PROCEEDINGS OF THE U.S.-MEXICO BORDER
CHILD AND ADOLESCENT HEALTH FORUM

Social Determinants of Health
Access to Care
Health Conditions and Health Disparities

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# Table of Contents

**Purpose and Objectives** .............................................................................................................. 4

I. Opening Remarks .......................................................................................................................... 4

II. Presentations ................................................................................................................................. 9

   A. Children’s Health Conditions in the U.S.-Mexico Border Region. ............................................. 9
       Texas KIDS COUNT: Our Border, Our Future ................................................................. 9
       Salud en la infancia de la frontera norte de acuerdo: al reporte La Infancia Cuenta en a Frontera Norte (2008) (Children’s Health at the Northern Border According to the Report Kids Count at the Northern Border, [2008]) ........................................... 11
       Questions and Answers: Children’s Health Conditions in the U.S.-Mexico Border Region, I .... 13

   B. Children’s Health Conditions in the U.S.-Mexico Border Region, II ....................................... 15
       Determinants and Conditions of Children’s Health in Mexican Border States/Municipalities ...... 15
       Determinants and Conditions of Children’s Health in U.S. Border States and Counties .......... 17
       Question and Answers: Children’s Health Conditions in the U.S. Mexico Border Region, II .... 19

   C. Social Determinants of Health.................................................................................................. 20
       Social Determinants of Health ............................................................................................ 20
       The Role of Border Trauma Exposure on Children and its Impact on their Mental Health and Substance Use .......................................................... 22
       Questions and Answers: Social Determinants of Health ................................................... 25

   D. Health Status and Disparities in the U.S.-Mexico Border Region ............................................... 26
       Why Childhood Obesity Must be Integrated into All Discussions about Border Health ....... 28
       Questions and Answers: Health Status and Disparities in the U.S.-Mexico Border Region ...... 32

   E. Access to Health Care ............................................................................................................ 34
       Access to Health Care Services ......................................................................................... 34
       Children Our Border, Our Future. ...................................................................................... 37
       Questions and Answers: Access to Health Care .................................................................. 40

Workgroup Sessions ......................................................................................................................... 41

   Workgroup 1: Best Practice Interventions in Children’s Health .................................................. 41
   Workgroup 2: Children’s Health Research ..................................................................................... 44
   Workgroup 3: Children’s Health Policy ......................................................................................... 45

Prioritization of Recommendations: Policies, Research, and Best Practices for Improving Children’s Health Care Today and in the Future in the U.S.-Mexico Border Region .................................................. 48

Results of Workgroup 1: Best Practices ......................................................................................... 48

Results of Workgroup 2: Research .................................................................................................. 50

Results of Workgroup 3: Policy ....................................................................................................... 50

Appendices .................................................................................................................................... 52

   Appendix 1: Agenda ..................................................................................................................... 52
   Appendix 2: List of Registrants .................................................................................................... 55
   Appendix 3: Presentations ........................................................................................................... 64
PURPOSE AND OBJECTIVES

The Offices of Border Health of New Mexico and Texas, in coordination with the U.S.-Mexico Border Health Commission, organized and hosted a one-and-one-half day forum to analyze the status of children’s and adolescents’ health along the United States-Mexico border and propose a series of strategic initiatives to improve healthcare access and health outcomes for children and adolescents. The forum was held June 2-3, 2009 at the Camino Real Hotel in El Paso, Texas. The forum consisted of a series of invited presentations by leading border health experts and children’s and adolescent health practitioners in plenary and separate work sessions dealing with: i) social determinants of health; ii) disparities in health status; and iii) access to health care.

The results of the forum, together with a critical review of previous research, current policies, and health data, will form the basis for the preparation of a white paper to be presented to the U.S.-Mexico Border Health Commission (USMBHC) as guidance for future programming in the development of policies, research agendas, and extension of proven best practices to other parts of the border region.

The forum was a precursor event to the 67th Annual Meeting of the U.S.-Mexico Border Health Association (USMBHA); the preliminary results of the forum were presented during a special plenary session at the meeting. The forum included many USMBHA members. Participation in the forum was by invitation only. There were 125 participants and 10 speakers. All six Mexican and four U.S. border states, as well as federal and national organizations and agencies, were represented.

The forum was organized into three half-day sessions. The first half-day session included an overview of children’s health data profiles for U.S. and Mexican border states and counties/municipalities. The second half-day session featured invited presentations by leading children’s health researchers and practitioners that further analyze children’s and adolescent health from three perspectives: social determinants of health, health status and disparities, and access to health care. During the third half-day session, participants and invited speakers broke into three workgroups to analyze and propose recommendations to improve children’s and adolescent health in the border region from the perspectives of policy, research, and best practice interventions.

The forum organizing committee was coordinated by the Offices of Border Health of Texas and New Mexico and included representatives of the Mexican Section of the USMBHC, the Mexican Secretariat of Health’s National Center for Child and Adolescent Health (CENSIA), and the Pan American Organization of Health/U.S.-Mexico Border Field Office (PAHO). The committee was supplemented by contracting a consultant, who acted as secondary sources researcher, data compiler, and scribe for the forum. The consultant will also prepare a white paper that focuses on binational approaches for improving children’s health status and access to care. Logistics for the organization and delivery of the forum were handled by staff of the Offices of Border Health of Texas and New Mexico.

I. OPENING REMARKS

Paul Dulin, Director of the New Mexico Office of Border Health, opened the forum by greeting and welcoming participants and explaining the purpose of the forum. Mr. Dulin emphasized the importance of child and adolescent health for the future of the border region. He cited increased concern about the health status of children and adolescents in regards to obesity, noting the strong correlation between obesity, diabetes and other health problems.

He also emphasized the Commission’s goal in supporting this forum: “The Commission wants guidance. Going forward with a five to 10 year strategic planning horizon, where should the Commission put its efforts?”

Mr. Dulin then reviewed the agenda before introducing the introductory panel of speakers from both Mexico and United States.
Manny de la Rosa, M.D.
Founding Dean of University of Texas El Paso Medical School
USMBHC Member from the State of Texas

Dr. de la Rosa welcomed participants, emphasizing that the room was full of “familiar faces” and that the people working in border health “know each other very, very well.” He pointed out that the people in the room work together across the border on many issues. Dr. de la Rosa also observed that both central governments, whether northern or southern, don’t understand the U.S.-Mexico border. He noted that the border is geographically different and geographically isolated from our central governments. He emphasized the importance of local liaisons in the border region, including sister cities and agreements developed at municipal levels rather than at the federal level.

Dr. de la Rosa reminded participants that the Commission was established as a venue for having the discussion about how to affect health along the border. The Commission continues to have these discussions about the needs of the border region – at local, state, and national levels – and to codify communication channels along the border. It is necessary not only to have the conversations, but to document them. Dr. de la Rosa also noted that this forum was the first of a planned series, “and what better focus than our future: children on both sides of the border.”

“We need to continue to have the communications open, clear, and consistent, because we know each other very, very well.”

Dr. de la Rosa observed that it is necessary to agree upon some definitions as we begin to have the discussions and begin to compare data. He reviewed the definition of the U.S.-Mexico border adopted by the La Paz agreement and used by the Commission, reminding participants that the focus area extends 100 kilometers on each side of the political line. He also noted that while people working and living in the border region understand that definition, he wasn’t sure that our federal governments understand it.

“We occasionally receive from our federal governments requests to have conversations in Chicago, Chiapas, about factors that affect bilateral exchanges of resources. But that’s not a border conversation. We need to be able to focus our conversation on the issues that affect the border.”

Dr. de la Rosa also noted that data between the two countries are often not comparable; there is a need for researchers to come to agreements on data protocols. He cited as an example the U.S. definition of adolescents, which extends to age 21; Mexico has a very different definition. So when researchers in the two countries compare national statistics, they are not talking about the same thing. “We’re talking about bananas and limones,” he said. He noted that an agreement is needed, and that one of the challenges is identifying some of the resources that are available. “We’ve done a very mediocre job of pulling some of the resources together,” he said. He noted that many resources available on the border remain unidentified. He cited universities in particular as underused resources to bring and focus research on the border, observing that there was representation from many different universities in the room. Dr. de la Rosa closed by welcoming the members of the U.S. Mexico Border Health Association who were present.

Luanne Southern, M.S.W.
Deputy Commissioner of Health, Texas Department of State Health Services.

Ms. Southern greeted and welcomed the participants to Texas on behalf of the Texas Department of State Health Services and Commissioner Dr. David Lakey. She congratulated the Commission for sponsoring this forum to address child and adolescent health and thanked the organizing committee.
“During more than 20 years of addressing mental health needs of children, youth, and families, I have held that it is the stories of the children and families we have worked with that we keep in our hearts, that keep a fire in our bellies for the work. I hope after all of us leave this event we will carry that fire in our bellies as we go forward to do our work.”

Ms. Southern cited several recent national reports on children’s health that have reemphasized the need to address child and adolescent well being through a public health approach. This approach focuses on the importance of early intervention, health and mental health promotion, and illness and disease prevention. Much emphasis has also been placed on the importance of access to care, which she defined as access to an array of services that are evidence-based and address risk factors such as exposure to trauma, obesity, substance abuse, tobacco use, and sexual activity. Several common approaches define best-practices approaches for children and adolescent health. She reviewed common elements and principles in best practices for promoting health among children and adolescents. These were:

1) Services should include prevention: for example, prenatal care, immunization, educating new mothers about postpartum depression, conflict resolution, violence and child abuse prevention, dropout prevention, and substance abuse prevention.

2) Services should include health and mental health promotion: for example, promoting healthy development of children through health education, drug and alcohol education, and educating parents about child development so they can recognize problems in very young children and seek care.

3) Services should include early monitoring of and intervention in behavioral health issues so young children are able to learn by the time go to school.

4) In addition, she said, services should incorporate certain principles:
   a. Services should be strength-based and solution-focused. We need to build on the strengths and assets that all children and young people have, rather than focusing on their problems and what’s wrong with them.
   b. Services need to be culturally and linguistically competent. Culture influences every aspect of human development, so services need to be individualized, sensitive, and responsive to the culture and primary language of each individual child and family.
   c. Services should be family-driven and youth-guided. Families should be full partners in decision making and planning. “Can we imagine an obesity prevention program without family support?” she asked. “I don’t believe that would be as successful as an approach that would include a partnership between the child, the school, and the family.”
   d. Services should be community-focused and if possible, neighborhood-focused. Services should be brought to families and children in their neighborhoods. Families should not have to go very far to access services.
   e. Services should be cross-disciplinary. She observed, “We cannot rely solely on the healthcare system to address the needs of children, youth, and families. We have to include schools, the faith-based community, health, sometimes law enforcement, sometimes child welfare and juvenile justice, mental health, and social services providers.”
   f. Services should be integrated. Primary and behavioral healthcare issues co-occur on a regular basis. Families often access care first through their primary care physician, pediatrician, or nurse-practitioners. Many times parents go to these providers because their child has behavioral issues that need to be addressed.

“We cannot rely solely on the healthcare system to address the needs of children, youth, and families. We have to include schools, the faith-based community; health, sometimes law enforcement, sometimes child welfare and juvenile justice; mental health; and social services providers.”
Ms. Southern then turned to a brief discussion of Texas’ border region in comparison to the entire U.S.-Mexico border, noting that health disparities are not reflected uniformly across the border region. The Texas border population is significantly younger than the U.S. population and the population in other U.S. border states. She noted that birthrates are high in the border region, a trend expected to continue. The Texas border population is 85 percent Hispanic, compared to other border states with populations that are no more than 45 percent Hispanic. Income, educational attainment, and obesity are health disparities that are particularly evident along the Texas-Mexico border.

“It is critical that we learn from one another, share best practices, and work toward joint solutions and policies.”

She noted that in 2008, with the support of the Commission, Texas had convened a strategic planning meeting of 12 of the 15 sister city binational community health councils. Two tiers of priorities were identified. Tier one priorities included diabetes, obesity, and nutrition, and tuberculosis; tier two priorities included dengue fever, early warning infectious disease surveillance, mental health, substance abuse, domestic violence, HIV/AIDS, and sexually transmitted diseases. Child and adolescent health and well being are relevant to several of those priorities, she concluded.

Lic. Clemente Villalpando
Executive Secretary, Mexican Section, U.S.-Mexico Border Health Commission.

Lic. Villalpando began by thanking the conference organizers, participants, and the Commission for the opportunity to come together to address children’s health issues in both countries. He emphasized the importance of the work of the forum and of sharing that work, adding that the participants were the key to making this forum successful. He noted the importance that the results of this conference be disseminated widely and used. There is no excuse not to take this information to all corners. We also need to recognize that healthcare is a right for children and all people. For both Mexico and the United States, the most important focus is on our children along the border.

“Infants and children have the right to these services independent of their race, color, religion, or language.”

Lic. Villalpando noted that there were many similarities between the two countries regarding children’s health issues along the border. He observed that we have the opportunity to work for the health of our children, and we hope in the future children will be able to work for the health of us – as adults. He also recognized all of the initiatives that have been created along border in relation to health.

“In both Mexico and the United States, our children are the most important reasons we need to continue our work. We will work for different solutions; we are gathered here to work on these solutions.”

Lic. Villalpando concluded by emphasizing again the importance of focusing on children along the border and their health and healthcare. He observed that this forum provided an opportunity to learn about the challenges we face in ensuring better health for our children.

“I hope that during this forum we can plant a seed so that we can continue to do the work that we do around healthcare in the U.S.-Mexico border.”
Dr. SanFilippo opened by recounting some his own experiences as a health practitioner working in Las Cruces, New Mexico, where he has practiced medicine in safety-net settings since 1982. He pointed out the stark contrast between his training as chief resident at an elegant clinic in San Francisco and the realities of practice in the border region.

“In my training at the University of Iowa, I took care of 2 million people. During my first year of practice in Las Cruces, I saw more child trauma, intentional and otherwise, than in five years there.”

Dr. SanFilippo then offered suggestions to participants for taking best advantage of the forum, emphasizing the importance of the workshops as a means to develop priorities using data that would be presented in the first portion of the forum. He also noted that the conference proceedings and white paper would be important products designed to influence legislators and policy makers. These data-centric products can be used to influence policy makers by shaping their intentions and composing norms that represent the best social and cultural values in the United States of America. It is also important to hear personal vignettes, personal stories.

Next, Dr. SanFilippo turned to a discussion of healthcare systems and emerging understanding of the influence of social systems in health and disease. Just as understandings of population health have evolved past disease-specific interventions, he noted, we are now evolving beyond behavioral health. We are looking at social, not physical health in the future. These social changes are going to require that we rethink many of the norms in our societies. We’re going to need to look at violence, security, fear, loss of trust in each of our societies. That means we have a lot to do – “we” being researchers, practitioners, and Commission members. He pointed out that these social changes will have a tremendous impact on health care.

It’s important for us to start with our essence, to build from the social capital we already have. In thinking about health care as a complex, adaptive system, it’s important to think about health care as more than just a set of individual decisions.

Dr. SanFilippo concluded by paraphrasing from former Commission member and Secretary of Health of Mexico, Dr. Julio Frenk, now Dean of the Harvard School of Public Health:

When we see 10 million children die of unnecessary causes in poor countries, it presents an ethical dilemma for all of us who are privileged to live in the United States. These children are not dying from rare diseases; we have the tools to prevent the death of a child. Apart from these humanitarian considerations, our world neighbors need to have healthy children and healthy adults to be able to grow economically. All of this in turn benefits the U.S. economy. Finally, in those countries where children die early and mothers die in the act of giving life, injustice breeds. This injustice can lead to unrest and, eventually, to the terrorist mindset that seeks to redress injustices through completely unacceptable means.

Jack Callaghan, Ph.D.
Director, Public Health Division, New Mexico Department of Health

Dr. Callaghan opened by thanking both the panelists for joining and the Commission for hosting the forum. He applauded the forum’s focus on children and adolescents. He noted that, from the perspective of the New Mexico Department of Health, New Mexico has multiple borders, including the neighboring states of Texas, and Arizona, as well as Chihuahua, Mexico.
Dr. Callaghan observed that New Mexico’s Secretary of Health, Dr. Alfredo Vigil, who is also a medical practitioner, is trying to lead New Mexico in terms of the border health issues that participants would be addressing next couple of days. He emphasized the strong interconnectedness of Mexico’s and New Mexico’s population:

Approximately 45 percent of New Mexico’s population is first, second, or third generation Mexican heritage. Fully 20 percent of New Mexico residents identify themselves as Mexicans; 20 percent of New Mexico’s border population has no proficiency in English; and Spanish is spoken in more than 50 percent of all homes. New Mexico is closely connected with its neighboring states, both in the United States and in Mexico, sharing everything from economies to burritos and enchiladas, a mainstay of our diet. We also share challenges in how we improve the health of our populations, including our children and adolescents.

In New Mexico, Dr. Callaghan observed, immigrants and migrants receive a host of health services through a network of safety net providers that includes 55 public health offices, 160 community health centers, and numerous providers in rural areas hospitals. The Women, Infants, and Children (WIC) program supports women and their children during pregnancy and early childhood, while low-income residents have many options for accessing prenatal care and children’s medical services. “We believe that in the interest of public health, no one should be turned away from our system.”

Dr. Callaghan concluded by noting that this conference was an opportunity to discuss the myriad needs of children on the border in the areas of behavioral health, physical health, medical care and to take the discussion to a binational level.

II. PRESENTATIONS

A. Children’s Health Conditions in the U.S.-Mexico Border Region.

Texas KIDS COUNT: Our Border, Our Future
Francis P. Deviney, Ph.D.
Texas Kids Count Director, Center for Public Policy Priorities.
Kids Count (Annie E. Casey Foundation)

Dr. Deviney divided her talk into five main topics: socio-demographic characteristics of border children and families, family economic security, overall child health, infant health, and health access along the border.

Dr. Deviney began with an overview of demographics in the border region as a key to understanding health needs and health disparities. Socioeconomic characteristics affect the kind of health care children receive and the kind of outcomes we see. In the United States, one out of four children lives in one of the four border states, and one out of nine children lives in one of the counties adjacent to Mexico. The border has a large population of immigrant families with limited access to health care and other services.

The border states have seen about an eight percent population growth since 2000, driven mostly by Arizona and Texas. Dr. Deviney cited a conversation with a doctor in McAllen who said his hospital “delivered an elementary school’s worth of babies every month.” This population jump is indicative of future pressures for schools, health services, and other systems, she noted.

Immigration status also affects children’s health and access to health care, Dr. Deviney observed. In the border region, one in five children lives in immigrant families; in Hidalgo, County, Texas, that ratio is about 60 percent. Most of those children are U.S. born and eligible for health services, although half of their parents are not citizens. Because of the way policies are structured, the children are eligible but parents often do not want to use services because they are trying to get permanent residency. They are afraid it will represent a black mark on their record.
Next, Dr. Deviney addressed family economic security in the border region. She pointed out a huge disparity in median household income between families living in border and non-border regions. In Texas, families living in urban settings in the border region have lower household incomes than those living in rural non-border counties. This points to policy decisions that can be made to bring jobs and more economic activity to the border. While median income in the border region is going up steadily, compared to inflation, it has reached a plateau.

Income differences between the border and non-border regions of the United States are reflected explicitly in child poverty data. Child poverty is not unique to border states; Census data show that child poverty is highest in the southern United States, Texas, and New Mexico. Dr. Deviney explained that when you “zoom in” on those data and compare border counties to non-border counties, you see that poverty is much, much higher in border counties, particularly in Texas and New Mexico. This is not seen in California, largely because San Diego is a fairly wealthy county. By drilling down from state to local, county-level data, researchers can start to really see where the problems lie for families. She emphasized that while immigrant families are more likely to lack economic security, the issue is jobs and economic opportunities available to those families.

In short, families living in the border region have a lower median income and wages are not keeping pace with inflation. The border region has the highest concentration of child poverty in the United States, and poverty is particularly high for children in immigrant families in border counties.

“When families feel strapped, when health insurance isn’t offered through your business, what are you going to do? It’s going to be one of the first things you cut.”

Dr. Deviney next addressed overall child health in the border region, using information from a Data Resource Center report that had been published the previous week. For the report, researchers examined the percentage of children who reported excellent or very good health. All of the border states showed a significant percentage of children in the border reporting poor health.

Infant health was a major focus of the report. Dr. Deviney focused much of the rest of her talk on infant health issues in the border region, including the “Hispanic paradox” (i.e. surprisingly good birth outcomes among Hispanic border residents despite multiple risk factors such as lack of prenatal care). While infant mortality does appear to be lower in some of the border regions, she proposed that data on infant mortality needs to be segregated. Infant mortality is a child who passes away before his or her first birthday. She observed that public health and clinical practitioners need to know at what age the infant died: fetal, neonatal, or post neonatal. Most infant mortality happens during the first month of life for very low birth-weight babies. Knowing this has an impact on the tactics public health and clinical practitioners take to improve infant mortality. For instance, if the infant was low birth weight, did the mother have adequate prenatal care?

When infant mortality data are analyzed in this way, they show that the pattern is the same in the United States and the border, even though the border is doing better overall. Most infant mortality happens during the first month of life among very low birth weight babies, many of whom are premature. This helps to show where we need to focus our efforts: on maternal health and premature births. Maternal health includes preconception health, starting at age 14 though the conception years. It also includes making sure women access good health care as soon as they find they’re pregnant.

Dr. Deviney observed that in Texas and across the border, preterm birth is quite common and one of biggest drivers for low birth weight babies. However, this is not unique to the border. Preterm birth is also common throughout the southern United States.

Prenatal care data show that in Texas, 40 percent of women in the border region receive late or no prenatal care. Adequate prenatal care is driven by the education level of the mother: 50 percent of women with less than a high school education have late or no prenatal care. Even among women who have graduated, one out of five women
in the border region has late or no prenatal care. She suggested that targeting those women with less than a high school education or only a high school education could be very effective in reducing preterm births and thus improving birth outcomes.

Another border issue is births to teens. Dr. Deviney observed that Mexico and the United States define teen births differently. In the United States, teen births are defined as births to women ages 15 to 19. Other data show that even at the upper end of that age group, women are more likely to postpone prenatal care, less likely to initiate breastfeeding, and more likely to have other risk factors, which is why Kids Count includes 19-year-olds in their data. In addition, when teen births are looked at by year of age of the mother, another pattern emerges: Older teens are more likely to be having a second or third child. In 2005, eleven 15-year-olds along the Texas border had their second child. In addition to the social, economic, and physical risks associated with teen pregnancy, these rapid sequential pregnancies put families at economic risk and the mother at physical risk with no length of time between pregnancies to recover.

However, Dr. Deviney observed, saying women need to get into prenatal care and having doctors who accept them are two different things. She spent the remainder of her presentation discussing healthcare access for children and adolescents in the border region. She observed that women in the border region are less likely to have private insurance; the rate of privately insured individuals is consistently dropping every year in Texas. Texas has had the honor of having the worst uninsured child rate in the country for the past decade. Arizona had a higher rate in 1997, but Texas “took it back,” she noted. In Texas, this may be partly due to a six-month reenrollment for Medicaid, a policy that Kids Count is lobbying to change. The frequent reenrollment period, she said, allows “a lot of kids to fall through the cracks and lose their health insurance coverage.”

But having more children enrolled in Medicaid does not solve the problem of healthcare access. Texas border counties have fewer doctors to serve children and families than the rest of the state. In addition, across the state, doctors are less likely to take Medicaid clients, largely because of low reimbursement rates for Medicaid claims. Doctors cannot afford to take on more Medicaid patients until Medicaid payouts are increased.

Dr. Deviney also pointed out that children in the border region are less likely to have a medical home than in other states. Border states are also less likely to offer preventative care to children and adolescents. Likewise, border states have the highest concentrations of uninsured children.

“If we zoom in on the data and concentrate on border counties, we see a huge population of uninsured children: an estimated 1.5 million. About half of those children are currently eligible for Medicaid and/or SCHIP. That’s an outreach problem and a policy problem.”

Dr. Deviney ended her talk with a call for more and better data about binational families. Although there are one million legal crossings every day, local, county-level data about families who straddle the border is limited. “We need to start looking for data that starts to capture the idea of a binational family,” she stated. Although individual studies exist, there are no good census data, nor is there consistency in those data that do exist.

Salud en la infancia de la frontera norte de acuerdo: al reporte La Infancia Cuenta en la Frontera Norte (2008) (Children’s Health at the Northern Border According to the Report Kids Count at the Northern Border, [ 2008])
Lic. Sandra Patricia Carmona

Lic. Gerardo Sauri, Executive Director, Red por Los Derechos de la Infancia en Mexico (Mexican Network for Children’s Rights), was scheduled to present. However, he was unable to attend the forum because of a medical emergency. In his stead, Lic. Sandra Patricia Carmona presented data from Kids Count at the Northern Border 2008, the
second regional report published by the Mexican Network for Children’s Rights (Red por Los Derechos de la Infancia en Mexico [REDIM]). The report was the result of a collaboration between Southwest Kids Count, sponsored by the Annie E. Casey Foundation, and REDIM.

The mission of the REDIM is to “promote a social and cultural movement so that children and adolescents know, practice, and enjoy their rights.” The report is part of a system of indicators designed to document the situation of children in Mexico and their rights. The report provides reliable and accessible information to help policy makers make legislative decisions and create policies affecting children, resulting in better actions to ensure their rights.

Like Kids Count reports generated in the United States, the report focuses on children’s rights and well being. Lic. Carmona noted that the researchers wanted to create a mirror image of studies going on in the southern border of the United States, focusing on families. Data collected for the report included demographic characteristics, family life and living conditions, family economic well being, education, health, and migration and safety.

“We’re not only going to take care of children, we’re going to get to know them as persons who have rights like everyone else.”

Lic. Carmona expressed hope that the current administration in Mexico will be able to see the rights of children as important. There’s a lot of work to be done, but hopefully children’s advocacy groups and policy makers will be able to talk in the same language. Lic. Carmona noted that Somalia is the only country that has not adopted a children’s code of rights and suggested it is time for a discourse between the United States and Mexico regarding children’s rights in the border region. She also observed the Mexico has much of the same information about children as in the United States. Kids Count Mexico is being generated to provide accurate information to policy makers, open up communication, and improve children’s well being. Kids Count data have been collected and updated for the last ten years, allowing researchers to gain objective information about the status of children in Mexico.

In the six Mexican border states, there are 38 municipalities, and these territories are about 10 percent of the national area. About two million children, about 35 percent of the 6.3 million children in Mexico’s six border states, live in these municipalities. The percentage of children varies between municipalities. The highest is in Nava, Coahuila, where 4 out of 10 people are children; the lowest is in Manuel Benavides, Chihuahua, where children account for three out of every 10 people. However, these numbers are probably an underestimation of the child population in these areas. Many births are not recorded officially, especially in rural areas (midwives, family-managed births, etc.). Thus, there is not a good accounting of how many children are actually living in certain areas.

“Many people are very concerned about children in Mexico, but their rights are often not considered.”

The data presented by Lic. Carmona focused on children 0 to 17 years of age, broken into age categories, starting with 0 to 8. While efforts are made to register those up to age 17 through this organization, she noted that adolescents “don’t want to be called a child,” so the process may need to be different for them.

Overall, children on Mexico’s northern border are much better off than in other areas of the country. However, Lic. Carmona pointed out, there are some troubling trends. For example, to go to school or to have access to healthcare services, children need to be registered. About 20 percent of children under the age of one are registered with Vital Records but may not have a birth certificate. In 20 of the 38 border municipalities the percentage registered with Vital Records decreased by 20 percent between 2000 and 2006, a trend she called “quite alarming because we’re talking about around 20 percent that didn’t go to school.” Of the 38 border municipalities, in Talla Baja the percentage of children who do not go to school increased between 1999 and 2004. However, in all the border municipalities, these numbers are still lower than the national rate.
Another troubling trend is seen in access to health care, Lic. Carmona noted. From 2000 to 2005, the percentage of children in the border region without access to healthcare services dropped from 42.3 to 36 percent. However, in four of these municipalities, the percentage has increased, and in fourteen of them, the percentage of children without access to care is higher than the national level of 53.7 percent.

Lic. Carmona observed that one indicator of malnutrition is the percentage of children in the first grade with short stature, or stunting. In 11 of the 38 border municipalities, the prevalence of stunting increased between 1999 and 2004. However, in all border municipalities, this figure is lower than the national average.

Even though the United States and Mexico have different cultures, Lic. Carmona noted, both cultures agree that having a child early is a problem: Some children are born to children. In the northern part of Mexico the percentage of 15 to 17 year olds having children is much higher than in the rest of the country. The national birth rate for teens ages 15 to 17 is 5.3 percent. In the municipalities of Hidalgo, Coahuila, Manuel Benavides, Chihuahua, and Saric, Sonora, 20 percent of adolescent girls are teen mothers.

Lic. Carmona then turned to a discussion of environmental factors and children’s health, noting that children’s home environments are as important an influence on children’s health as many of the economic indicators that she had discussed. Lack of running water in the home is associated with acute gastrointestinal diseases and infant mortality. The border rate for this indicator fell from 28.3 to 15.7 percent of between 2000 and 2005, better than the national average 48.4 to 38.5. Although it may seem that the situation on the northern border is one of the best in the country, four of the seven municipalities of Coahuila have higher percentages than the national average. In Ocampo, for example, seven out of every ten children do not have water in their homes.

“In these different municipalities, two out of ten children do not have water in their homes. We’re not talking about just one family, but many different families. Water should not be a question; it should be something there for free. Water is a fundamental right. If we have good water we can stop illnesses and decrease infant mortality.”

Living in a home with a dirt floor increases the risk of lung diseases such as asthma, she noted. The border region appears to fare better than the rest of the nation on this indicator; however, in some areas of the border rates have increased.

Although the border overall fares better than the rest of the nation on these indicators, 8 of the 38 border municipalities have “gotten stuck,” said Lic. Carmona, with children still living in homes without running water and with dirt floors. She concluded that health advocates need to continue to address quality of life for children in their home environments.

“Rights are not just one thing here and another thing there – they have to be interconnected. To be capable of improving children’s health we have to pay attention to their rights in other areas – for example to have a good clean place to live.”

Questions and Answers: Children’s Health Conditions in the U.S.-Mexico Border Region, I

Question/Comment:
Alex Padilla
University of New Mexico New Mexico Border Consortium
It is very important that you bring up the issue of children’s rights; in tomorrow sessions, we need to use the data you have presented. I believe we have a grave responsibility during these workshops to address these issues. I think that we need to try to find a balance on the emphasis of rights for children and access to healthcare, including immunizations. There’s a high risk of considering these two discussions as incompatible. When we discuss the rights
of children, one of those rights should be that children receive their immunizations on time. How do we go about finding concrete questions and an adequate balance between children’s rights and children’s health? In the areas of health, what would be your suggestions?

Lic. Patricia Carmona responded: I think that if we look at the rights of children we will be able to help their well being. In terms of analyzing information and indicators, the data don’t always provide all the correct information. Many of the indicators are not distinct. It depends on places and families being included. We need to look at the different places where people live and the different family situations in which they live, because we’re talking about children. How can we work to ensure that all of these resources are available for them?

Question/Comment:
If we are really going to talk about children’s rights we also need to figure out that we as adults are part of that space. We have some direction over these statistics. How many women are we seeing? How many young women are we seeing? How many adults are having children in families with members who are smokers, using recreational drugs, or engaging in other risky behaviors?

Answer:
Dr. Deviney responded: Most of the births are to young women – women out of their teens. The majority are not happening with teen moms, although they do constitute a significant proportion. That said, women without a high school education, who are at the highest risk of having low birth weight babies, cross over the age range. Although the issues in the two countries are different, the focus on the rights of children is the same. As adults we are the ones that choose. In the United States, we should pose the same question. The answer may take a different form. Do we see health care for children as a basic human right? We really posed that question to the Texas legislature, which ended yesterday. On several major bills, the answer was no. We advocated for a move from a six to a 12 month renewal period for Medicaid. The second bill was a measure to allow lower middle class families to be able to buy into a children’s health insurance program. Neither bill passed. Even the governor said he didn’t think the majority of Texans supported a bill to allow children to buy into health insurance. It’s going to have to come from a grassroots voice that says, no – you’re wrong. We do believe that every child has the right to healthcare.

Question/Comment:
Is low birth weight for teens related to tobacco use? Did you find any correlation?

Dr. Deviney responded: We don’t have the data broken down by border use. The percentage of smokers is very low generally, but we could get it broken out by age.

Question/Comment:
Melanie Goodman, Field Representative
Senator Jeff Bingamen
Are women in urban border counties more likely to have late or no prenatal care? Can you talk about rural versus urban rates of prenatal care?

Dr. Deviney responded: For our studies, we focused on those counties that actually touch the border. Of those, in Texas, four were considered urban (El Paso, Webb, Cameron, and Hidalgo). I don’t have a good explanation for why that is. We do know that the medical centers that exist are in the urban areas. This is a question I would pose back to the group, given your personal experiences in the communities.

Paul Dulin responded: One proxy measure might be federally designated Health Professional Shortage Areas.
Determinants and Conditions of Children’s Health in Mexican Border States/Municipalities

Dra. Diana Coronel

Mexican Health Secretariat/National Center for Children’s and Adolescent Health (CENSIA)

Dra. Coronel shared data on the health of children in the border region of Mexico. She emphasized the importance of reviewing the specific data on each side of the border in both Mexico and United States and looking at trends over time. She opened with information on causes of death for children in Mexico less than ten years of age, pointing out that the majority of these numbers did not change significantly between 1990 and 2005.

Dra. Coronel noted that Objective 4 of the United Nations Millennium Goals 2007 is to “reduce mortality among children less than five years of age.” She reviewed Mexico’s standing on four goals related to that objective: overall mortality for the age group, mortality due to gastrointestinal illnesses, mortality due to respiratory illnesses, and infant mortality. She observed that not only on the border, but worldwide, the most important influence on infant mortality is maternal health. Throughout Mexico, poor maternal health continues to be a problem.

She emphasized the importance of the Millennium 2007 objectives and noted that poor maternal health and child mortality are problems worldwide. She also noted that child mortality rates varied widely within Mexico.

Dra. Coronel observed that there are problems with data collection in Mexico. Although Mexico has different institutions that collect information, researchers must work through projections. Dra. Coronel observed that much information is missing, largely because of poor reporting. She noted that child mortality rates appear to be very different from those reflected in the data.

“We say we don’t have any problems but we have a child who dies in the back yard and nobody knows; that death is not reported.”

Dra. Coronel pointed out that on most measures of children’s health, the northern states are doing better than the southern states. In terms of both infant mortality and overall child mortality, rates in border states were lower than the national mean. The highest mortality rates for children under five were in Chiapas at a rate of 32.8 per 100,000. Rates in Chiapas were 15.9 higher than in Baja, California.

“The northern states are much better off than the southern; they are more favorable for our children.”

Dra. Coronel then reviewed causes of mortality for children in three different age groups: zero to four, five to nine, and 10 to 19. She noted that, as shown on the pie charts of mortality causes, “other” was the most frequent category for each age group. “I don’t like that term,” she said. “If we don’t know, we just toss it into the general melting pot.” If public health practitioners do not know exactly what the cause of death was, and if they don’t have the data, then they cannot address the root causes of those deaths. She suggested that data-gathering efforts need to become more organized so that the accuracy of these data can be proved. She expressed hope that sometime in the future CENSIA will be able to provide more accurate data for maternal health status, causes of infant death, and causes of maternal child health deaths.

In terms of mortality for children under five years, the most frequent known cause of death is asphyxia or trauma at birth; the second is congenital heart defects. These factors point to the importance of addressing maternal and child health. For children five to nine, the two most frequent known causes of death are motor vehicle collisions and leukemia, both at 12 percent. Cancer rates are rising among children. In the 10 to 19 year-old age group, leading causes of death were motor vehicle collisions, pedestrian versus motor vehicle accidents, and suicides; leukemia dropped to fourth.
It is important to track these different patterns of mortality in order to develop different strategies to address causes of death, Dra. Coronel noted. She observed that infectious respiratory diseases are still a significant cause of mortality among children, despite implementation of strategies to address the issue.

In terms of children’s mortality throughout Mexico, the state of Chiapas had the highest mortality rate (32.8 deaths per thousand children under five years of age); this was 15.9 times higher than in Baja California Sur (2.1), and exceeded the national rate of 14.2 by 2.3 times. The national rate, however, has been going down. In 1990 the national mortality rate was 19.2; it is now 14.2. In comparison to other states across the nation, border states are doing better.

Dra Coronel then turned to a discussion of preventable diseases: gastrointestinal infections, respiratory infections, and malnutrition. She noted that rates for all had improved dramatically since 1990; however, there is still great variance between different states and municipalities.

Dra. Coronel observed that deaths due to diarrheal illnesses were largely preventable, yet children continue to die due to these infections. The national mean for children’s mortality due to respiratory illnesses is 18 percent. This is partly because many children are growing up in situations that put them at risk for respiratory problems, for instance living in a home with a wood-burning stove. In seven states throughout Mexico, including Chihuahua, the rates are higher than the national mean. In the other five states in the border region, rates are lower than the national mean. However, respiratory illness due to viral and bacterial infections is also a significant problem in the border region, especially in the states of Chihuahua and Coahuila. Although children in Nuevo Leon generally fare far better than the national mean, the incidence of both pneumonia and asthma incidence peaked significantly in Nuevo Leon during 2001-2002. She noted that this anomaly remains unexplained, although it appeared to be related to external factors such as chemical exposures.

The most dismaying data, Dra. Coronel observed, were regarding the prevalence of teen pregnancy, abortion, and birth. Teen pregnancy and birth rates have increased since 1990, and abortion rates have also increased. Teen pregnancy is a significant problem in the border states. Rates are almost twice the national mean in Baja California and Nuevo Leon, and almost three times the national mean in Sonora. Malnutrition, Dra. Coronel noted, affects a significant portion of Mexico’s children. She presented data on mild, moderate, and severe malnutrition in both infants less than one year of age and preschoolers (1 to 4 years of age). Among border states, Chihuahua and Sonora are most affected; in other border states, malnutrition rates are generally lower than the national mean.

She next turned to injury data for children in Mexico’s border regions. From 2003 to 2007, rates varied widely in border states; in some states, rates increased and then came back down. However, she noted, many injuries in children are not reported, leading to disparities between the data and actual rates.

Dra. Coronel’s last topic was cancers in children in the border states. Leukemia is the leading cause of cancer death in children in all border states. Leukemia causes 55 percent of all cancer deaths among children in Baja California and 68.57 percent in Coahuila. Dra. Coronel emphasized the importance of good surveillance tools to ensure that cancer deaths are reported accurately; such a program would allow improved services for these geographic areas. “The public organizations I mentioned are working together but not seeing everything, because many children are not being registered with Vital Records. Health problems may be reported to a physician, but doctors are not reporting those problems to data-gathering institutions.”

In conclusion, Dra. Colonel noted that public health infrastructure in Mexico is inadequate for many of these programs to continue and resources are inadequate to support them. It is difficult for the border states to be able to work on these issues, and many children continue to live with these types of conditions.
Determinants and Conditions of Children’s Health in U.S. Border States and Counties
Sam Notzon, Ph.D., Director of International Statistics
Centers for Disease Control and Prevention/National Center for Health Statistics

Dr. Notzon opened by acknowledging his ties to the border region. Although located in the Washington D.C. area, he was born and raised in Laredo, Texas. “Be assured I do my best to tell everyone in Washington about the border,” he said. He also acknowledged his coauthor Juan Albertorio, who assisted in putting together data for today’s presentation. Dr. Notzon also observed that a lot of the data come from a draft report that is still in process but that he hopes will be published soon. The report contains “a lot of very useful information that I know our data community will find useful.”

He also noted that “because I’m a data person working for a data organization; I’ll talk about the data sources and some of the measurements issues.” He observed that there would be some overlap between his presentation and the Kids Count data just presented; however, he said he felt the repetition was justified, considering the importance of social determinants of health. He would also look other issues concerning various measures of disparity; despite differences in data sources, in most cases his findings agreed with the Kids Count data. When it did not agree, he said, he would talk about why.

Dr. Notzon began his presentation of data with a map of the border region, acknowledging that forum participants had probably “seen this slide a hundred times.” However, he said, he wanted to point out that most data about the border region come from counties, and he wanted the audience to be aware of that restriction.

Dr. Notzon outlined the demographic characteristics of the border population. He said that growth doesn’t appear to be happening as fast as from 1990-2000, based on 2006 estimates. However, he cautioned, the Census Bureau was surprised in 2000 and that may be true in 2010. The population in the border is growing for all ages and especially for children. There’s been a lot of discussion about the proportion of Hispanics. The greatest proportion is in the easternmost portion of the border, and the proportion trends downward as you go west. In 2000, about half of the overall border population was Hispanic, but 62 percent of children were Hispanic. The birthrate among the Hispanic population is much higher than in other populations.

He also reviewed data on per capita income, which, he noted, the Kids Count presenters had talked about already. He pointed out that there was a big difference between national, border state, and border county income levels, especially between Hispanics and non-Hispanic whites. He questioned whether per capita income was the best measure, turning to data regarding the percent of children living below poverty. This measure shows the same thing: poverty is higher for children in border counties and highest for Hispanic children in those counties. In some border counties, 40 percent were living below poverty, based on data from the U.S. Census Bureau’s American Community Survey (ACS). The ACS, Dr. Notzon noted, is a useful tool for border researchers because it provides county level data. “There are hundreds and hundreds of tables, which are not all that user friendly, but you can get useable data,” he said.

Dr. Notzon next reviewed information on types of households in the border region that have children present, focusing on households headed by single men and single women. These figures were not markedly different from those in the rest of the United States: Roughly one-third or more are single-parent households. One important difference is found in California, where a lower proportion of households is headed by single parents: about 30 percent versus 35 percent. This is important for children in terms of family income and many other influences.

“Disparity increases as we move from the national to the border level. You can take any socioeconomic indicator you want and find the same trend.”
Dr. Notzon’s next topic was maternal health and birth outcomes. He began by reviewing available information on the percent of mothers in the border region who receive timely prenatal care, beginning in the first trimester. The lowest rates tend to be in Arizona and extend to New Mexico. Those levels in some cases have gotten worse rather than better. He noted that birth rates are notably higher among Hispanics. Overall the border rate is higher than the U.S. rate; when that rate is subdivided by ethnicity, the data show that the Hispanic birth rate is notably higher. This holds true not just for teens but for Hispanic women at every age, even those women at the end of childbearing age. Early teen births, defined as births to teens less than 18 years of age, are also extremely high among Hispanics in the border region, higher than the U.S. rate by a factor of about 7. He reemphasized that women under the age of 18 who give birth are at higher risk of adverse outcomes and pregnancy complications.

In terms of attendance at birth, he noted that border counties in New Mexico stand out because of very high rates delivered by nurse midwives. In contrast, births by cesarean section are higher overall on the border than the national rate, which is more than thirty percent. Although substantially lower in Arizona and New Mexico, births by cesarean section are way above average in Texas. In some of the largest of counties in Texas, the cesarean section rate is more than 45 percent.

Dr. Notzon reviewed data on birth outcomes, focusing on low birth weight infants and the Hispanic paradox: “The thing that’s remarkable is that the low birth weight rate for Hispanics in the border region is no different than the low birth weight rate as a whole for non-Hispanic whites. Normally, in most of our populations, as incomes go down, health measures are worse.” In terms of preterm delivery, based on birth certificates, the rate is higher for Hispanics. However, he stated, this is “probably more a mis-estimation of gestational rate.”

“If you look at the birth weights of these preterm babies, it is very clear that they are actually four weeks older than it says on the birth certificate. If you adjust for that, the preterm birth rate is lower among Hispanics than among non-Hispanics.”

Dr. Notzon then turned to a discussion of health status and risk factors. He observed that data regarding health insurance status came from the National Health Interview Survey (NHIS). He also pointed out that surveys that use telephone interviewing don’t reach families without telephones, which generally are poorer families, nor do you reach families with only cell phones. That means you are reaching not a representative sample of the population.

The NHIS data showed that the proportion of children without health insurance in the border states was highest in Arizona and Texas. There is a striking disparity between Hispanics and non-Hispanic whites. In terms of accessing health care, for those who don’t have insurance, cost was an issue. Dr. Notzon reviewed additional data on the percentage of children whose care was delayed or received no care. For the indicator “usual place of care,” community health center clinics are a big source of care, but in particular in California and New Mexico. The difference was primarily among Hispanics as opposed to non-Hispanic whites.

In terms of specific health conditions for children in the border states, the percent of children reporting asthma in last four months was about the same in all four states, while Attention Deficit Hyperactivity Disorder (ADHD) and learning disabilities were highest in Texas and lowest in California.

Data on risk factors showed not too much difference between states in measures for tobacco use or alcohol consumption; in terms of seatbelt use, there was a higher rate in Arizona. The obesity rate was is higher in Texas. However, there are problems with the way the data are measured. High school students are not necessarily reliable when they report height and weight.

Dr. Notzon then reviewed morbidity-related factors for the border. Data from the national immunization survey showed that immunization is higher in border counties. These data were from 1998-2002. Dr. Notzon expressed hope that more recent information would be available soon. Hospital discharge rates were highest for respiratory related ill-
nesses, including asthma. He noted that these data are about children discharged from the hospital, not emergency room data. He also pointed out that diabetes diagnoses were significant. Data were from Arizona, California, and Texas; New Mexico did not provide data. Data on cancer cases, likewise, is available from all states but New Mexico. For leukemias, lymphomas, and central nervous system cancers, the proportions were pretty much the same in the three states reporting data. The percentage of lymphomas and neuroblastomas was smaller. The cancer incidence rates in the three border states were low: Most were not statistically significant. Leukemias are most important.

Dr. Notzon next turned to causes of death for children in the border region. He noted that for infants up to age one, most childhood deaths in the border region stemmed from complications related to prematurity with a large “other” category. But starting with ages one to four, external causes of death become more significant. Traumas are a big issue. The leading cause of death across all older age groups is motor vehicle collisions. Among children 5 to 14, one-fourth of deaths are due to motor vehicle collisions; from 15 to 19, the proportion is almost one-third. Two-thirds are from external causes, including a large proportion of homicides, mostly firearm related. For all children ages 1 to 19, motor vehicle collisions are the leading cause of death. In terms of mortality rates from state to state, the rates are much higher in Arizona and New Mexico. These data are for border states, not counties, because the county-level numbers are too small.

Dr. Notzon finished his presentation with a review of childhood health programs in the border region, with information from a chapter prepared by Paul Dulin for the border health status report to summarize what is being done on the border. These programs focus on access to care, surveillance, immunization, obesity/diabetes, chronic disease, mental/behavioral health, and environmental health. Most of these projects have been awarded “models of excellence” awards. Some were developed by private groups, and some are joint activities of public and private groups. Taken together, they give some idea of what communities along the border are trying to do.

Question and Answers: Children’s Health Conditions in the U.S. Mexico Border Region, II

Comment:
Sam Notzon added: I knew there was something I was missing: Nobody’s mentioned statistics on diabetes. We don’t have good data on childhood diabetes on the border. The same goes for obesity. These are two of the major health issues affecting children on the border, and nobody is tracking it.

Question/Comment
We’re seeing the consequences of obesity in adults and children, including cardiovascular disease and other complications. More and more often these are affecting younger people along the border. We’re also seeing a high incidence of cesarean sections. Can you comment?

Dr. Notzon responded: Good question. It’s curious that cesarean section rates are higher in counties with such great birth outcomes. It’s hard to say if the high c-section rates are necessarily because of complications of prematurity. I haven’t looked recently at data by indication for cesarean sections, as best as you can get from birth certificates. These indications include multiple births, first deliveries to mothers 35 and older, and so forth. In areas with high c-section rates, rates for those indications were very high, so it’s got to be something else. It can be training – for instance obstetrical training that doctors receive – reimbursement, or other things. I honestly don’t think it could be indications.

Dr. R.J. Dutton responded: Texas has partnered with Kids Count to do a sampling of fourth graders with a survey on kids as well as kid’s attitudes. The sample has been designed to be representative of border rural and urban areas. We’re about a year away from these data, and we hope to be able to share those data in the next 18 months or so.
Dr. Notzon responded: Thank you very much. Just a note to other states: You can do the same. Did I mention that in Mexico, NHIS is collecting data on BMI? As part of that we actually do measures of height and weight. The sample is designed to produce reliable estimates for each state.

Question/Comment
Paul Dulin, Director
New Mexico Office of Border Health
I want to know why there are so many problems with the data in Mexico, and what you can do so there can be more data.

Dra. Coronel responded: The principal causes of data problems in Mexico are multiple systems, parallel systems, and problems with conflict. At this moment the national system is being checked. We believe that the most important thing is to review and then identify these systems that are not working.

Dr. Notzon responded: Not in terms of infant mortality, but in the Kids Count presentation, I’d like to stress the need for binational data. One area that is crying out for more work is binational data. I’m still skeptical about low infant mortality rates in those border counties. We can look at the populations with the same characteristics in other states and find substantially higher infant mortality rates.

Another participant commented: I just want to piggyback on Sam’s comment about binational data: I understand the cesarean problem has a lot to do with liability. A lot of cesarean sections are prescribed whether necessary or not, because they don’t have a record of prenatal care.

Dr. Notzon responded: Mexico has highest cesarean section rate in world, about 40 percent (Brazil says it’s higher but the data aren’t good). Why liability concerns would affect that, I don’t know. Maybe there’s an excess of lawyers?

C. SOCIAL DETERMINANTS OF HEALTH

Social Determinants of Health
M. en C. María de Jesús Muñoz Daw, Chief,
Department of Statistics in Chihuahua, Diabetes Association of Mexico

Dra. de Jesús Muñoz Daw focused her presentation on the social determinants of health in Mexico, a key component of health promotion. She opened by reviewing the Ottawa Charter, which defines the promotion of health as the process that allows people to gain greater control of their own health while improving the health of others. She observed that the health status is significantly affected by several conditions, including housing, education, food, revenue, a stable ecosystem, sustainable resources, social justice, equality and peace. These elements, she noted, are fundamental to good health.

Dra. de Jesús Muñoz Daw next addressed poverty statistics in the border states. She defined three levels of poverty, based on income guidelines and the limitation on resources associated with each level:

1) food poverty (alimentaria): not enough income to purchase adequate food;
2) capacity (capacidad): enough income to purchase adequate food but insufficient to cover healthcare and education; and
3) heritage (patrimonio): enough income to purchase adequate food but not enough to cover clothing, housing, transportation, and so forth.
She reviewed statistics on poverty in Mexico, noting that poverty rates have been changing rapidly. In 1990, poverty was low, mostly because work was available. It peaked in 1996 and started to decline after that. In 2006 about 42 percent of Mexico’s population was living below federal poverty level. She noted that in the border states, poverty levels were generally lower than throughout the rest of the nation. Levels of food poverty were far lower – for instance, 1.3 percent of the population in Baja California, compared to 18.2 percent nationally. Among border states, Tamaulipas has the highest poverty rates in all three categories.

Dra. de Jesús Muñoz Daw next discussed poverty in different municipalities in the border region, noting that it was much more complicated than demonstrated by state-level data. She cited extreme poverty amongst the Tarahumara Indians despite an overall low poverty rate in Chihuahua. In terms of poverty trends, she noted that food poverty decreased significantly between 2000 and 2005 in Baja California, Nuevo Leon, and Sonora; the change was not as significant in other border states.

Basic services are lacking in a large percentage of homes in some of the border region, Dra. de Jesús Muñoz Daw noted. In the border states overall, 14 percent of residents live in homes without running water, sewage systems, or electricity. The percentage varies widely from state to state. Sonora and Tamaulipas have the most homes without sewage systems; both states are at levels above the national average. This is a problem that needs to be addressed, she said. In terms of homes that have dirt floors, Sonora has the most in the border region, above the national average.

Dra. de Jesús Muñoz Daw then presented data on wages in each border state, using the geographically determined minimum wage as a guide. She noted that many families in the border region live at or near minimum wage. There is a need to raise or augment salaries, especially in Chihuahua, where more than 19 percent of people live on less than minimum wage. Many of these families don’t have homes.

Income levels are directly related to people’s food buying and consumption habits, Dra. de Jesús Muñoz Daw observed. In Mexico, people who are very low income tend to purchase corn tortillas and beans, often leading to malnutrition as the result of an imbalanced diet. A second problem often occurs in homes with one parent: If that parent is working, she or he has less time to purchase and prepare food. Both children and parent end up eating on the street. Not only is eating on the street more expensive, but they start eating tortas, burritos, sodas, and other high-calorie, low-nutrient foods. They thus move from malnutrition to bad nutrition. She observed that many families now face these types of economic situations.

Dra. de Jesús Muñoz Daw next presented data from 2005 on the percentage of youth and children 15 years of age who were illiterate or did not complete primary school. While illiteracy rates were lower in the border states than in the rest of the nation, they were still significant, especially in Tamaulipas and Chihuahua. Incomplete primary schooling was more prevalent, with Chihuahua slightly above the national mean of 46.0 percent and most other states close. Even in Nuevo Leon, the most affluent state, more than 30 percent of children did not fare well on this indicator.

Many children are working; while some of those children also attend school, a large percentage drops out of school to work, especially among adolescents. Among children 5 to 13 years of age, about 18 percent are working, from 14 to 17 years of age, about 70 percent are working. These children are far less likely to attend school. For instance, in Baja California, 41 percent of these children don’t go to school.

“These are children who have not completed their schooling so they can have something in the future. They will have no careers.”

In households where children work and do not attend school, families often face economic hardships. Families headed by a single parent are more likely to have economic difficulties. In many of these cases, parents are not working.
Dra. de Jesús Muñoz Daw noted that educational coverage increased in Mexico between 2000 and 2005. Disparities remain, however, for people of different ethnicities and indigent populations. In Chihuahua, the majority of the indigent population is Tarahumara Indian. Among this population, most children in Chihuahua do not complete primary school. In Baja California, among children ages 5 to 14 who speak indigenous languages, 76.5 percent go to school. However, 11.3 percent of those children cannot read or write.

“We can see we’re finally getting these children into school, but we’re still struggling with this.”

Dra. de Jesús Muñoz Daw next turned to a discussion of Mexico’s efforts to achieve the objectives set at the Millennium Summit by the year 2015:

- Objective 1 is to eradicate poverty and hunger. To achieve this objective, Mexico needs to cut in half the population that is 1) earning less than a dollar a day; 2) hungry; 3) among children under five years, underweight; and 4) not getting enough protein in their diets.

- Objective 2 is to ensure that all children have primary schooling, children from one to five have preschool education, and all children 12 and over enter secondary school with a 90 percent completion rate.

- Objective 3 is to eliminate inequality between women and men, especially in primary and secondary schools. Indicators are the literacy rate of women between 15 and 24 years and the ratio of boys to girls in primary school. Both of these indicators have improved. She attributed this improvement partly to the expectation that women have to go out and work.

However, just sending children to school is not enough, she noted. Education must also be of high quality. Mexico belongs to the Organización para la Cooperación y el Desarrollo Económicos (OCDE) [Organization for Economic Cooperation and Development], which works on economic development. Reports from the Program for International Student Assessment (PISA) 2008 show that Mexico occupies the last position in indicators that measure the performance of the education system. Only 41 percent of those who enter secondary school complete their studies. Among those aged 25 to 34 years, 39 percent have completed high school. This problem is nationwide, in both the northern and southern states.

Among youth 15 to 19 years, Mexico has the lowest rates of educational achievement of member countries. Almost half of these children – 45.1 percent – do not attend school. Of these, 62 percent are employed, and the remaining 38 percent do not study or work. This raises another social problem, Dra. de Jesús Muñoz Daw pointed out: What do these young people do with their free time? Is it related to an increase in crime rates?

In conclusion, Dra. de Jesús Muñoz Daw said, these statistics that reflect some of the work currently being done in Mexico. Some of the solutions are working for public health policy, creating supportive environments for health, strengthening community action, the development of personal skills, and reorienting health services. It also means working with the government to develop civil systems such as education and workforce/economic development, as well as working with the different health services. We must continue this work with the state and society to develop these strategies and to start new programs together to continue this work.

The Role of Border Trauma Exposure on Children and its Impact on their Mental Health and Substance Use
Luis E. Flores, M.A.LPC, LCDC, RPT-S, Executive Vice President
Serving Children and Adolescents in Need (SCAN), Inc.

Mr. Flores opened by noting that many of the socioeconomic conditions on the U.S. side of the border create risk factors for traumatic stress, mental health problems, and substance use. From the U.S. perspective, a strong border means stronger communities and healthier communities. Quoting from the World Health Organization, he empha-
sized the importance of “not only good material conditions, but from early childhood onwards, [the] need to feel valued and appreciated.”

“Safety is important to healthy human beings. Safety is learned in the context of relationships. When you see a child resting on her mom, having that meaning of safety, it is due to that relationship, that attachment. Imagine also if the mother suffered from depression, what would be the impact on that child? If that mother suffered from domestic violence, what would be the impact on that child? If she struggles financially, having two jobs to make ends meet, what would be the impact on that child? And if she copes by using substances, what would be the impact on that child? We also need to think about neighborhoods. We know that when both are disrupted, when we don’t provide safety to our children, it’s going to have a great impact.”

Mr. Flores provided a brief overview of the activities of the organization he works for, Serving Children and Adolescents in Need (SCAN), Inc. The organization has about 20 different programs that provide support to at-risk children and youth. These programs include substance abuse, trauma center, runaway homeless youth, and many others. They serve most counties in southeast Texas, including border counties. One of SCAN’s programs is a rural border intervention program, provided in collaboration with the state of Texas and specifically designed to meet the needs of border regions. SCAN has been in existence for more than 27 years. He noted that he would be sharing his perspective from the field, as someone who is a program director and manages programs.

Mr. Flores then discussed risk factors for substance use and mental health disorders. Much of the data he presented was based on Texas Kids Count data. These factors are:

- **Poverty:** He noted that poverty was extreme in his service area, which stretches from the Rio Grande Valley to Brownsville. Notably, total poverty in the region is 30 to 45 percent, and children’s poverty is 40 to 55 percent. Poverty is highest in Starr County, one of the poorest areas in the nation. In comparison, the overall poverty rate in Texas is about 17 percent and child poverty is 22 to 23 percent.

- **Low educational attainment:** People who have not completed high school are at higher risk of family violence, substance use, and other problems. High school graduation rates are lower in the Texas border counties, about 36 percent in Starr County, compared to 80 percent for Texas overall. In comparison with the state of Texas, border counties have a lot lower rates of any type of college education.

- **Lack of resources:** Fewer resources are available in the border region, health and otherwise. Mr. Flores noted that the data he presented here were provided by Mike Maples of the Texas Department of Health. In regards to mental health and substance abuse services, more than 20,000 children have been identified as in need of services, of those, only 25 percent receive services. Among adults, almost 45,000 have been identified as having serious mental health needs – that is, bipolar disorders, major depression, and/or schizophrenia – while only 34 percent access services. Figures for substance abuse are even worse; data for children and adults are about the same. Only a small percentage is able to access treatment.

- **Shortage of healthcare professionals:** Mr. Flores also observed that the number of healthcare professionals drops as you get closer to the border. In Laredo there is only one child psychiatrist, who serves a population of 245,000. What does a family do when they need to access services? The same pattern holds true for psychologists and clinical social workers: as you get closer to the border, the number drops. In rural Texas the numbers are lower, but in the rural border the numbers are even worse.

Mr. Flores next discussed adolescent substance use problems he sees in the field, noting that the picture is “not a surprise.” He observed that cheap drugs, alcohol, and prescription drugs are easily available and affordable, as are cocaine, marijuana, crack, and Rohypnol. Use of cocaine increases as youth reach eleventh and twelfth grades; as they continue to use it, they increase their use. Border students are three times more likely than non-border students
to use these substances. According to surveys performed by SCAN, that’s because of easy access and perception: students actually saw cocaine, crack, heroin, and inhalants as less dangerous than tobacco, alcohol, marijuana, and steroids.

“How come we don’t have a methamphetamine problem? We have so much cocaine, marijuana, crack, inhalants, and heroin that is so affordable.”

Mr. Flores next presented data from three SCAN programs: juvenile drug court, youth recovery, and MEP. The sample was about 200 to 220 participants. He observed that regular outpatient treatment is the least intensive type of treatment for substance use. About 39 percent of program participants had some internalized disorder – for example depression or anxiety – while 61 percent had an externalized disorder – for example a conduct disorder. About 39 percent reported having both internalized and externalized disorders. The numbers increase a lot when severity of substance abuse increases. Half of the kids with substance abuse problems report internalized disorders, 70 percent report externalized disorders, and almost half have both. This means there are major hurdles in helping them.

“ar the in the United States we have a division between mental health and substance abuse treatment.”

Mr. Flores noted that death from heroin overdose is a significant problem among adolescents in the region, citing a newspaper clipping titled “Dead teens: Cheap heroin attracting far younger abusers.” Laredo had the highest number of kids who injected heroin. He emphasized the need for treatment and the link to previous traumatic experiences. The vast majority (about 75 percent) of youth in residential care report having gone through a traumatic experience. The percentage is higher for females – almost 82 percent. Females also tend to have more severe substance use problems and multiple other problems including physical and emotional relationship violence.

These youth experience multiple barriers to accessing care, including the need to travel long distances to access residential treatment. Mr. Flores emphasized the need for continuing care, including a seamless connection from residential treatment to outpatient treatment. He noted that the first 90 days after youth leave residential care is the most likely time for a relapse to occur. Addressing those barriers is going to impact the adolescent’s recovery. He cited difficulties with mental health needs in Laredo, where the community health intervention center has excluded immigrants.

Mr. Flores observed that many children are being raised by an impaired caregiver who cannot parent appropriately. The impact on those children is substantial. In addition, mental health treatment and substance abuse treatment are two separate systems, making it difficult to integrate treatment. He suggested that youth need to work with different types of professionals to receive more integrated treatment.

Another risk factor, Mr. Flores noted, is community violence. Drug cartels are actively recruiting youth in the border region. While the drug wars are not a new phenomenon – he recounted one of his own experiences growing up in a border community affected by the violence – the problem is that it really now affects the general population. He cited a study on border violence and environmental safety, which showed that border students have less environmental safety in neighborhoods and at school. They live with the reality of kidnapping, murders, and extortion. The border itself becomes a cue for danger. He noted that many people have become afraid of going across the border, even though families often straddle both sides of the border. Remarkably, the border remains very dynamic despite these pressures. Yet the violence disrupts the lives of kids around the border.

As a case study, Mr. Flores presented Janie’s story: Janie’s mom was kidnapped and never found. He showed a letter she wrote as part of the treatment she received while she struggled to recover from this traumatic experience.

He used Janie’s story to transition to a discussion of child traumatic stress. Child traumatic stress is the result of events that threaten children’s capacity to cope, leading to feelings of terror, powerlessness, and out of control physiological arousal. Child traumatic stress is the reaction to this event. The traumatic stress is expressed in multiple ways: re-
experiencing the traumatic event or having intrusive thoughts about the traumatic event, including feelings, nightmares, and dreams. Children may become hypervigilant, fearing that something bad will happen. They may be prone to avoidance and have difficulties with mood regulation. Anger is many of the times one of the results of traumatic stress. These children have difficulty regulating their own emotions and often dissociate, feeling as if they are not part of their bodies, in dream or movie. They may be unable to recall aspects of the traumatic event.

Child traumatic stress can occur when children experience one acute event such as a car accident or sexual assault. When caretakers are the ones who cause the trauma, the impact on the child’s development is more severe. It impacts every aspect of child’s life. The events change the child’s perspective on the world and self. These children are unable to trust others, and they have difficulty making friends, navigating losses, and dealing with other things that happen in life.

Children find a way to adapt to these conditions, many times with unhealthy coping behaviors such as substance abuse. Mr. Flores pointed out that traumatic stress affects not only mental health but physical health, noting behaviors that increase the risk for mental and physical health problems. In this way, traumatic stress is commonly linked with substance abuse in adolescents, Mr. Flores observed. Youth may use substances for self-medication. Conversely, substance abuse may decrease youths’ ability to cope, leading to increased traumatic stress symptoms. In addition, youth who use substances are more likely to engage in risky behaviors. He observed that substances sometimes help people cope: “You have to see substance abuse as a coping mechanism, negative but sometimes effective.”

Mr. Flores also discussed the link between trauma, substance abuse, and the adolescent brain. Both substance abuse and trauma have severe impacts on the brain. Adolescence is a time of great brain growth, putting youth who experience trauma and use substances at great risk of multiple long-term mental, emotional, and physical health problems.

Trauma, mental health problems, and substance abuse do not occur in a vacuum, he noted. Discrimination, negative stereotyping, poverty, and exposure to community violence all increase the risk of these events.

“We know that adolescents from minority groups have higher exposure to traumatic experiences and more severe symptoms.”

Mr. Flores referred participants to the National Child Traumatic Stress Network (website www.nsctsn.org). The NCTSN was created as an initiative of Congress in order to increase access to services. Many research centers and top experts are part of the network. It includes many collaborative groups that create and offer “really good products,” including resources in Spanish.

Mr. Flores concluded his presentation with a set of nine recommendations, which are described in the last slide of his presentation. These recommendations, he said, were designed not only to increase access to treatment, but to increase our understanding of trauma and its effects on health.

Questions and Answers: Social Determinants of Health

Question/Comment:
My great concerns are related to the shortage of mental health services in the border region. Unfortunately, with current workforce capacity issues, it’s not going to get better. If you look at where our graduates from psychiatry are going, it’s not into community medicine: It’s either into academics or private practice. That needs to change.
Both presentations this morning got to the issue of our communities feeling disenfranchised and disempowered. Substance use, mental health, violence, drug cartels being able to recruit such young adolescents into their enterprises: All these are symptoms of a much larger issue. In regards to why people don’t pursue education, it is totally economic, and it’s no different on American side. When a community feels so disenfranchised, these symptoms are to be expected.

Luis Flores responded: Thank you; I agree.

Question/Comment:
Thank you for your presentations. Your work is very important for our youth on both sides of the border. We need to look at being able to implement access to different types of services. These are generally families that don’t have both parents, and because mom has to work children are left alone. We need to find places for youngsters to go where we can offer wonderful things to them like music, culture, so they can avoid this other craziness. In addition, we need to look at educating parents to help adolescents. We have a lot of poverty; it is going to be very difficult with these families. But we need to do something for these families and provide strength to the children.

D. HEALTH STATUS AND DISPARITIES IN THE U.S.-MEXICO BORDER REGION

Dra. Teresa González de Cossío opened her presentation with a brief overview of the effects of diet on overall health. She noted that the illnesses caused by malnutrition and obesity are well documented. Some consequences are short term, while others are long-term. Information on body weight from the moment of birth to infancy can help public health practitioners learn about causes and how to address them.

The causes of malnutrition, Dra. González de Cossío noted, are complex. Immediate causes of malnutrition include poor diet and diseases such as metabolic disorders or HIV/AIDS. Underlying causes build on basic causes – socioeconomic and political context, lack of capital, and poverty. Data on these underlying causes are limited, she observed. However, she said, she would be presenting data in relation to poverty that have created a vicious cycle that leads to chronic malnutrition. These include lack of access to health care, education, and other basic services, poor maternal health, lack of availability of healthful food, and other gaps. Malnutrition is also passed from generation to generation. She noted that there have been several “very interesting” studies of the different causes, all of which have the potential to impact malnutrition rates among children. Globally, 60 percent of deaths among children less than five years of age are associated with malnutrition.

Dra. González de Cossío observed that the “other side” of malnutrition is obesity. Obesity in children often leads to psychological and physiological problems such as obstructive sleep apnea, asthma, non-alcoholic fatty liver, gastroesophageal reflux disease (GERD), polycystic ovary syndrome (PCO), orthopedic disorders, and more. As adults, these children are likely to continue to be obese and to develop cardiovascular disease and metabolic and endocrine disorders such as diabetes.

Dra. González de Cossío noted that normal, bell-shaped curves result when the distributions of height, weight, and age for sex are plotted. Three studies of malnutrition and obesity have taken place in Mexico, one each in 1988, 1999, and 2006. These studies tracked, for the first time, real data in relation to the probabilities of overweight and underweight and what they represent.
Data from these studies show the prevalence of stunting or low height for children under five is greatest in the southernmost states. In 1988, 22.8 percent of children across Mexico were of short stature; in 1999, that percentage had dropped to 17.8; by 2006, it had dropped to 12.7 percent. The percentage of stunting among indigenous children is much higher. In 1988, stunting affected almost 55 percent of indigenous children under five. By 2006 it had dropped to just over 35 percent. Hardly any change in rates has occurred in the northern states; most of the change has occurred in the central and southern states. She attributed these changes to increased efforts in these areas, including nutritional programs. The focus has been on improving the nutrition of families in poverty. However, much work remains to be done. If the decline were to continue at the same rate of progress, it would take 22 years to reach the goal of 2.5 percent.

Dra. González de Cossío observed that, in contrast to malnutrition, obesity and overweight are increasing throughout Mexico, especially for women. Women 20 to 49 years of age are most affected. Between 1999 and 2006, overweight and obesity rates increased from 20.2 to 26.8 among girls ages 5 to 11, from 28.5 to 32.5 among adolescent girls ages 12 to 19, and from 61.0 to 69.3 among women 20 and older. The proportion of women ages 20 and older who are obese, as opposed to overweight, is also much higher. The spike in obesity after women reach the age of 20 years is a serious problem that needs to be addressed, she noted.

Dra. González de Cossio then turned to a discussion of nutrition in children and adolescents specific to the border region. She briefly reviewed the ten principle causes of mortality in the region, noting that the leading causes – cardiovascular disease, cancers, and diabetes – are all related to overweight and obesity.

Malnutrition is less of an issue for children under age five who live in the border region than in other parts of Mexico. Fewer than five percent of children in the border region suffer from stunting, although rates in urban areas are higher than in rural areas of the border. Dra. González de Cossio pointed out the low rate of stunting in the border region brings down the national average. Malnutrition remains a great problem for Mexico as a nation.

Height-to-weight ratio (body mass index [BMI]) is one of the most important indicators of nutrition and underweight or overweight. By tracking BMI along with age, Dra. González de Cossio said, researchers can start to understand patterns of overweight and malnutrition. Many countries have begun tracking BMI in their healthcare systems.

She noted that prevalence of malnutrition in preschoolers in the southern states is 22.7 percent. In the northern states, the percentage is much, much less – 6.3 percent. In terms of overweight, the overall percentage of overweight preschoolers in the northern states is 3.4 percent. However, prevalence of overweight for preschool children is much higher in rural areas, at 5.6 percent. She observed that city dwellers have better access to many less costly, healthier foods than do children who live in rural areas.

Dra. González de Cossio next compared data on underweight, overweight, and obesity in preschoolers for countries throughout Latin America and the Caribbean. Obesity defined as a BMI of greater than 30, is prevalent in Mexico: Mexico is sixth out of 15 countries in obesity rates. Underweight is also a significant problem.

Data on malnutrition in school children ages of 5 to 11 years show there is not a significant public health problem in the northern states. About 4.5 of schoolchildren in the border region are underweight, compared to a national mean of 9.9 percent. In contrast, overweight and obesity are becoming more prevalent in the border region. Among children 5 to 11, about 30 percent are overweight or obese, a much higher percentage than in other areas of Mexico. Rates of obesity (22.6 percent) are higher in rural areas; overweight is more prevalent (24.1) in urban areas. The problem is worse in adolescents in the border region, 37.5 percent of whom are overweight or obese. Children aged 5 to 11 who are overweight or obese are likely to continue to gain excess weight as adolescents and adults. Growing concerns about obesity are not unique to the border region, or to Mexico, Dra. González de Cossio observed. Obesity is a global epidemic, and effective interventions need to be identified. Different regions in Mexico have been working to develop strategies and clear indicators to measure obesity rates, as well as probing creative
ways to drop these rates. Addressing the obesity epidemic will require the coordinated efforts of large health organizations and institutes. Working together, they can find ways to meet Mexico’s goals around overweight and obesity.

“We need to look at how we can have good programs and more money to try to drop these rates of overweight and obesity.”

In conclusion, Dra. González de Cossío reviewed several of her main points.

- The leading causes of death in the border region are related to overweight,
- Social and economic conditions of the population of the border region are relatively better than the national average:
  - About two-thirds of homes are owner-occupied.
  - Illiteracy rates are lower.
  - Housing is generally better.
- In terms of health indicators, there are marked differences between rural and urban populations.
- It is alarming that around half the population is economically active during their adolescent years (12-plus).
- Chronic malnutrition and overweight are both problems for children in the border region.
- Chronic malnutrition is a minor public health problem in children in the border region and less prevalent in urban than in rural areas
- Overweight and obesity affect all children in the border region, starting from preschool. It is especially prevalent in adolescents
- The problem of overweight is alarming and exceeds that of malnutrition

Dra. González de Cossío noted the need for improved systems to provide rural health care and surveillance and to address chronic malnutrition and overweight/obesity in children and adolescents in the border region. Rapidly rising rates of overweight and obesity indicate the need to start working with children during preschool ages.

“Prevention is key. We need to work with these populations very early.”

Obesity prevention and health promotion efforts also need to take into account the environment, Dra. González de Cossío observed. The environment influences access both to healthy foods and to recreational facilities where children and adolescents can be active. Health promotion efforts need to evaluate children’s environments, and we need to alter those environments to allow children to participate in physical activities. Public health programs to address overweight and obesity need to start working with children at very early stages, even during the prenatal period. Successful programs will encourage physical activity, breastfeeding among moms, and provide nutritional information to parents, schools, and local authorities.

Why Childhood Obesity Must be Integrated into All Discussions about Border Health
Dr. Eduardo J. Sanchez, MD, MPH, Vice President and Chief Medical Officer,
BlueCross/BlueShield of Texas
Former Health Commissioner of Texas

Dr. Sanchez spoke energetically about the need to address childhood obesity in the border region. He asked participants to think about three questions as he spoke and in anticipation of the workshops: First, what works (research)? Second, in what settings are those things working (programs)? Third, what needs to be done to do more those things that do work (policies)?

Dr. Sanchez began the main portion of his talk by presenting data on the top three leading causes of death in the United States: heart disease, cancers, and stroke. But, he observed, it is also important to look at the underlying causes of death and to ask the question: “What are the things that are making us sick?” Among underlying causes
of death, although tobacco is still number one, the second one is eating poorly and not being physically active. The
third one is immoderate use of alcohol. Tobacco cessation efforts have shown that public health interventions can
make a difference. In 40 years, the United States has cut in half the prevalence of people who smoke, and there have
been good health consequences as a result. We know that Latinos are less likely to smoke than are African-Ameri-
cans and whites, and that may be one reason why Latinos seem to be able to live longer with chronic diseases such
as diabetes.

“No discussion about child health is complete unless we start talking about childhood obesity, north or south. In the
United States, the discussion about health reform is incomplete unless we start talking about childhood obesity and
incorporate that discussion.”

But there are three disturbing trends: increasing prevalence of obesity, increasing prevalence of diabetes, and the
increasing cost of medical care. Dr. Sanchez emphasized that they are related. He cited Ken Thorpes’s calculation
that 25 percent of the cost of medical care is attributable to obesity. As the percentage of those who are overweight
or obese goes up, medical costs will also go up.

“The problem with obesity has become so overpowering that no single remedy guarantees a solution. The problem
with health reform is that no remedy that doesn’t include childhood obesity is going to work.”

Referring to data on obesity prevalence from the CDC’s Behavioral Risk Factor Surveillance System (BRFSS),
Dr. Sanchez noted that obesity prevalence is not distributed evenly. Dr. Sanchez predicted that Texas will be one of
the “red” states – that is, a state with obesity prevalence of greater than 30 percent. Similarly, among children, the
prevalence of obesity is increasing from one decade to the next – from one year to the next, all across the land. This
reflects a pattern similar to that presented earlier regarding some of the states in Mexico.

Dr. Sanchez argued that obesity prevalence and its ethnicity patterns need to be understood in the context of de-

gographic shifts. Latino boys are much more likely to be obese. Among girls, African-Americans are more likely to
be obese, but Latinas are not far behind. Almost 50 percent of Latino boys are overweight, among girls, both African-
Americans and Latinas are more likely to be overweight than whites. With demographic shifts, Latinos will make up
25 percent of the U.S. population by 2050. The increased prevalence of obesity among Latinos is going to make a
huge difference in overall obesity prevalence.

“If we don’t take care, the burden of this is going to overwhelm the healthcare system with the problems of obesity
in children that turns to obesity in adults.”

Using data from the Texas Department of Health Services, Dr. Sanchez observed that in Texas, border counties have
some of the highest childhood obesity rates, ranging from 25 to 30 percent in some regions. However, in one re-

gion the prevalence of obesity actually went down between 2000-2002 and 2004-2006, suggesting that “there are
interventions that can make a difference.” However, childhood obesity rates are escalating rapidly in the southeastern
part of Texas, which includes the border. This region includes the city of McAllen, the subject of a major article
on healthcare reform in The New Yorker by Dr. Atul Gawande. Gawande focuses on why the cost of the care in
McAllen is almost twice the cost of medical care in El Paso, all other things being the same.

“The border is not monolithic.”

Dr. Sanchez observed that chronic diseases associated with overweight and obesity are becoming more prevalent
in children. Type 2 diabetes mellitus, in particular, is closely associated with obesity. Importantly for the border, the
prevalence of diabetes is race and ethnicity dependent. Among whites it is about 7 percent; African-Americans and
Mexican-Americans, it’s about 12 percent; and among American Indians, about 14 percent. Whites who are di-
agnosed with diabetes are much more likely to have type 1 diabetes. American Indians are much more likely to de-
velop type 2 diabetes. And among Latinos and African-Americans, the ratio is 50-50. This reflects a dramatic change from the days when a child with type 2 diabetes was an anomaly. That is no longer the case in Texas. These children need to take three medications, one for diabetes, one for cholesterol, and one for high blood pressure. By the time they’re 30 or 40 they will have complications – full-blown heart disease and other things.

As demographics change to reflect an increase in the proportion of Latinos in the general population, overall prevalence rates will be affected. The number of obese adult Texans is predicted to triple over the next 30 years from 5 to 15 million. The healthcare workforce will not grow at the same rate. In year 2000, 10 percent of young people were obese; in 2007, 20 were obese. Obesity is on the rise in some of our cohorts. The percent Latinos in border counties differs by state. This tells us that Texas has more of a challenge just because of demographics in its border counties.

The next issue Dr. Sanchez discussed was poverty and un-insurance and their effects on health. Throughout the United States, Latinos are more likely to be uninsur ed than even African-Americans, who tend to be poorer. Latinos who live in the border region have even higher rates of un-insurance. People who live in colonias are least likely to be insured. Texas has the highest un-insurance rate in the United States. Un-insurance can predict the level of educational attainment an individual reaches, in particular high school graduation. Dr. Sanchez emphasized the importance of providing educational attainment opportunities for border youth, especially Latino youth, in addition to access to health care. Texas has the highest un-insurance rate in the United States, with 25 percent of the population uninsured.

Dr. Sanchez’s next topic was high school graduation. He emphasized the link between educational attainment and overall health. In regards to educational attainment, Dr. Sanchez observed, Latinos have the lowest graduation rate. “When you have an increasing number of Latinos in school districts who are less likely to graduate, you are creating a challenge for communities. You are creating an inability to compete. You are creating an opportunity for more jails. You are creating more of the kind of racism that exists when people make assumptions about me and others in this room because of how we look.”

When using the indicator “less than nine years of education,” among Latinos the rate is high throughout the United States and highest in Texas and border counties. Educational attainment is directly related to health behaviors such as smoking, nutrition, physical activity, and access health care appropriately. The mortality rate is almost three times higher for people with less than 12 years education than it is for those with high school degrees.

“We have two possible futures: one with overweight, middle-aged people competing with elderly baby boomers for limited health resources. That’s our future if we don’t do something about it. Or we can change the future. We can have a future where our young people are eating smart, being active, and reducing the demand for that expensive care. We’re not going to reform health in this country or in any country if all we do is insure everyone and make the system work a little better.”

Citing a model from the Institute of Medicine (IOM), Dr. Sanchez pointed out that fixing childhood obesity is extremely complicated. There are many factors. Obesity prevention is not just about eating right and being active, it is about understanding that there are individual factors, places where we spend our lives, and there are sectors that make decisions that affect out ability to do these things.

Dr. Sanchez then returned to the topic of health reform. “Universal access has been the focus. I say reverse overweight and obesity. Here’s why.” He cited planning efforts by multiple groups involved in health reform efforts that have suggested that providing government-sponsored health insurance and reducing administrative costs can save $2.1 trillion over ten years. Based on the current cost of obesity – $100 billion per year – he calculated, using a 5 percent increase for inflation (not including increasing prevalence of obesity), that the cost of obesity over a ten-year period
would be $1.3 trillion. I just fundamentally do not believe that we won’t wipe out the full $2.1 trillion if we don’t do things that focus on the health of the population, not with doctors, but with population health measures like making sure people can afford healthy food, can be physically active, by making sure that pregnant women understand the relationship between what they eat and their pregnancy, and changing programs like WIC to work better and provide healthier food.

Dr. Sanchez proposed that that the United States needs a national action plan to reverse childhood obesity. We will not be able to overcome our health reform challenges if we can’t do that. Why focus on children? Dr. Sanchez cited a paper by Wang and colleagues projecting the rate of obesity in 2030: If current obesity trends continue, more than 75 percent of the U.S. population will be overweight or obese, and by then the cost of obesity will be $800 billion per year. Dr. Sanchez emphasized that development of such a plan will require the involvement of “all kinds of folks representing all kinds of sectors.” He also suggested that the border needs its own action plan to reverse childhood obesity.

“We need data that inform what’s happening at a local level to the extent that that data can inform what’s happening at a local level. We need monitoring and surveillance capacity. We need research capacity. We need to invest the dollars to figure out what works and where it works and where else it might work. We need to build the capacity to take research and turn it into what works on the street. We need implementation capacity. We need to be able to know what works and what it is that allows us to make it work on the street. We need evaluation capacity, so we can measure what we’re doing.”

Dr. Sanchez referred to a joint U.S.-Mexico workshop on preventing obesity in children of Mexican origin that occurred in 2007. One of the primary recommendations of that workshop was that a joint U.S.-Mexico taskforce on obesity be developed. He suggested that the Commission take on that task. Focusing on the six areas identified during that workshop: advocacy, funding, training of the labor force, scientific evidence, program evaluation, and consistency in programs and messages. He also noted that the cost to implement a comprehensive school health program demonstrated to reduce childhood obesity is $10 to $15 U.S. per year.

Dr. Sanchez concluded with a list of “ten things” that need to be done to address childhood obesity in the border region:

- No child left behind – education, education, education.
- Science based nutrition guidelines for all foods in schools.
- 30 minutes per day physical activity in schools – based on HHS guidelines.
- Universal coordinated school health programs.
- Universal school breakfast/lunch.
- Develop and standardize health/nutrition guidelines for FNS/SNAP/WIC.
- Summer food programs for eligible children.
- Community access to good food – healthy, green, just, and affordable.
- Water over soda.
- No child left inside.

Dr. Sanchez concluded by calling for the U.S.-Mexico Border Health Commission to develop a border health action plan to prevent and reverse childhood obesity.
Questions and Answers: Health Status and Disparities in the U.S.-Mexico Border Region

Question/Comment:
Dr Hector Gonzales, Director
Laredo Department of Health
Thank you for the last two presentations. I want to pick up on Dr. Sanchez in a challenge to the Commission and to our authorities and policy makers. It is a time for action. This country, the United States, does not believe in prevention. We have to call for action, especially on the border, because I think we do have some best practices, and we are already beginning to develop databases with the information we do have and to solve problems. This legislative session again ignored the border. I am asking the policy makers and the Commission in particular to take it to the next level and call for action to really invest in prevention. If we don’t do that, we can strategize as much as you want; we won’t have an impact. I implore the Commission members: We really need their support to take the message to the Secretary of Health and Human Services. At the same time, I want to say congratulations to all of the local public health programs and services and professionals, because we are making a difference.

Dr. Sanchez responded: Let me say one thing, Hector, and this is a friendly amendment. Let’s talk about health promotion – prevention is part of that. But let’s talk about promoting health. It’s going to take education, and health will be one of the things that comes with it. Because smarter people will be able to get jobs, and that equals promotion of economic development, health promotion, and prevention is a piece of it. Prevention happens too much in the doctor’s office. We need to be promoting health outside of doctors’ offices.

Dra. González de Cossío responded: One thing we have to be involved in is creating healthier environments where children can get outside and exercise. That means creating parks and other recreational facilities. Not only do we need to pay attention to nutrition and the foods we eat, we need to focus on the capacity to exercise. This is not only the responsibility of healthcare systems. We need to be involved not in one specific area; we need to look at different types of programs.

Question/Comment:
Dr. Ronald J. Dutton, Director
Texas Office of Border Health
I’m really glad you had that slide about the childhood obesity prevention workshop that was held in Cuernavaca. That conference was about Mexican-Americans in the United States and Mexican youth in Mexico; it wasn’t a border-specific focus. It would be great if we could get the Institute of Medicine (IOM) and the Instituto Nacional de Salud Publica (National Institute of Public Health) to help the Commission develop an action plan. At the Board of Governors’ Conference, we passed a recommendation last year requesting that the Commission orient itself towards obesity prevention. So the train is leaving the station. When we look at diabetes mortality in the U.S. and Mexican borders, and the complications associated with it, it is a well-established disparity. We see that in the Mexican data, although not in the U.S. data – the difference between children’s obesity versus diabetes. I see that in many places along the border in diabetes mortality data.

Dr. Sanchez responded: I’m serving on the IOM standing committee on childhood obesity. I think the committee would be very open to the discussion to with the U.S.-Mexico Border Health Commission to cosponsor a workshop on border childhood obesity: activities, planning, infrastructure, strategic direction, call it what you’d like. I think they would be very open to talking about it.

Question/Comment:
You link obesity to the healthcare reform and you mentioned a lot of people being at the table whatever the numbers are that can be saved due to prevention are big. I think one of the problems is that people change jobs, they change school districts, they change health insurance plans. One of the problems is that say a person invests in a Blue Cross plan, there’s no incentive to lose weight or get healthier. One thing to do would be to brainstorm a bond
or something if someone in a plan that they could get a battery of health measures like BMI; if they lose weight, when they switch away from that plan they get a payment. Right now there’s no cost: people could get worse in terms of health without paying anything.

Dr. Sanchez responded: Great ideas.

**Question/Comment**
Jonathan Lee-Melk, M.D.
Chiricahua Community Health Center
Pediatrician at the Federally Qualified Community Health Center in Douglas Arizona.

Question about the obesity – actually two questions. One is, in regards to the slide where you talk about tobacco: I was recently at a conference where information was presented about what has worked worldwide, regardless of culture, social class, and so forth, and they looked at limiting advertisement, education in schools, commercials, etc. etc. etc. and what they found that their regardless of where or what they were dealing with, was that there was one factor that really limited the use of tobacco – and that was the cost of cigarettes, mainly moderated through taxation. That’s question number one: What do you think about taxing obesogenic foods? The second thing is: as a practicing pediatrician, I can counsel people about obesity but I can’t quote for it, I need to invent something else like an allergy, a runny nose, a skin rash.

Dra. González de Cossío responded: In response to the first question: Effectively we should be able to tax these types of mal-nutritional foods. We have to have a dialogue in relation to these types of foods. Unfortunately up to now it has been carried out very negatively, creating a much greater problem. We have had a lot of negative publicity in relation to taxes. This has cost us and will continue to threaten our health. But we need to start to mention increasing taxes on these types of nutritionally empty foods. Last year we made a strong effort to be able to remove these types of things from schools.

Dr. Sanchez responded: A couple of points. First, about taxing: there’s an article in the New York Times. New York tried it; it got squashed. Is it a good idea? It can work. But let’s talk bigger. Food in this country. Food in the United States is relatively inexpensive. In fact we produce 500 to 600 kilocalories more per day than the population needs to eat on a per capita basis. And they try to sell it to us. So that food is out there. Over the last 15 years, the cost of fruits and vegetables has gone up, while the cost of sweets, sugars, fats, and oils has gone down. It may take more than just a tax. It may require that we take a step back to say are there some policy levers that could be pulled that maybe result in subsidizing fruits and veggies more than wheat and corn? Sweets are cheap because of high fructose corn syrup.

Medicare does have an ICD-9 code. The Alliance for Healthier Generation – which is the Clinton Foundation, the American Heart Association, and a handful of health plans – has actually put on the table the notion of an obesity benefits package. I’m struggling with it because it’s not evidence-based, and I’m not convinced it wouldn’t make more sense to just send somebody to the YMCA and pay them to get some nutrition counseling from a dietitian than to pay a doctor. You may know what to do, but most of our colleagues generally don’t know what to do when one of their pediatric patients shows up overweight or obese.

**Question/Comment:**
Mary Reyes Sanford, Regional Coordinator
Arizona First Things First

I’d like to thank you both for your presentations today. They’re very informative and very exciting. I think that some of what’s been talked can be implemented without it costing anything. I for example, am going to go back to my community and as a volunteer, talk to the leadership of the church that I fellowship and offer health promotion classes. I just wanted to thank you and let you know that.
Addressing the obesity problem is difficult: try to push one side down and the other one goes up. There’s no solution from only the health sector; it’s got to be an absolutely comprehensive approach. Otherwise it will fail. That where my question and problem originate. There’s a tremendous disconnect at the highest policy level between the health sector, the educational sector, and the commercial sector. It has to do more with who you know and not really what would make sense.

When I did a review of 300 papers of obesity interventions that worked, only three or four had partial results. Most were failures, mostly because of short, late, limited interventions. We had successes for a year or two, but the net effect was zero. Nothing happened to those kids as far as preservation of weight loss.

Two other points: Families need to be taught about healthy eating. Even when healthy school lunch programs were implemented in the elementary school, we found that the number of kilocalories consumed per day decreased at the school were gained during dinner at home. There was no education for parents. These efforts really have to be comprehensive, global, and continuous.

Third, we cannot concentrate only on food – it’s got to be about health and health promotion. There’s no question that we have to start early. At a program in El Paso, we had multiple different sectors involved. We all tried to get together and do things for kids. But there were no grants, no money, and no programs. There was talk, but there were no policies that make sense for our children. There was no global, comprehensive approach to combating obesity. Particularly in the border. We need to make these efforts comprehensive, continuous, and global. There’s a tremendous disconnect with what we have to do and what’s really happening.

Dra. González de Cossío responded: It is important to understand that the environment has a lot to do with these problems with malnutrition and overweight. We have to address the environment that’s involved as well as incorporating evidence-based decisions and approaches so we can work in these areas.

E. ACCESS TO HEALTH CARE

Access to Health Care Services
Dra. Manjari Quintanar Solares
Subdirector of the Universal Immunization Program, Mexican Health Secretariat/National Center for Children’s and Adolescent Health (CENSIA)

Dra. Solares opened by greeting the audience and noting that she would be “presenting a different panorama in relation to access to health services in Mexico.” Her focus would be on Mexico’s health system and current efforts to improve access to care.

She noted that access to care is defined as “the process by which to satisfy the health-related needs of an individual or a community.” Ideally, each individual can receive health services when they need them. Access to care also involves individuals seeking care and following recommendations for continuing care. Yet multiple socio-cultural and organizational factors affect access to care, including economics, cultural beliefs, social setting, and demographics. She observed that healthcare systems differ between the United States and Mexico. In Mexico, data regarding indicators related to social determinants of health are collected via that social security system.

“We need to have foreseen the type of services that will provide the correct interventions.”
Dra. Solares said that because forum participants from the United States may not be sure how the system in Mexico functions, she would begin with an overview of Mexico’s National Health System. She provided a brief overview of the background of Mexico’s National Health System. In 1943, Mexico created the Instituto Mexicano del Seguro Social (IMSS – social security system). In 1960, the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE), a similar system serving government employees, was begun. Both fall under the umbrella of the Sector Salud (SS – Health Sector). In 1983 the national healthcare system was added to the Constitution of the United Mexican States, based on Article 4 of that document. In 2002, the government began requiring people to pay a small quota to receive health services. Health care was put into the Constitution to assure the right to health care for all. Everyone has the right to receive this service through the social security system.

Dra. Solares observed that current efforts to add to the healthcare system are numerous and ongoing. Mexico’s development plan directly addresses health issues, and with the current president’s support, they hope to begin a national coalition. Plans include the development of a healthcare census and strengthening the public health system with additional clinical services and hiring additional people to work in that system. She said she was hopeful that this will be a universal healthcare system once it is in place. Creation of a healthcare census is a major objective, albeit one out of many. They hope that this will provide much more open access to services in the healthcare arena. Other strategies they are using to increase access to care include “Caravans of Health Care,” during which healthcare professionals travel to different communities in rural and frontier areas where no health care exists. Through projects such as these, they are trying to augment the national health care system, she noted. They’ll be providing this type of care almost every day to communities that do not currently have access to health care.

Dra. Solares noted that another strategy is to provide healthcare for children through El Seguro Médico para una Nueva Generación (healthcare for a New Generation). All children born in 2006 or afterward and enrolled in this program will have access to preventive health care during the first years of life.

Dra. Solares noted that CENSIA researchers have collected and continue to collect data about access to health care in Mexico. In 2000, about 40 percent of Mexicans had some limited type of access to health care. By 2005, it had risen to 50 percent. There has also been an increase in the number of healthcare services offered by the public health service.

“The percentage of people with access to care went from 40 to 50 percent. That’s not a great increase, but it’s still a substantial increment.”

Healthcare coverage rates were somewhat higher, but decreased between 2000 and 2005. Coverage, she noted, includes people who are affiliated with Seguro Social (Social Security) or other federal employees’ and teachers’ unions healthcare systems, and Seguro Popular (subsidized health insurance/services for those not otherwise affiliated with Seguro Social or other systems. In more rural and/or less industrially developed and agricultural states and municipalities, the coverage rate of Seguro Social or other insurance systems is much lower.

In terms of access to healthcare, the northern states are generally doing better than the southern states. Chihuahua and Baja California have the highest percentage of people enrolled in the system, between 60 and 65 percent. In Sonora and Tamaulipas, the rate is about 60 percent. In other words, a major part of the population in these states is insured. People along the border are eligible for enrollment in the IMSS and the ISSSTE, two of the governmental healthcare systems along the border.

Still, about 4 out of every 10 children in border towns have no access to health care, Dra. Solares observed. She suggested that this could be because the northern border is a very dynamic, complicated border. Many Mexican children living in the area are waiting to come into the United States, or have migrated from other areas to work in the maquiladoras. This internal migration leaves them vulnerable. This rate is higher than in some of the southern states in Mexico, where about 50 percent of children and adults do not have access to health care. She suggested that healthcare access rates are higher along the border because services are more available. In addition, children can cross the border to receive other health services in the United States if needed.
Immigration status is a deterrent to accessing care in the southern part of Mexico, she noted. People come in from South and Central America, but they won’t access health care because they’re afraid that they may be deported. Internal migration also leaves people vulnerable, a situation most common in the border region.

The National Center for Children’s and Adolescent Health (CENSIA) works with all different age groups to provide essential health services, including immunizations and health education and promotion. Through its vaccination program, CENSIA targets children in each state with different strategies. Strategies for addressing the issue of migrant health include active participation and collaboration in organizing the annual meetings of the U.S.-Mexico Border Health Association, cooperation with the National Institute of Migration, participation in the annual Binational Health Week, collaboration with the National Center for Farmworker Health, promotion of collaboration agreements on health of migrants to U.S. states, the Mexican Repatriation Program, working with the consulates of Health of Mexico, and bi-national research projects on migrant health.

“In general, we know that 50 to 55 percent of Mexicans now know that they have access to health care. We need to look at additional programs to ensure that immigrants also have access to health care.”

A major focus of the Secretary of Health, noted Dra. Solaras, is providing health care and disease prevention to all age groups. Under El Seguro Médico para una Nueva Generación, children will be registered to ensure follow-through on healthcare needs. Vaccinations are provided through programs like health fairs for immunizations. A national program begun in 1980 provides national health weeks and health fairs across the nation. These events include immunizations and preventive education. The health weeks take place in February, May, and October in each community, and each week focuses on a different age group. This year, the program will initiate family planning services. These types of health fairs will continue as part of a five-year plan to immunize 90 percent of children in Mexico and provide integrated care to all children. The goal is to increase the current immunization rate, which is 83 percent.

One part of the plan is to make sure that all of the responsible government agencies and programs are charged with carrying out immunization programs, providing immunization cards, holding health fairs, and offering services across the entire spectrum of healthcare access. They’re doing this to make sure that all of the population is vaccinated and they’re hopeful that the percentage rates will stabilize at a very high rate. They’ll be looking at different geographical areas to make sure everyone is being vaccinated. In terms of responsibility, the Secretary of Health is in charge of 50 percent; the social security system 43 percent, and the ISSTE 7 percent.

Dra. Solaras noted that to ensure that local areas have input into the program, each state has a committee. That committee decides on how many immunizations are needed for which communities and reports back to federal level. Committee members also decide which areas of their own state they will be immunizing through the health fairs. Dra. Solaes concluded with several key points:

• Universal access to health services and the portability of benefits across geographical areas and between institutions are central to preventing social exclusion and promoting equal opportunities, regardless of income, employment status or place of residence.
• Access to quality health care is essential to improve the health of residents of the United States-Mexico border.
• Access to quality care is necessary for individuals to obtain preventive health services.
• Efficient health services also can educate people about modifiable risk factors for achieving effective control of diseases.
• The portability of benefits across geographical areas is closely linked with the autonomy of individuals and their freedom to move within the national territory, without thereby undermining their right to health protection.

“We now have a program that covers the majority of the population, is portable and beneficial to many different geographic zones. It is a joint effort between different institutions. It has centralized elements to avoid social exclu-
sion and to promote equality, opportunities, independence, at the different income levels given the labor conditions in different places of residence.”

She concluded by saying she hoped this information would be useful to participants in knowing what has been done to get programs up and running on the Mexican side. She noted the importance of working together to ensure children’s access to health care and to carry out all of the actions she had described, because “we are the ones responsible.” She expressed hope that all of these actions will be fulfilled, and that a 100 percent vaccination rate will be achieved for Mexico’s children.

Children Our Border, Our Future.
Bruce Lesley, President
First Focus, Inc.

Mr. Lesley opened by noting his roots in the U.S.-Mexico border and acknowledging Dr. de la Rosa as the “mentor who really inspired me to do the work I’m doing today. First Focus, he explained, is a children’s advocacy group in Washington D.C. that’s about 3 years old. The focus of the group is on our nation’s children and certainly our future. He explained that he would be focusing today on answering the question: “What is the relation of the border and kids?” One in four children in the United States lives in a border state, and one in nine lives in the border region.

“As we shortchange our nation’s children we also shortchange the border and our future.”

Mr. Lesley observed that there is a strong perception that everything goes really well in terms of policy around kids. Children’s advocates at First Focus believe differently. He quoted Washington Post journalist Dana Milbanks’ comment on children’s policy in response to a First Focus press conference that involved kids talking about their experiences in trying to access health care: “Lawmakers on both sides know that a piece of legislation stands a much better chance of passage if it’s about kids.” However, Mr. Lesley noted, there’s a gap in perception: All of bills that Mr. Milbanks cited in his article have not passed. He noted that although there is very strong support in the nation for children’s issues, that support doesn’t necessarily resonate with politicians, often because people don’t vote for the interests of kids. He cited as an example Texas Governor Rick Perry’s view that the Children’s Health Insurance Program (CHIP) “is not what I consider to be a piece of legislation that has the vast support of the people of the state of Texas.” Texas has the highest rate of uninsured children of any state in the United States.

Mr. Lesley then presented what he characterized as “the bad news” regarding what’s been happening in children’s policy over the last five years. Researchers at First Focus established a baseline of how children fare in the budget by looking at financing of children’s programs. The information was placed on their website in 2008. They found that children’s programs were segmented into “silos.” Although each organization perceived that policy affecting its area it was bad, the bigger picture was lacking. First Focus researchers found that spending on children’s programs had declined by 10 percent over those five years. Only 10 percent of federal funding was spent on children’s programs.

The decrease was not because of a lack of money, Mr. Lesley argued; during the same period there was an overall increase in federal spending of $231 billion. Only one percent of that increase went to children’s programs. If not for Medicaid, overall spending on kids actually would have gone down. Medicaid, he noted, is an entitlement program. Spending on children’s discretionary programs actually declined five to six percent; at the same time, other discretionary programs such as the Maternal-Child Health program actually got an eight percent decrease. Increases to Medicaid and the mandatory Vaccines for Children program totaled $3.2 billion. If not for that increase, spending on children’s programs would actually have declined.

“I really like to think this is not something subject to tradeoffs or negotiating in terms of children’s health.”
Next, Mr. Lesley turned to what he called “the good news”: passage of CHIP. He noted that from a polling perspective, the support for CHIP was overwhelming. On an eight to one basis, people overwhelming supported the passage of CHIP; it is not a partisan issue. He quoted a polling expert: “You have to understand how amazing this is. Fifteen percent of Americans hate everything. To have only 10 percent not supporting anything is remarkable.” Most importantly, Mr. Lesley observed, CHIP is working. As the uninsured rate for adults is increasing, the uninsured rate for children is going down, largely because of CHIP. It has dropped by one third. Reauthorization is expected to reduce the uninsured rate among children to below eight percent. Mr. Lesley noted the huge disparity in spending on Medicare versus CHIP, emphasizing how inexpensive it is to provide health insurance for children.

“Passage of CHIP is one of the biggest accomplishments in health care since the passage of Medicare/Medicaid.” The second piece of “good news,” Mr. Lesley observed, was that the 2009 stimulus package contained $144 billion in increased spending for kids, most of it for education. More than 18 percent of stimulus funding and current tax cuts is directed toward children and children’s programs. In addition, fiscal year 2009 appropriations have almost made up for the decrease in spending on children’s programs that occurred over the previous eight years, restoring spending on children’s programs to 2004 levels in 100 days. He noted that these were “three major wins for kids that I’ve not seen in my 20 years in Washington.”

Still, Mr. Lesley cautioned, we are left with a giant federal deficit of more than $100 trillion, and it is likely that children’s programs will be “first on the chopping block” when it comes time to pay that deficit, because children are not a major voting constituency.

Mr. Lesley noted that as well as working on healthcare reform, First Focus staff is working on CHIP implementation issues. Through CHIP and other policy changes, significant progress has been made on reducing the rate of uninsured of kids. He cited elimination of the five-year waiting program for legal immigrant children. That bill had been fought since 1996, for 13 years. He noted that success in passing that bill was partly because of reframing the issue, changing the name of the bill from “The Legal Immigrant Children’s Health Improvement Act” to “Ending the Five-Year Waiting Period for Immigrant Children.” Mr. Lesley noted that the change in approach was the result of communications research showing that they needed to “start from the kid’s angle.” He gave the example of a child with cancer – should she have to wait for five years to get treatment? He emphasized the importance of framing the policy debate as a children’s issue.

Mr. Lesley also pointed out that children have unique healthcare needs, and even within the category of children, adolescents have unique healthcare needs. Any issue in health care can be viewed from a pediatric angle that’s often not thought of. For instance, Mr. Lesley said, the stimulus package contains $19 billion for electronic health records, starting with the Medicare program. He suggested that starting with 70 year-olds was not the most effective use of that money.

“Why wouldn’t you start with kids, especially kids in the foster care system, who bounce around from house to house and provider to provider? It would give them consistency and eliminate the need to basically start over with each healthcare provider.”

Mr. Lesley also noted that children are often forgotten in healthcare reform debates. He cited Massachusetts, which passed a statewide health care plan covering adults. “The day after it was passed, people asked, ‘What about kids? No one had even thought about it.’” He suggested that the first step in ensuring access to health care for children should be protecting children’s existing avenues to healthcare coverage; the second step, he said, should be addressing access for the remaining uninsured children.

“If we pass a federal policy that basically gives people a tax credit, kids who already have coverage may actually lose ground. That’s something we need to be careful of. We need to be careful not to develop a plan that leaves hundreds of millions of families worse off.”
One of the big issues being talked about, he observed, is capping to pay for health reform. He cautioned that paying for reform by capping the tax deductibility of employer healthcare coverage may not be the best solution for children. Employer coverage is already a problem for kids. Some don’t provide it at all; others offer it but don’t subsidize it as much as individual coverage. The cost of family coverage is almost five times the cost of individual coverage.

Mr. Lesley also noted that community health workers (CHWs) can play an important role in helping to ensure access to health care for border children. In the proposed healthcare reform legislation, there is a prioritization for CHWs. While this prioritization is not necessarily for the border, it is especially important that CHWs be used in the border communities.

Turning to key policy proposals, Mr. Lesley suggested that a progressive agenda for children’s health care is to change the default from non-enrollment to enrollment. In the present system, children have to “opt in”; they are not automatically enrolled. He advocates a program similar to Medicare for seniors, in which children would be automatically enrolled at birth and parents would be responsible for choosing the plan. He also noted that the process of enrollment into current systems such as Medicaid for children is redundant and complicated and could be streamlined.

“If you’re enrolled in any social services program, many of which have more stringent eligibility requirements than Medicaid or CHIP, why do you have to come in and prove again that you’re eligible?”

From a policy perspective, Mr. Lesley said, an “opt out” process could significantly drop the uninsured rate for children. He noted that this framework “piggybacks” on Dr. Sanchez’s observations that the children’s health depends not only on access to health services but on multiple factors including quality, cost, lifestyles, equity, and performance of child health systems.

Mr. Lesley proposed four steps to achieve policy change. He observed that one of the problems is that children’s advocates often do one or two of these things, maybe even three, but never do all four.

The first step is sharing knowledge at forums such as this one. Once data are available, the second step is translating research into policy. This step is often the least taken. He cited a meeting of seven children’s groups in Washington. After data were presented, the question “What are we all going to do about it on a policy basis?” was asked. Mr. Lesley recalled that not a single person raised their hand.

In response, First Focus decided to look at reauthorizations that are coming up in the legislature and decide on concrete action steps to address them. First Focus also put together a book of 22 research papers pertaining to federal policy and children. This allowed them to move from a stance that said, “Here’s the problem,” then walk out the door, to a solution-oriented focus that incorporates action plans.

The third step is building will, Mr. Lesley noted. Advocates for children need to agree on an agenda and speak with one voice. In comparison to senior citizens groups such as the AARP, children’s groups are “all over the place: Each and every one of them appears to have a different message.” He noted that effective communication strategies build hope, using as an example an advertisement from a group trying to garner support for the people of Darfur. The group first used an advertisement that focused on the dire situation (i.e. the problem statement) with no success. A second advertisement focused on the potential for a solution and had a much greater impact. Leaving people with a problem statement creates a sense of hopelessness. Instead, communications need to leave people with a positive statement about the hope and aspirations we have for our children.

The fourth step, Mr. Lesley said, is re-framing children’s health issues in a manner that resonates with both individuals and policy makers. He cited work he had done with a Republican pollster who had responded to a phone call: “It’s about time. You children’s groups are the stupidest people on earth.” Advertising campaigns use kids all the time, Mr. Lesley observed. Children’s advocacy groups tend to shy away from using children in advertisements. When ad-
vocating for children, public health practitioners need to be careful to use “words that work,” such as “our children,” and avoid “words that don’t work,” such as “capacity building.” He gave a list of words that work and words that don’t work (detailed in slides), which had been provided by the pollster.

In conclusion, Mr. Lesley observed that the present political and economic climate provides multiple opportunities for improving children’s programs. Many issues are currently being reviewed, and we should seize this opportunity to do better by our kids and our nation’s future.

Questions and Answers: Access to Health Care

Question/Comment:
Thank you for your presentations. On behalf of the State of Chihuahua in the north of Mexico, thank you for working to continue immunizations for children and for all families.

Question/Comment:
Dr. R.J. Dutton, Director,
Texas Office of Border Health
Texas Department of State Health Services
Bruce, one of my big fears at this meeting was that we’d be lost in the panorama of health priorities regarding children and adolescents. I noticed in your presentation that there was indication that childhood obesity, dental services, and immunizations were priorities. I know Mexico has focused on immunizations as one of the obvious prevention actions that they are emphasizing. Could you comment on how you arrived at those above the other 74 you had in your list?

Mr. Lesley responded: One of our charters is a focus on health disparities. If you look at the data on those issues, you’ll see huge disparities in immunizations, childhood obesity, and dental care. I would also add infant mortality. We actually created a border set aside for infant mortality. So it was really for those reasons — I was trying to set some sort of framework to allow us to focus on a few issues.

Question/Comment
Susan Kunz, MPH
Director of Health Promotion and Disease Prevention
Mariposa Community Health Center, Inc.
Could you talk a little bit about if your organization is working with private sector at all, and what might be the role in philanthropy?

Mr. Lesley responded: First Focus was created by three philanthropic organizations: The Atlantic Philanthropies, the Annie E. Casey Foundation, and the David and Lucille Packard Foundation. The three of them created us with these purposes. One is that about a quarter of our money is commissioned for policy-related papers. That’s very different from most advocacy groups. The second is to provide grants to state child advocate groups. There’s no American Association of Retired Persons for kids. We can’t have kids sign up to be members of First Focus. So one of the things we do is we get philanthropic money to try to build capacity levels at states to support children’s policy. The issue of the private sector is something we need to work on. For example, in North Carolina, there are 55 private sector partners. These are corporate interests in that state, which are very supportive with money and time. IBM is saying “we should do this for kids because it’s important for our nation’s future.” I think that’s a very good point — we need to have business involved.
WORKGROUP SESSIONS

Work session participants used prepared data profiles and information provided by invited speakers on related topics as a basis for discussions. Work sessions were structured to describe and analyze principal issues, reach a consensus on principal findings, and make recommendations (including policy, research and best practices) that treat the issues presently and in the future.

WORKGROUP 1: BEST PRACTICE INTERVENTIONS IN CHILDREN’S HEALTH

Paul Dulin, Moderator

Purpose: Share ideas and best practices with each other and provide input for preparation of the white paper.

Paul provided a review of the U.S.-Mexico Border Health Commission and its mission as background for the group.

Question #1
What are some examples of successful initiatives in the border region?

Programs that address maternal, infant, and child health:

- Funding from the State of New Mexico provides care for uninsured women along border. Services are provided in public health offices, private practices, and clinics.
- Promotoras used the Healthy Start projects in New Mexico and Arizona as a model for prenatal care through age five. A physical education component is being introduced into the program.
- The Women, Infants, and Children (WIC) program provides nutrition, education, and breastfeeding promotion. The program serves pregnant women, infants, and children to age five. Fit WIC provides physical education and breastfeeding support. It helps women and families buy healthful foods at grocery stores.
- An immunization outreach program is used to sweep homes and bring a mobile vaccination van. The program pre-advertises to alert people that the van is coming. The goal of the program is to reach a 90 percent immunization rate.

Programs for adolescents:

- In Chihuahua, Mexico, an adolescent community health workers team has been created. The program trains the team on good hygiene, teen pregnancy, STD prevention, etc.; team members then provide training and education to adolescent peers. The program works to promote education and school attendance. Another program offers teen-to-teen training with similar topics. El Paso has a Teen Advisory Board that operates similarly.
- Teens are asked to take care of an egg for one week as a deterrent to teen pregnancy/parenting.

Obesity/diabetes:

- Healthy Las Cruces chose one pilot school to change physical and health habits through education. For example, the program has looked at what may be preventing kids from walking to school.
- Bienestar focuses on four components: nutrition, obesity, BMI, and glucose. Education is provided to children and parents.
- A program in Chihuahua works with 23 secondary schools to focus on diabetes education, similar to Bienestar. The program developed a baseline of information. Parents are taught how to prepare nutritious meals. The program is also training teachers to be aware of symptoms of diabetes and how monitor blood glucose levels.
- In California, a program called “First Five” provides families with support during children’s first five years.
- Steps to a Healthier U.S. turned into Steps to a Healthier Yuma. The grant-funded program uses a peer-to-peer model to train parents and special action groups (community members). The groups helped develop projects such as knapsack daycare training. An article about the program is available via SOPHE.
Behavioral health:

- Five programs along the Texas border focus on behavioral health, combining prevention and intervention. The programs include classes for substance abuse prevention and involve parents. They use interventions such as motivational interviewing. The goal is to improve quality of life. Promotoras are used to carry out the program.

Environmental health:

- The “Frameworks” program looks at children’s communities, homes, and environments. The program takes place in three stages. First, a public health professional gathers a comprehensive survey (roughly 100 houses) of the community. The survey includes the number of children under five, the number of pregnant women, diseases, etc. This information is then brought to the attention of health authorities for suggested interventions. The program is currently in a pilot phase in the city of Chihuahua.

Data and policy:

- Binational health councils have been supported by the Commission since the 1990’s and chaired by health authorities. The councils provide a forum for health providers in border towns to share epidemiological data and a mechanism for provision of coordinated care of patients who go back and forth across border. For example, a child was receiving care and prescription medications in Mexico and the school on the U.S. side was not recognizing it.
- Child Fatality Review Teams in Texas review deaths of children in each county with various stakeholders. The team looks at facts that may have lead to child death, whether it was preventable, and what could prevent another child’s death. The team discusses risk factors (i.e. SIDS, low birth weight, etc.).

Question #2: Name and rank most important child and adolescent health needs.

Question #3: What are the recommended programmatic approaches and role of binational institutions?
<table>
<thead>
<tr>
<th>Needs/Issues</th>
<th>Proposed Actions to Meet Needs</th>
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<tbody>
<tr>
<td>Trauma*-informed integrated behavioral health services in a primary care setting (substance, mental, medical, etc.).</td>
<td>• Sharing of resources, creating awareness, basic understanding of traumatic events, model of unified binational programs, i.e. substance abuse.</td>
</tr>
<tr>
<td>*Trauma: Any experience that overwhelsms the child’s capacity to cope and that can negatively impact the child’s overall development.</td>
<td>• Establish a new federally designated border region 11 (binational). Timing may be perfect due to H1N1 and drug cartel activities.</td>
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<tr>
<td>*Trauma: Any experience that overwhelsms the child’s capacity to cope and that can negatively impact the child’s overall development.</td>
<td>• Make FQHC funding available for border health programs (CDC, SAMHSA, HRSA).</td>
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<tr>
<td>Workforce shortages (all providers).</td>
<td>• Create a best practices guidebook based on programs on both sides of the border.</td>
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<tr>
<td>Lack of well-trained, culturally competent providers (CLAS).</td>
<td>• Enhance and expand provider recruitment to border regions (incentives, recruitment and retention).</td>
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<tr>
<td>The recruitment of clinical and technical staff is difficult in the border region and/or rural areas.</td>
<td>• Provide continuing education for providers and other professionals on both sides of the border.</td>
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<tr>
<td>Lack/scarcity of culturally and linguistically competent workforce affects success and efficacy of health and medical practices and interventions.</td>
<td>• Grow our own health professionals using the Health Careers Opportunity Program (H-COP) to encourage high school kids (esp. Hispanic, Native Americans and those from rural areas) to enter medical and allied health fields. Provide special summer and dual-credit courses at local and regional universities and community colleges.</td>
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<tr>
<td>Parents who do not understand how to communicate good health messages.</td>
<td>• Develop binational health professional licensing and reciprocity agreements.</td>
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<tr>
<td>Single parents who work in maquiladora industries often must leave their children at home alone and at high risk of accident/injury.</td>
<td>• Increase funding to recruit and retain professionals.</td>
</tr>
<tr>
<td>Need for sexual health and healthy relationship promotion/education from an early age that depoliticizes the issues and takes religion out of the discussion.</td>
<td>• Require all federally and state-funded programs to adopt and use CLAS standards.</td>
</tr>
<tr>
<td>Access to care for a migratory population; postponement of care until criticality requires emergency care.</td>
<td>• Adapt best practices for cultures, based on research, information from families, and use of focus groups.</td>
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<tr>
<td>Immigrants and migrants often do not know how to access health care.</td>
<td>• The U.S.-Mexico Border Health Commission should provide education to inform agencies of impact on health, etc.</td>
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<tr>
<td></td>
<td>• Replicate a pilot program in Chihuahua and Juarez that provides home care for children. Up to 15 kids are served in one home within their community. A foundation provides this at the community level and hires and trains housewives ($2.00/day per child).</td>
</tr>
<tr>
<td>Cross-cutting issues for all of the needs identified above.</td>
<td>• Use promotores/as in communities.</td>
</tr>
<tr>
<td>Obesity, physical activity, and nutrition</td>
<td>• Provide in-school education.</td>
</tr>
<tr>
<td>Concept of health education and health promotion (versus “prevention”)</td>
<td>• Provide family/community communication skills training.</td>
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<td></td>
<td>• Develop youth programs that focus on “future” development.</td>
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<td></td>
<td>• Provide peer-to-peer mentoring that includes informal education and health promotion.</td>
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<td></td>
<td>• Use promotores/as for outreach.</td>
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<td></td>
<td>• Produce a guide with information for migrant population that includes where to locate services, resources, etc.</td>
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<tr>
<td></td>
<td>• Use a MARCOS style project that divides cities into community health units.</td>
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WORKGROUP 2: CHILDREN’S HEALTH RESEARCH

Robert Guerrero, Moderator

Question 1: Describe and rank the most important voids in knowledge concerning social determinants, health disparities, and access to quality and timely child and adolescent health care in the U.S.–Mexico border region.

The group provided a list of nineteen priorities, which can be broken down into the following topic areas.

Social determinants:
- We know a lot about social determinants, but we are more interested about the key ingredients that make these interventions successful. Can the Models of Excellence programs be used?
- Children having to enter the workforce in jobs such as agricultural work, fast food restaurants, construction, etc.

Risk factors:
- It is important to know more about factors associated with not smoking, not drinking, and a healthy diet.
- Risk factors are not the same as benefit factors. We need to identify who will benefit from interventions and investigate the distribution of resources and its relationship to outcomes.
- It is important to know how children perceive health promotion, but it is also important to understand why they expose themselves to risks.

Health promotion and education:
- Research is needed into how adolescents perceive and respond to the health promotion information they are receiving: behavioral research.
- What health literacy components should be conveyed? Access core curricula in school systems to ensure that they correlate to best-practices health education.

Access to Care:
- What is border health? For example, how many binational families are receiving dual medical attention (trans-border). What drives a particular family to seek care on either side of the border? What are the patterns of trans-border medical attention? Health-seeking behavior?

Specific health topics:
- Obesity
  - Programs that promote health and prevent obesity in children are doing well in schools; however, there are some children who do not attend school. What works in rural areas where children are not in school? Homeschooled children?
  - Identify other illnesses associated with childhood obesity.
- Access to mental health care
  - How big is the problem?
  - What is the impact of mental health on those children in terms of health status, school performance, use of illegal substances, etc.?
  - Effectiveness research. What interventions are most successful?
- Violence
  - Investigate the impact that violence has on children and adolescents.
- Maternal mortality
  - Document the issue of maternal mortality in the border region.
- Visual, hearing, and oral health
  - Investigate the impact of early detection of visual, hearing and oral health impairments in children and adolescents.
There are programs for visual, hearing, and oral health but it is important to analyze the data and publish. What services are available to children on the border?

- Child abuse
  - Research into child abuse in the border region.

Application of research:
- We need to ensure that information captured in the work sessions reaches decision-makers.
- Research should be mission-oriented. Implement the action and then evaluate the outcome.
- Evaluate best practices.

WORKGROUP 3: CHILDREN’S HEALTH POLICY

Moderators: Jose Moreira, Ronald J. Dutton, Analicia Villanueva

Question 1: What are the most important policy deficiencies affecting access to appropriate child and adolescent health care?

Maternal, infant, and child health:
- Hospitals in the United States should be baby friendly, including not giving formula routinely.
- Policies in both the United States and Mexico should encourage breastfeeding.
- Women, Infants, and Children (WIC) should be a core service.

Access to care:
- United States
  - Some states have coverage for undocumented residents, others do not have coverage.
  - Children with chronic conditions, both documented and undocumented, may not be able to access services. Some states cover only residents; some states don’t even cover residents.
  - Every agency needs to be open to facilitating access to health care. We need to stop working in silos.
  - We need universal health care for both documented and undocumented residents. “People are people.”
  - We need a more holistic approach to health needs.
  - Undocumented immigrants need to be covered at the national level, not just at the border.
  - National health care reform should include incentives for health care providers to go to the border, not leave.
  - Policy position: The Commission needs to say that we need to have all children covered.

- Mexico
  - Access to social services.
  - Two major institutions theoretically cover the entire population (children and adults) by providing vaccinations and essential services: IMSS (40-50 percent); ISSTE (9 percent). Social Security covers the rest.
  - In border states, it is often difficult to locate migrants. Find a way in border states to have a common document and share information systems, at least for vaccination schedules.
  - Develop a binational immunization card.
  - Ensure that American children living on the Mexican side are also included in immunization programs in Mexico.

- Both sides:
  - How can we make sure that children and adolescents get access to equal services in both sides of the border?
  - We need to be aware of the difference in distributive ethics in both sides of border (difference in resources, etc.).
Each state’s Office of Border Health needs to propose policies that address the needs and concerns for health promotion and prevention.

There is a need for coordination among different organizations, including private and state institutions.

Both sides need to dis-incentivize cesarean section.

Insurance should be provided for children’s caretakers.

Incentives are needed for midlevel providers such as nurse practitioners and to reduce barriers to practice.

We need a binational information system for immunizations. The border should be treated as a single region for purposes of immunization record-keeping.

Binational provider networks need to be addressed.

Prevention is not covered by most health insurance policies; only health problems are.

Question: What is the power of the Commission to address these problems? How can voices from local residents reach the Commission? The Commission tends to look at issues from high levels. We still have old problems unsolved that have supposedly been addressed by the Commission.

Social Determinants of Health:

- Both sides of the border need to declare a “crisis situation.”
- Treating the border as one region is a great idea.
- Communities need to support healthy eating and safe physical activities.
- Promote school models that include some of these policies: mandated physical activities; healthy food in schools, better environments that promote healthy habits, etc.
- Stimulus funds should be provided to address these needs.

Ask that the commissioners (Dr. Cordova and Dr. Sibelius) of the Border Health Commission convene the different segments of the cabinet, education, jobs, economy/trade, energy, transportation, agriculture, security to review policies that impact health, to address the following priorities for this group: [no priorities were listed].

Question 2: What are the top five policy priorities for improvement?

- Access to health care
  - Universal Health Care should include:
    - Immunizations
    - Oral health
    - Mental health
    - Child Obesity prevention
- Health infrastructure
  - Create a binational information system
  - Devote more resources to border areas (USMBHC)
  - Strengthen infrastructure in both sides of the border

Social determinants of health

- Create safe and healthy communities
  - Injury and Violence
    - Unintentional injuries involve children, not just adults. Injury control and prevention efforts are needed on both sides of the border.
    - Better regulation and control is needed. Make sure laws regarding car seat use are enforced.
  - Promote a culture of exercise and healthy food
  - Promote community environments that support active living and healthy eating for children to prevent obesity and diabetes and dental diseases
• Infrastructure development is needed, specifically to improve education.
• Teenage pregnancy prevention.
  o The educational sector needs to be involved, not just the health sector.
  o In Mexico: Hold a National Week of Teenagers to promote responsible sexuality, and so on. One could develop adolescent binational health weeks. This would help to improve the prevention of pregnancy among adolescents.
  o Adolescent health education is needed.

Synthesis:
• Universal health care should be a priority.
• We need to create healthy environments.
• More funding is needed.
• Better infrastructure is needed.
• Violence, injury prevention and safety are priorities.
• Service learning opportunities should be available to everyone.
• We need to be able to use the media to educate adolescents about prevention of sexually transmitted diseases.
• It is more powerful when adolescents educate themselves (GAPS)

Question 3: What should be the role of private healthcare providers, local governments, federal governments, and binational or international institutions?

• Create safe living environments for children and adolescents. Communities need to define for themselves what safe and healthy environments mean for them (families, schools, etc.).
  o Building healthy communities involves identifying their needs and partnering with other sectors, mainly the education sector.
  o What can we do for binational students (i.e. those who cross the border daily)?
  o The Commission can play a role in developing policies that have been identified by local communities.
  o Start at the local level and move to state and national levels.
  o Every sector has a role: education, transportation, health – “Health in all.”
• Access to health care.
  o Universal health coverage.
  o Access to basic care should be available to everyone.
  o Policies should cover adolescent pregnancy.
  o Violence and injury prevention (safe and healthy communities) is part of access to care.
  o A binational card immunization card is needed.
  o Oral health should be included in policies.
  o Mental and substance abuse should be included.
  o Obesity and healthy eating should be included.
• Are institutions willing to go beyond their comfort zone? This is a matter of political will.
  o We should ask the Commission to use its convening power to convene the different sectors more often.
  o The Commission’s role is to convene binational institutions of different sectors. This will create political will.
  o Problems in the border are already well-known and documented. Business will probably not do their share in helping solve the problem (wage, work safety, environment, etc.). What are the responsibilities of the maquilas in the border?
• We need to think about root causes, for example, obesity (BMI) and to educate people and organizations. We need policies that mandate necessary change.
• Data
  o Communities need to know their statistics are. Information empowers community.
  o Use data and use cost. Powerful data can make a difference. Include the cost to address the problem.
    Collectively find means of how to address the problem. We need to create the political will to change.
  o Use of information is a key feature.

Synthesis
1. Now is the time for universal health care in the United States. What is the border piece to this national policy? Immigrants may not be included in the “universal.” Universal means everyone.
2. We need to educate our children so they can become educated adults who can live better.
3. Instead of focusing solely on economic policies that increase business, we need to develop health policies that improve quality of life for everyone.
4. Things that impact the border have a national impact as well. Border issues are national issues.
5. Other industrialized countries invest more in their people than we do, not only in their military power.
6. Strengthen bilateral coordination to operate programs and projects. Conventions, regulations, and programs should be signed by both sides. Coordinate and evaluate progress. This would help Mexican institutions responsible for health in the border region.

For all of these points, identify local needs and develop local, state, and federal support and resources to address those needs.

PRIORITIZATION OF RECOMMENDATIONS: POLICIES, RESEARCH, AND BEST PRACTICES FOR IMPROVING CHILDREN’S HEALTH CARE TODAY AND IN THE FUTURE IN THE U.S.-MEXICO BORDER REGION

PRESENTATION OF RESULTS OF WORKGROUP 1: BEST PRACTICES
Paul Dulin presented the results of the “best practices” workgroup, starting with a review of the initiatives that had worked or were perceived to have been successful in the U.S.-Mexico border region (see Best Practices presentation above). He noted that these initiatives were from the U.S. side, the Mexican side, and binational. Mr. Dulin also observed that the group felt that the Commission should review these suggestions and recommendations and, when appropriate, act as a catalyst for implementing these recommendations.

1. Problem: Lack of integrated mental and behavioral health services: We need trauma-informed behavioral health services in primary care settings. We need to make sure that services are integrated and that behavioral health is recognized as part of primary care. Proposed solutions were:
   a. Resources need to be dedicated and shared across the border.
   b. Establish a new federally designated health region, Region 11. It would also be binational. Mexico would have a similar type of designation. It doesn’t exist right now. We have the La Paz agreement, but operationally, it’s not treated that way.
   c. Federally Qualified Health Centers (FQHCs) need to have funding available for border health programs that address behavioral health.
   d. Create a best-practices guideline for both sides of the border. This may be something that stems from the Commission’s Models of Excellence program. What are best practices for child and adolescent health? The group proposed a few of them, but what are the evidence-based practices?

2. Workforce shortages are an issue. The lack of well-trained, culturally and linguistically competent providers affects both sides of the border. It also leads to problems with communication. Patients are not receiving the information. Even though they say they understand, they don’t. Doctors or nurses are not communicating with their patients because they don’t speak the language or understand the culture. It’s a big problem up and down the border, and it needs to be addressed. The difficulty of recruiting skilled healthcare providers to the border and to rural areas is another area of concern. This is a problem on both sides of the border, despite incentives. Proposed solutions were:
a. Look for better recruitment and retention strategies and incentives.
b. Continuing education and binational provider education. Once providers are working in the border region, there is a continuing education requirement but not about increasing the capacity to have gain assets better trained, continually trained, about the health system on both sides of the border.
c. Take advantage of the Health Careers Opportunity Program. This HRSA funded program tracks children at mid-school and secondary school levels into health-related careers. After completing their degrees, these individuals tend to return to those communities. This is a “grow our own” approach to healthcare workforce development.
d. Binational health professional licensing that would allow physicians and other providers to practice on both sides of the border.
e. Develop programs to train providers in cultural competence.

3. Many single parents have to leave children at home while they work, because they don’t have the means to pay for child care. This puts children at high risk of accidents, violence, and other factors. The proposed solution was:
   a. Develop a home care system for children as they do have in Chihuahua; where they have a program to train housewives in different communities and they’re paid about $2/day per child up to a maximum of 15 kids in the home.

4. Sexual health and healthy relationships. There is a need for health education, not only in schools, but at the community level. Such education needs to be about the comprehensive health of the child or adolescent, including sexual health. The issue needs to be depoliticized and religion needs to be taken out of the question. It’s all about health education. Proposed solutions were:
   a. Use community health workers, who are a key asset in doing this at the community level.
   b. Focus on improving family and community communication skills by offering training within these communities.
   c. Youth programs that focus on future development, peer-to-peer education, and mentoring by adolescents.

5. Access to care for migratory population is a problem both in Mexican and U.S. border regions. Many migrants don’t know how to access care, so they don’t seek health care until critical care is needed or they are past the cure threshold. Proposed solutions were:
   a. Use promotoras/CHWs to educate migrant populations.
   b. Produce a guide of information for migrant populations.
   c. Replicate the MARCOS project, which works in individual neighborhoods of about 100 homes. These homes are assessed and interventionists then work with families as needed.

6. Obesity and diabetes were recognized as a problem, but the group also recognized that it cut across all of the other issues they had discussed.

Questions/Comment:
Dr. Gilbert Handal
To write a white paper is something that we all take very seriously, of course. White papers are based on evidence. How many of the initiatives you discussed have the evidence of being effective and cost effective? Among all these projects, which ones really are proven to be effective? You really fight for the things that you really target specifically what you want to do. One of the ways to find is to do the ones that have been measured. Obesity – after reading the literature, very few things work.

Mr. Dulin responded: I don’t think anyone would disagree with you that evaluation is one of the weakest aspects of knowledge on the border, especially in the areas of behavioral health and obesity. Any intervention, any programmatic approach, has to have an evaluation framework to assess whether that program is working or not.
PRESENTATION OF RESULTS OF WORKGROUP 2: RESEARCH

Robert Guerrero presented the results of the research workgroup. He noted that the group “had a very spirited conversation and discussion” and that participants were “very dedicated to the things they talked about.” The group came up with a list of 19 important voids in knowledge. There was a lot of discussion about what should be there. They then tried to prioritize. “There was a moderate meltdown, but I think we did finally come to a general consensus,” he noted. The 19 research priorities can be grouped into the following five areas:

1. Research into obesity and its related illnesses.
2. Healthy weight of women of reproductive age and weight gain in pregnant women.
3. Best practices and the effectiveness of research. There was a discussion about research that had been done and information being given to adolescents, for instance, and the research wasn’t of use to them.
4. Maternal mortality and infant mortality. A lot of those 19 had to do with issues related to these two topics. Much work has already been done, but the need is making it border specific. Most existing work is focused on states in both countries, but not border counties.
5. Research into the effect of violence on the border. That is a large area that includes different topics from child abuse, on one side of the spectrum, to what is the effect on our children of this daily inundation of violence that is happening in our communities.

PRESENTATION OF RESULTS OF WORKGROUP 3: POLICY

Dr. Ronald J. Dutton presented the results of workgroup three, which had addressed questions of policy. He observed that as he began the group, “It occurred to me that best practices and research lead to policy, but we gave it a shot.” He noted that the prevailing themes were:

1. Creating safe and healthy communities.
   a. Promote a culture of exercise and healthful foods.
2. Universal health care, especially in the context of current debate about health care reform in the United States.
   a. The issue of undocumented immigrants in the United States needs to be addressed in healthcare reform, even though it is a difficult political question. There is a special concern for undocumented children and their special health care issues.
   b. Specific areas for universal access are immunizations, mental and behavioral health, and childhood obesity prevention.
3. Policies are needed to discourage cesarean sections and encourage baby-friendly environments in hospitals, including the promotion of breastfeeding.
4. Stop working in silos. Policies need to focus on creating programs that are more efficient in delivering health care.
5. Look at the border region as one epidemiological region. Barriers to achieving that goal need to be removed.
6. A binational information system needs to be developed. Policy issues need to be addressed to facilitate the exchange of information about health status in children. This will require investment of resources, strengthening infrastructure, and the support of the Commission.
7. The Commission needs to be a key player in policy development.
   a. One of the strengths of the Commission is its ability to convene people. How do we use the Commission to convene multi-jurisdictional entities to cut across these silos we’ve identified as being barriers to improved border health?
   b. Use the Commission’s convening power binationally and not just in the area of health.
   c. The Commission needs to make a case for the border as a unique and special population regarding health reform.
8. Address root causes of health problems and develop policies that address determinants of health.
   a. Policies need to address educational attainment and income levels. One good example that was given about effecting change was tobacco.
   b. Use tobacco-cessation efforts as a model for a comprehensive, multi-sectorial response to overweight and obesity.

   a. Adolescent pregnancy: The GAPS program was mentioned as method of using promotoras for health promotion. Such a program involves using promotoras of same age level for peer-to-peer education and health promotion.

10. Include the private sector, especially the maquila industry, in policy discussions. Dr. Dutton noted that “the maquila industry is an underused resource that has really affected health and doesn’t have a role in investing in public health in this community. It’s not something politically easy to address, but we certainly felt that it should be considered as an important policy area. You don’t hear much about it but it’s obviously one of the major players at the table.”

Question/Comment
Dr. Gilbert Handal
One of the things we’re trying to maximize is the interactions between communities and public policies. To link the two requires the will of practitioners. When we discuss best practices, we need to remember that the ones that are acceptable should depend on the conditions and should not depend on politics. They are policies we can implement ourselves and that we can really encourage people to adopt based on best practices, societal interventions, and professional society recommendations and guidelines. For example, in a project that addressed child abuse on both sides, we both learned about best practices. We want the people to be involved. I truly believe that we as civilians and a group can truly come out with those policies.

The other group has addressed issues that really have to do with very difficult changes but changes we realize have to take place. Take, for example, child abuse. There was no change happening south of the border in terms of child abuse. Now, Mexico City has taken the lead, and we’ve published a couple of books on best-practices guidelines for addressing child abuse. Professional societies on both sides of the border developed a statement.

Many of these policies are very difficult to implement because of the differences in systems, policies, and cultures between the two countries. But there are some basic things we as community members should push up the ladder to the federal levels in both countries.

Dr. Ronald J. Dutton responded: I think it’s an excellent point when you mention that professional societies would develop a statement and that would have the credence and professional society backing. There’s been an effort to implement these best practices and have them inform policy, and it has fallen short. This is probably because of lack of clear professional backing. The USMBHA has been too amorphous to get specific, meaningful recommendations out. The Commission’s position is to try to get relevant, meaningful white papers out in a binational context to be believable and credible. Other groups have also developed statements. But they don’t have the substance of a professional group. A pediatric group knows this particular area better than any other group. Those kinds of mechanisms are really powerful. We’ve looked at how you get border-wide institutions to be better organized and to start working together. Furthermore, if the message from the pediatric societies can be carried by the Commission to policymakers and legislative conferences, it would be a big benefit. It would go a long way to an effective change in policy.
APPENDICES

APPENDIX 1: AGENDA

Camino Real Hotel—El Paso, Texas—June 2-3, 2009

Preliminary Agenda

Tuesday, June 2
1:00-1:30 PM  Registration of participants - Outside Salon C & D - 2nd Floor
1:30-2:00 PM  Inauguration of the Forum - Salon C & D - 2nd Floor

- Overview of the agenda, objectives and products expected from the Forum
- Importance of Children’s Health in the U.S.-Mexico Border Region
  - Manny de la Rosa, MD, Founding/Regional Dean, Texas Tech University, Health Sciences Center, and USMBHC Member for Texas, U.S. Section, U.S.-Mexico Border Health Commission
  - Luanne Southern, MSW, Deputy Commissioner of Health, Texas Department of State Health Services
  - Lic. Clemente Villalpando, Executive Secretary, Mexican Section, U.S.-Mexico Border Health Commission
  - Dr. Octavio Martínez, Director General, Chihuahua State Health Services
  - Bruce SanFilippo, MD, Chief Medical Officer, Memorial Medical Center, and USMBHC Member for New Mexico, U.S. Section, U.S.-Mexico Border Health Commission
  - Jack Callaghan, PhD, Director, Public Health Division, New Mexico Department of Health
2:00-3:30 PM  Children’s Health Conditions in the U.S.-Mexico Border Region
  - Kids Count (Annie E. Casey Foundation)
    - Lic. Gerardo Sauri, Executive Director, Mexican Network for Children’s Rights
    - Frances P. Deviney, PhD, Texas Kids Count Director, Center for Public Policy Priorities

3:30-3:45 PM  Break

3:45-5:15 PM  Children’s Health Conditions in the U.S.-Mexico Border Region
  - Determinants and Conditions of Children’s Health in Mexican Border States/Municipalities: Dra. Diana Coronel, Mexican Health Secretariat/National Center for Children’s and Adolescent Health (CENSIA)
  - Determinants and Conditions of Children’s Health in U.S. Border States and Counties: Dr. Sam Notzon, Director, International Statistics Program, CDC/National Center for Health Statistics

5:15-5:30 PM  Overview of agenda and mechanics for June 3 sessions

6:00-7:30 pm  Welcome Reception Camino Real Hotel Courtyard
  Mariachi Son de Mexico & Ballet Folklorico Totec

Wednesday, June 3

8:00-8:30 AM  Registration - Outside Salon C & D

8:30-9:45 AM  Social Determinants of Health
  - MEXICO: M. en C. María de Jesús Muñoz Daw, Chief, Department of Statistics in Chihuahua, Diabetes Association of Mexico
  - UNITED STATES: Luis E. Flores, M.A.LPC, LCDC, RPT-S, Executive Vice President, Serving Children and Adolescents in Need, Inc.

9:45-10:00 AM  Break (coffee/refreshments)

10:00-11:15 AM  Health Status and Disparities in the U.S.-Mexico Border Region
  - MEXICO: Dra. Teresa González de Cossio, Medical Sciences Investigator “F”, Center for Nutrition and Health Investigation, National Public Health Institute
  - UNITED STATES: Dr. Eduardo J. Sanchez, MD, MPH, Vice President and Chief Medical Office, BlueCross/BlueShield of Texas

11:15 AM-12:30 PM  Access to Health Care
  - MEXICO: Dra. Manjari Quintanar Solares, Subdirector, Coordination and Operation of the National Immunization Council (CONAVA), National Center for Children’s and Adolescent Health (CENSIA)
  - UNITED STATES: Bruce Lesley, President, First Focus
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<th>Time</th>
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<tr>
<td>12:30-1:45 PM</td>
<td>Lunch and Welcome - <em>Salon A &amp; B</em></td>
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<tr>
<td>1:45-2:00 PM</td>
<td>Overview of the Objectives and Mechanics for Workgroup Sessions¹</td>
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<tr>
<td>2:00-4:00 PM</td>
<td>Workgroup Sessions <em>(coffee/refreshments set up in each workgroup room)</em></td>
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<tr>
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<td>• Workgroup 1: Best Practice Interventions in Children’s Health - <em>Pancho Villa Room 2nd Floor</em></td>
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<td>• Workgroup 2: Children’s Health <em>Research - Kohlberg Room 2nd Floor</em></td>
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<td>• Workgroup 3: Children’s Health Policy - <em>Brahma Room 3rd Floor</em></td>
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<tr>
<td>4:00-5:30 PM</td>
<td>Plenary Session to Report on Results of Workgroup Sessions - <em>SALON C &amp; D</em></td>
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<tr>
<td>5:30-6:00 PM</td>
<td>Prioritization of Recommendations: Policies, Research, and Best Practices for Improving Children’s Health Care Today and in the Future in the U.S.-Mexico Border Region</td>
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<tr>
<td>6:00 PM</td>
<td>Announcements, Acknowledgements, and Adjournment</td>
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¹ Work session participants will use prepared data profiles and information provided by invited speakers on related topics as a basis for discussions. Work sessions are structured to describe and analyze principal issues, reach a consensus on principal findings, and make recommendations (including policy, research and best practices) that treat the issues presently and in the future.
# APPENDIX 2: LIST OF REGISTRANTS

## Contact List of US Participants US-Mexico Border Child and Adolescent Health Forum

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APPENDIX 3: PRESENTATIONS

KIDS COUNT (ANNIE E. CASEY FOUNDATION)
- Frances P. Deviney, PhD, Texas Kids Count Director, Center for Public Policy Priorities
- Lic. Gerardo Sauri, Executive Director, Mexican Network for Children’s Rights

CHILDREN’S HEALTH CONDITIONS IN THE U.S.-MEXICO BORDER REGION
- Determinants and Conditions of Children’s Health in Mexican Border States/Municipalities: Dra. Diana Coronel, Mexican Health Secretariat/National Center for Children’s and Adolescent Health (CENSIA)
- Determinants and Conditions of Children’s Health in U.S. Border States and Counties: Dr. Sam Notzon, Director, International Statistics Program, CDC/National Center for Health Statistics

SOCIAL DETERMINANTS OF HEALTH
- MEXICO: M. en C. María de Jesús Muñoz Daw, Chief, Department of Statistics in Chihuahua, Diabetes Association of Mexico
- UNITED STATES: Luis E. Flores, M.A.LPC, LCDC, RPT-S, Executive Vice President, Serving Children and Adolescents in Need, Inc.

HEALTH STATUS AND DISPARITIES IN THE U.S.-MEXICO BORDER REGION
- MEXICO: Dra. Teresa González de Cossío, Medical Sciences Investigator “F”, Center for Nutrition and Health Investigation, National Public Health Institute
- UNITED STATES: Dr. Eduardo J. Sanchez, MD, MPH, Vice President and Chief Medical Office, Blue Cross/BlueShield of Texas

ACCESS TO HEALTH CARE
- MEXICO: Dra. Manjari Quintanar Solares, Subdirector, Coordination and Operation of the National Immunization Council (CONAVA), National Center for Children’s and Adolescent Health (CENSIA)
- UNITED STATES: Bruce Lesley, President, First Focus