicans who choose to migrate to the U.S. in search of work come with a certain health capital. In other words, there is some degree of natural self-selection in terms of physical health. If undocumented, they must be particularly strong and healthy enough to cross the border and then to engage in the heavy manual labor often offered to them. Most migrants come fully immunized and having grown up on a diet based on more fruits, vegetables and grains than many in the U.S. However, once here, their health capital deteriorates severely in just a few years. They are disproportionately represented in dangerous industries (construction, manufacturing, and agriculture) and in hazardous occupations within those industries (Labor Occupational Health Program, UCB, 2002.) Certain factors also increase the risk of these occupations for migrant workers, such as a decreased likelihood in reporting hazards on the job due to fear about job security, legal status, language issues or lack of knowledge about their rights (Labor Occupational Health Program, UCB, 2002.) Furthermore, the low pay of these occupations means that over 25% of people of Mexican origin live in poverty here in the U.S., as compared with 20% of Latinos overall and 10% of the non-Latino population (Santibañez, 2003). This level of poverty manifests itself in poor diet, inadequate living conditions, and increased vulnerability to short-term and chronic sickness.

Their Economic Role

Both the U.S. and Mexican economy depend on the labor of migrant workers in the U.S. Undocumented workers alone generate goods and services worth more than \$120 billion

a year in the U.S. (Martin, 1996). In Mexico one out of every 20 households benefit from the remittances, which tend to concentrate in communities with less than 2,500 inhabitants (CONAPO). And, during the 1990s Mexican immigrants sent home some \$33 billion in remittances (CONAPO, 2000). In 2003 alone, the total of remittances was \$14.5 billion, becoming the highest single source of income for Mexico (Orozco, 2003). As we all know, migrant farm labor is the foundation of the multi-billion dollar U.S. agricultural industry (National Center for Farmworker Health, 2002). Of all California's fieldworkers, 95% are immigrants. Ninety-one percent were born in Mexico. And many of the remaining 5% are children of Mexican parents (California Institute for Rural Studies, 2001). In other industries, Latinos account for 25.1% of textile workers, 20.5% of cleaning and building service workers (U.S. Department of Labor, 1998) and 15% of all construction workers (National Safety Council, 2002). The U.S economy is dependent on the healthy bodies of migrant workers to do the manual labor still required in our industrial society. However, the market place does not factor in the cost to these bodies, but prefers to consider them a resource that can be depleted then disposed of when no longer of use. In reality, the "fragmented" bodies of migrant workers are subsidizing the actual cost of our food, clothing, and shelters. It is therefore our responsibility to educate ourselves about the true state of health (physical and mental) of migrant workers and to work to preserve their health, not only because they are a valuable resource but because they are human beings deserving our respect. As Almudena Ortíz has said, "We must put a face on the hands that labor [for] the food we eat." And clearly any attention to migrant well-being has to be understood as a bilateral

responsibility because of this population's dual economic and social impact on both countries.

The Hazards to Their Health

The hazardous occupations of migrant workers, combined with generally low wages and little access to health services, have resulted in a much higher incidence rate for many serious injuries and illness in migrant workers than in the general population. Latinos have a 14% fatality rate in the workplace, yet make up only 11% of the workforce (U.S. Department of Labor, 2002). Cardiovascular disease is the leading cause of death among Latinos in California and nationwide, as well as among the Mexican-origin population (National Vital Statistics Report, 2000). Musculoskeletal conditions are the most commonly reported health problem among the nation's 2.5 million agricultural workers, who are faced with numerous ergonomic hazards in fields, nurseries, orchards and packing sheds (Davis, 2000). And the prevalence of diabetes in Mexican Americans is 1.8 times higher than in non-Latino whites (Harris, Flegal, Cowie, Eberhardt, Goldstein, Little, Wiedmeyer and Byrd-Holt, 1988-1994). The Latino population makes up 12% of the total population of the U.S. but 15% of the population aged 10-19, the majority of them of Mexican origin. The teen birth rate for Latinos is nearly four times the birth rate for non-Latino white teens in California (California Department of Health Services, 1995). While the infant mortality rate among migrants is 25% higher than the national average (National Center for Farmworker Health, 2002).

The Scope of the Challenge

Clearly migrants and their families deserve and are in desperate need of improved health care access and effective health insurance coverage in order to preserve their health.

However, the scope and complexity of realizing this, especially in these economic and political times, seems daunting. The sheer size of this population presents a challenge.

In the United States there are 39 million Latinos, of which 67% or 22.5 million are of Mexican origin (U.S. Census 2002). In California alone, there are 11 million Latinos, of which 8.5 million are of Mexican origin, comprising 25% of the state's total population (U.S. Census 2002). Compounding the difficulty, a large percentage of this population does not have health insurance — the surest access to affordable health care. In California, almost 1/3 of Latino children and 41% of non-elderly adult Latinos are uninsured — the majority of Mexican origin. There are 2.25 million uninsured Latino adults in California, roughly twice as many as any other group (UCLA Center for Health Policy Research, 2001). In California, only 43% of Latinos have job-based insurance, compared to 71% of non-Latino whites (Brown, Niñez and Rice, 2001).

The Obstacles to Health

The disparities are further exacerbated by the tremendous number of obstacles facing migrants of Mexican origin who need access to health services for themselves and their families. Because of language and education barriers as well as misinformation, many Mexican migrants are not even aware of programs for which they might be eligible.

Many migrants do not seek health care benefits through state or county health care programs for fear of jeopardizing their ability to obtain legal residency, endangering their

current Green Card, preventing them from sponsoring a family member, or hurting their sponsor. Some are undocumented and are, therefore, ineligible for many programs.⁵ Even when documented, many migrants work in occupations that do not tend to provide health insurance, like agriculture. In the U.S. 70% of the agricultural-worker population does not have health insurance (National Center for Farmworker Health, 1999) and one out of every three Mexican immigrants in California is in a farmworker household (Gabbard). In a representative sample survey of agricultural workers, only 7% were enrolled in any government program serving low-income people (The California Endowment, 2001).

The Mexican migrant also faces cultural differences when seeking health services in the U.S. They have less of an awareness of preventive care and tend to only seek health services when they are really sick. Only 1.4% of all visits to migrant health clinics are for general medical exams, 39% below the U.S. average (National Center for Farmworker Health, 2002). Gender also plays a major role in a migrant's health. In Mexico, women tend to be the gatekeepers of health, recommending where to go for treatment and how follow up care is administered. In the case of agricultural workers in California, 82% are male, half of them come unaccompanied and the majority has families in Mexico (California Institute for Rural Studies, 2001). In practice, this means many male migrant workers simply do not seek medical attention. In a representative-sample survey in California, nearly 32% of male agricultural workers said that they have had never been to a doctor's office or a clinic in their lives, while only 48% had been to a

⁵An estimated 4.5 million unauthorized Mexicans live in the U.S. (Bean, Van Hook, and Woodrow-Lafield, 2001).

doctor or clinic at least once during the previous two years (The California Endowment, 2001).

THE STRATEGY

The abundant health care needs of this population appear to be almost in inverse proportion to the scarce resources currently allocated to addressing migrant health issues. And the cost of building an effective health care system to improve the health of migrant workers and their families from the ground up would be astronomical. Does this mean that there is no realistic hope for change? How can we begin to meet so many desperate needs with such limited resources? The third annual Binational Health Week demonstrates that amazing (and measurable) outcomes can be created by mobilizing existing resources and organizations, creating connections, and then following up in a systematic way.

The key to Binational Health Week's effectiveness lies in the synergy of bringing together so many hundreds of groups and thousands of individuals who are interested in and committed to improving migrant health. For one week a year, CMHI pulls out all the stops to try to focus everyone's attention on the health of migrants and their families. The months leading up to that week in October are spent making innumerable phone calls, writing letters, sending emails, teleconferencing, and holding meetings to contact all the legislators, speakers, consulates, university resources, organizations, clinics, hometown associations, federations, clubs, promotores/as, individuals and the press.

In fact, the groundwork for the next BHW begins almost as the last one wraps up. The general planning guide for the 2003 BHW outlined the following goals, tasks and timelines:

- At least nine months prior, CMHI renews its efforts to continue building collaborative relationships with county clinics, community-based organizations and Mexican consulates by writing letters and preparing information packets on BHW.
- At least six months prior, CMHI defines the target counties/geographic service areas and forms a BHW task force headed by a local BHW coordinator, which will determine funding and other resource needs and identify potential resources.
- At least four months prior, these task forces develop outreach and BHW promotional and material distribution plans.
- At least two to three months prior, CMHI distributes fact sheets, BHW summary sheets and other pertinent data to the local task forces to help them develop their own area-specific fact sheets and calendar of BHW events and activities, which will be included in the BHW master calendar.
- At least one to two months prior, CMHI and task forces develop a BHW evaluation plan and data collection tools for local activities and events, establish deadlines, and compile preliminary reports and estimates. The evaluation process includes questionnaires to be completed by each task force, summarizing the binational health week activities held in each location, including the type of service provided, and the number of persons reached. An additional questionnaire

is completed by each person receiving services to collect data on demographics and health history.

- As soon as possible after BHW is over, CMHI collects, compiles, and evaluates the data, writes the final report and shares the results with the press and all who were involved.

DISCUSSION OF AREAS OF STRATEGIC CONCERN

This diverse resource of volunteer power, however mighty when mobilized, is also an area of potential weakness for CMHI. The Initiative must depend on the dedication, good will and follow-through of all these politicians, academics, public and private health professionals, community groups, press and individuals continuing to make this commitment of time and energy year after year. CMHI recognizes how important it will be to keep migrant health issues visible and as a priority if BHW is to continue to be successful at improving the health of migrant workers and their families.

Furthermore, CMHI must acknowledge, plan for and try to address the many complexities and potential difficulties inherent in the political and health care environments in both countries. These include:

- CMHI's commitment to serving all Mexican-origin population *including the undocumented*, which could inhibit efforts here in California.
- An unstable political climate in both California and Mexico, which could become unfavorable to address health issues affecting Mexican-origin population

- Two different sets of infrastructure, California's and Mexico's, which make coordinating and planning cumbersome.
- Health care delivery systems and other non-profits in California, which are not networked or linked, making the process of working with them more time consuming.

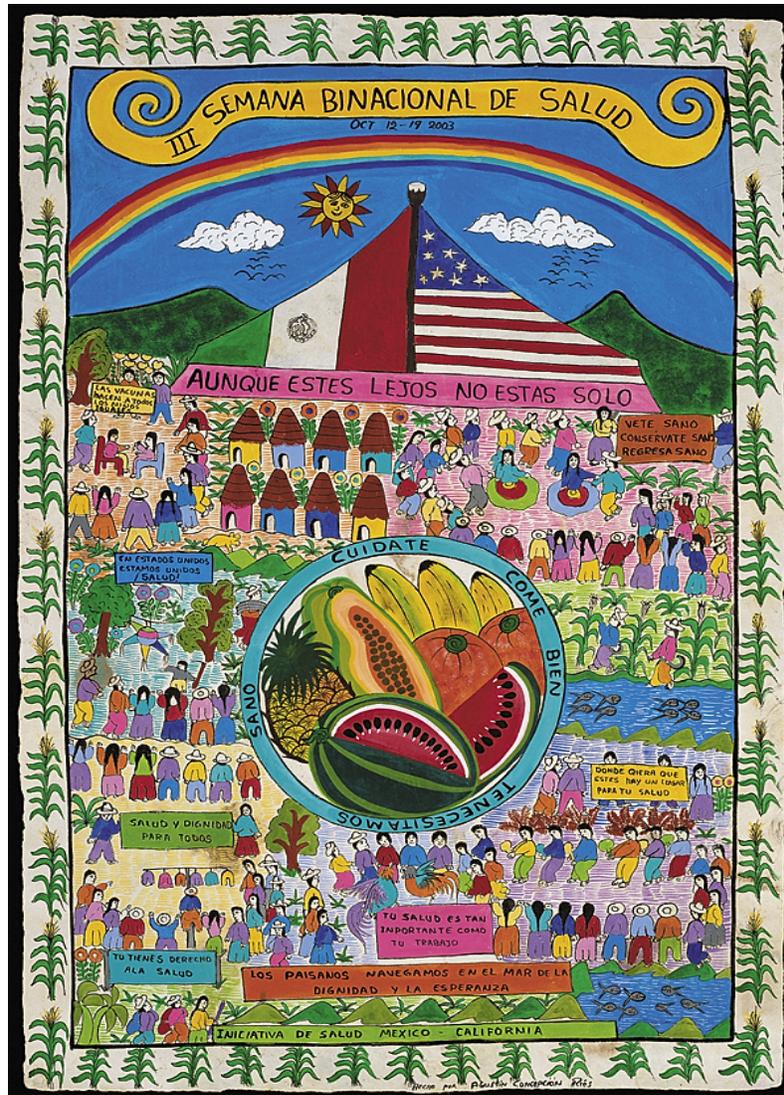
The results of BHW, however, demonstrate clearly that the strategy—always in the process of being fine-tuned—can and has produced concrete, measurable improvements to the health of migrants during the three years of BHW's existence.

DISCUSSION OF RESULTS

The third Binational Health Week (BHW) activities took place from October 12-19, 2003, in 22 California counties and in 8 Mexican states. Each county provided a variety of *health services and health promotion activities* unique to its own area and available resources. Some of the counties held activities focusing on HIV/AIDS to join those scheduled nationally to observe National Latino AIDS Awareness Day (October 15). Fresno, Los Angeles, Orange, San Mateo, Alameda, Monterey, and San Francisco counties hosted guest *promotoras/es* (community outreach workers) from Mexico. Over the course of the week an estimated **70,440 people received 119,242 health-related interventions**, such as screening for HIV, diabetes, and breast cancer; tests for blood pressure and cholesterol levels; eye and dental exams; educational workshops; and health insurance enrollment information.

Local coordinators provided leadership in the organization and promotion of BHW activities with the guidance and technical assistance of CMHI staff. Local support was made possible through the joint efforts of at least 1,260 volunteers and 334 agencies, including representatives from local and state health departments, community-based organizations and clinics, college and university campuses, local government, foundations, and Mexican Consulate representatives.

At least 1,200,000 pieces of printed culturally and linguistically appropriate material were distributed. (Each of the past three BHW campaigns has had a unifying image that was printed on posters, cards, flyers, brochures, agendas, etc. to link these materials together. An example of the 2003 image is below.) In 2003 materials for the general public included: BHW posters; guides to health maintenance organizations; and educational leaflets on pediatric oral health, STDs, domestic violence, nutrition, family planning, diabetes, and cancer — many of them donated by Mexican government. Specialized materials that were distributed included bilingual dictionaries of health-related terms, requests for research proposals, and training manuals for *promotoras/es*. There were four venues that displayed the BHW mural, which includes health promotion messages, Mexican icons, and the BHW slogan: “*Aunque estés lejos, no estás solo,*” (“Although you are far, you are not alone,”). Thanks to the California HealthCare Foundation, 1,500,000 bilingual guides to insurance and public benefits programs were distributed as a supplement to the newspaper *La Opinion*. The guide describes health insurance programs for the low-income population in California.



A Binational Public Policy Forum was held at UCLA on October 16-17. It was a major political event, with the participation of approximately 285 people, including a delegation of 70 Mexican representatives and public health officials as well as distinguished guests from both countries. The forum was intended to elevate migrant/immigrant health issues as a policy priority in the U.S. and Mexico, and to develop bilateral working recommendations. Expert presenters included representatives from the University of

California Office of the President, UC Santa Cruz, UCLA, the University-wide AIDS Research Program, California State University at Fresno, the United States-Mexico Border Health Commission, the California Public Policy Institute, the California Policy Research Center, the California Department of Health Services, the United States Department of Health and Human Services, the California Department of Managed Care, Stanford Medical School, Texas A & M University, The California Endowment, the California HealthCare Foundation, the United Farmworkers of America, the California Institute for Rural Studies, the California State Legislature, and the California Office of the Governor. From Mexico, there was representation from the Mexican Consulates in California, the Ministry of Health, state secretaries of health from 7 of the Mexican states with high international migration (Baja California, Guanajuato, Jalisco, Michoacán, Morelos, Oaxaca and Puebla) , *el Poder Legislativo, el Consejo Nacional de Población, Instituto para los Mexicanos en el Exterior, Instituto Mexicano del Seguro Social, Universidad Autónoma de México, Programa de Jornaleros Agrícolas de México, El Colegio de la Frontera Norte, and Centro Nacional para la Prevención y Control del SIDA.*

The BHW media campaign comprised 53 print articles in 21 newspapers in both countries. There were also 76 radio programs which aired 10 public service announcements produced by Radio UNAM (*Universidad Nacional Autónoma de México*) and CMHI for Spanish broadcast stations. Additionally, CMHI sent press packets that included health statistics on the Mexican-origin population to media statewide. Two of the main TV Spanish-channel, FOX en Español and Televisa, aired 87 hits advertising

BHW events. Approximately 80,000 people watched daily TV news with BHW commercials. Four press conferences were held throughout participating California counties. Thirteen information telephone lines and toll-free numbers were set up to inform the public about BHW events and services. Also, Mexico provided radio, print, and TV media coverage. CMHI also created a documentary on Binational Health Week as a visual testimony of the planning and coordination of BHW and highlights some of the binational activities implemented during BHW.

Growth of Binational Health Week in California 2001 – 2003

<i>Year</i>	<i># of Counties</i>	<i># of Health Events</i>	<i># of Estimated People Reached</i>	<i>Estimated # of Participating Agencies</i>	<i>Estimated # of Health Interventions</i>
2001	7	98	18,720	115	37,444
2002	12	167	21,710	280	51,000
2003	22	224	70,440	334	119,242

The growth of Binational Health Week since its inception in 2001 is best illustrated in the table above. The number of counties in which BHW promotional and educational materials was distributed, and health activities held, has steadily increased, from 7 in 2001, to 12 in 2002, and to 22 in 2003. The estimate for numbers of interventions was conservatively estimated by defining an intervention either as educational or as the provision of a health service, including health screening services.

CONCLUSIONS

Given the health disparities that characterize vulnerable and low-income populations, BHW plays an important role in creating political dialogue among state, local, and federal programs that is intended to improve the quality of life of Mexican-origin communities. Community-mobilizing efforts such as BHW, and public policy that is informed by health data that are collected bilaterally, should maintain the issue of migrant health as a priority in research, program planning, and resource allocation.

As realists, CMHI knows that in one week they cannot change the inadequacies and gaps within the public and private health care systems that are supposed to address the health problems of the migrant population. However, as pragmatists relying completely on a huge mobilization of political leaders, organizations and volunteers, they know they cannot expect or sustain more than a short period of dedicated time and resource commitment from these groups and individuals. Even though, many of these organizations work yearly round with underserved populations.

CMHI short-term strategy is to create an intensive, week-long political and educational “fiesta” to shift the social and political focus to migrant health care issues, creating a foundation for policy and community work throughout the year. Their long-term strategy is to bring together the people who are working on migrant and/or health issues in both California and Mexico, give them an opportunity to meet and learn from one another, make connections, and then be able to use one another as resources and for collaborative projects in the future.

People have always used social networks to find food, homes, jobs, information, etc. The question is how to discover and develop these networks to create positive social change or, as network theorists would say, how to “knit the net.” Krebs and Holley describe how acting locally can become acting globally:

Transformation that leads to healthy communities is the result of many (often small) collaboration among network nodes. Complexity scientists describe this phenomenon—where local interactions lead to global patterns—as *emergence*. We can guide emergence by understanding, and catalyzing connections. For example, knowing where the connections are, and are not, allows a community development organization to influence local interactions (Krebs and Holley, 2002).

Using this very un-hierarchical model, CMHI is seeking to transform the health care system on a global level by making thousands of small key connections within and between the local communities, organizations, universities, states and federal governments involved with the migrant population. While this allows CMHI to capitalize on existing resources and take advantage of the innovations possible among such a diverse group of networks, it also requires that CMHI relinquish any claims to ownership or control. Now in its fourth year, the concept of BHW no longer belongs to CMHI. It belongs to the community. CMHI continues to provide basic guidelines facilitate meetings and provide support, but BHW is now is an organism of its own with its own binational health network. Who knows how it will grow.

REFERENCES

Bean, Frank D., Van Hook, Jennifer and Woodrow-Lafield, Karen. *Estimates of Numbers of Unauthorized Migrants Residing in the United States: The Total, Mexican, and Non-Mexican Central American Unauthorized Populations in Mid-2001*. Pew Hispanic Center, November 2001.

Brown, E. Richard, Niñez Ponce, and Thomas Rice. *The State of California's Health Insurance in California: Recent Trends, Future Prospects*. Center for Health Policy Research, UCLA, March 2001.

California Department of Health Services. Report of Final Natality Statistics, Center for Health Statistics. *Monthly Vital Statistics Report*, 45:11, 1995.

California Institute for Rural Studies, Rural California Report. Fall 2001. *Who Does California Farmwork*, Vol. 12, No. 3.

Clayson, Zoe Cardoza, Casteñada, Xóchitl, Sanchez, Emma and Brindis, Claire. The Intersections of Culture, Health and Systems in California Latino Communities. *International Quarterly of Community Health Education*, Vol. 19, No. 4, 1999-2000.

CONAPO. "Las remesas: uno de los beneficios más evidentes de la migración". (www.conapo.gob.mx)

CONAPO, Migracion Mexico-Estados Unidos Presente y Futuro, 2000. (www.conapo.gob.mx)

Davis, Shelley. Farmworker Justice Fund, Inc. Testimony of the Farmworker Justice Fund, Inc. on the Proposed Ergonomic Standard – May 2000.

Gabbard, Susan. Acuirre International, personal communication.

Harris, MI., Flegal, K.M., Cowie, CC., Eberhardt, MS., Goldstein, DE., Little, R.R., Wiedmeyer, HM., and Byrd-Holt, DD. *Prevalence of diabetes, impaired fasting glucose, and impaired glucose tolerance in U.S. adults: The Tirad National Health and Nutrition Examination Survey, NHANES*), 1988-1994. *Diabetes Care*, 21:518-254.

Krebs, Valdis and Holley, June. "Building Sustainable Communities through Network Building," 2002.

Labor Occupational Health Program, University of California at Berkeley. The Working Immigrant Safety and Health Coalition (WISH), 2002. website: <http://ist-socrates.berkeley.edu/~lohp/projects.htm>.

Martin, Monica in Excelsior, Mexico DF, 1996.

National Center for Farmworker Health, 1999. Online: www.ncfh.org.

National Center for Farmworker Health, 2002. Online: www.ncfh.org.

National Safety Council. *Hispanics at Risk: National Safety Council and Environmental Protection Agency Hold Second In a Series of Forums Exploring Health Safety Issues Among Hispanics*. www.nsc.org/gov/hispanic.htm, 2002.

National Vital Statistics Report, 43:11, July 2000.

Orozco, Manuel, *Changes in the Atmosphere? Increases in Remittances, Price Decline, and New Challenges*, March 2003.

R. Rouse, Questions of Identity. Personhood and Collectivity in Transnational Migration to the US, *Critique of Anthropology*, 15:4, pp. 351-380, 1995.

Santibañez, Jorge, 2003. Presentation to IME at meeting in Mexico City.

The California Endowment, 2001. *Suffering in Silence: Who are California's Agricultural Workers?* Derived from the California Institute of Rural Studies.

UCLA Center for Health Policy Research. *The State of Health Insurance in California, 2001*. Derived from the California Institute of Rural Studies.

U.S. Census 2002 Summary File 1 (www.census.gov).

U.S. Department of Labor, Bureau of Labor Statistics, full report. 1998.

U.S. Department of Labor, Office of Public Affairs. OSHA National News Release, February 2002.