2017

(GDJ, 2015)

MEXICO: GLOBAL PARTNERSHIPS

For Occupational Therapists Who Teach, Volunteer, & Work

KAZUMI S. BOWMAN, OTD, OTR/L

In Partial Completion for Occupational Therapy Doctoral Degree at
St. Catherine University, St. Paul, MN

Contents

ACKNOWLEDGEMENTS

I am glad to express my deepest appreciation to my doctoral advisor, Dr. Kate Barrett, OTD, OTR/L, at St. Catherine University, who guided me through the doctoral coursework and this project for her patience and encouragement.

I sincerely appreciate my mentor, Dr. María Cristina Bolaños, PhD, TO, at Instituto de Terapia Ocupacional, who inspired me with the idea of this project, and shared with me the invaluable insights about the challenges experienced by Mexican occupational therapists.

In addition to my advisor and mentor, many people helped me develop this document. This project was culmination of my three years of doctoral coursework. I am grateful for all who directly or indirectly provided me with their support, especially the Mexican occupational therapists who were so kind and compassionate. I also deeply appreciate the international occupational therapists who participated in interviews and surveys when I developed this document.

Development of this document was not possible without generous supports from everybody.

ABOUT THIS DOCUMENT

This document was developed for all occupational therapists who plan to visit Mexico for global partnership projects. In this document, global partnerships are broadly defined as all knowledge exchange activities between host and visiting occupational therapists, including teaching, working, and volunteering, with the special interest on advancement of the profession. It has four chapters, (1) global partnerships, (2) Mexican culture and contexts, (3) Mexican occupational therapy practice context, and (4) logistical information. Although it is easy to read only the chapter(s) visiting occupational therapists are interested in, the author recommends that they read the entire document. The first chapter is particularly important because it helps visiting occupational therapists realize the significance of understanding the basic concepts of global partnerships, especially the role of contextual knowledge.

The reflective questions throughout the document encourage readers to seek further knowledge unique to each host partner, community, and/or institution (the same questions are provided in a worksheet format in Appendix A). Appendices provide the practical information necessary for visiting occupational therapists, such as the lists of occupational therapy schools and the names of health-related organizations in Mexico.

COPYRIGHT AND FAIR USE

Please feel free to contact the author at kazsbowman@gmail.com for any questions or concerns.

MAP OF MEXICO

States of Mexico

(Covarrubias, 2007)

Abbreviated States

AG: Aguascalientes

CL: Colima

GT: Guanajuato

HG: Hidalgo

ME: Mexico

MO: Morelos

NA: Nayarit

PB: Puebla

QT: Querétaro

TB: Tabasco

TL: Tlaxcala

VE: Veracruz

INTRODUCTION

Think of a situation where an occupational therapist from another country visits your country, and he or she starts treating clients as an occupational therapist without following local regulations and/or having a professional license. Or, an occupational therapist from another country starts teaching staff at your local community centers without contacting your state and national associations. The intentions of these visiting occupational therapists may be good, and the services provided by them may be meeting the goals of the specific local communities or groups, but how do these actions positively and negatively influence the overall health and growth of the occupational therapy (OT) profession in your country?

"I want to go abroad to help people in need." This idea seems so simple. Most of those who visit foreign countries have good intentions to help the host country; however, occupational therapists are now questioning the way global services are being provided under the name of "doing good" Suarez-Balcazar, Hansen, & Muñoz, 2015, p. 117). This is important because providing services only with the good intentions without understanding the host country's unique contextual factors may potentially do harm (Elliot, 2015). In response to this emerging awareness, visiting occupational therapists may need to think:

- How will my good intentions and actions be perceived by the host partners?
- How will my actions lead to sustainable change?
- How will my contributions lead to the growth of the OT profession in that particular country?

These questions are important because the health workforce is the foundation for improved health of all people and stronger health systems (World Health Organization [WHO], 2006), and the degree in how the OT profession in a given country has developed may greatly influence the health of its citizens. The WHO definition of the health workforce development indicates the need of comprehensive systems level change. It also encourages visiting occupational therapists to think about how their volunteerism fits (or does not fit) into a bigger picture of empowering the OT profession in that country, and to take a lasting measure to strengthen the OT profession in host countries through a responsible and reciprocal partnerships.

Mexico has experienced global partnerships that lead to positive outcomes for the OT profession as well as frustrating situations (M. C. H. Bolaños, personal communication, n.d.) similar to that depicted at the beginning of this introduction. This document is intended for occupational therapists around the world who plan to visit Mexico for global partnership projects, so that they have the basic knowledge to start their preparation for their visits. The content was developed based on current evidence and the opinions of various stakeholders, including members of the Mexican national occupational therapy organizations, an educational institution, community organizations, and international occupational therapists who previously visited Mexico for international collaboration.

The author's hope is that this document will contribute to meaningful global partnerships that build capacity within the community in need and the OT profession in Mexico.

I. GLOBAL PARTNERSHIPS

This chapter provides some of the important concepts in global partnerships. They include the need to expand visitors' perspectives beyond meeting local needs, the introduction of emerging ideas in global partnership development, and the recommendation of the sensitive approach when developing relationships with partners who have culturally different backgrounds.

A. IMPORTANCE OF BROADER PERSPECTIVES

In recent years, global partnerships focused on knowledge exchanges are gaining more attention among occupational therapists because they appeal to students, clinicians, and educators. Global partnerships are important for individuals who participate in the process because collaborative projects provide opportunities for both personal and professional growth. One study demonstrated that visiting health care professionals appreciate gaining leadership skills and increased awareness of diversity (Hague, Sills, & Thompson, 2015). Although it centered on the international education projects by a non-occupational therapy discipline, another study reported that practitioners in the host countries value the chance to improve their clinical skills (Elobu et al., 2014). The literature supports that global partnerships have the capacity to positively impact health care practitioners, including occupational therapists, in both host and visiting countries.

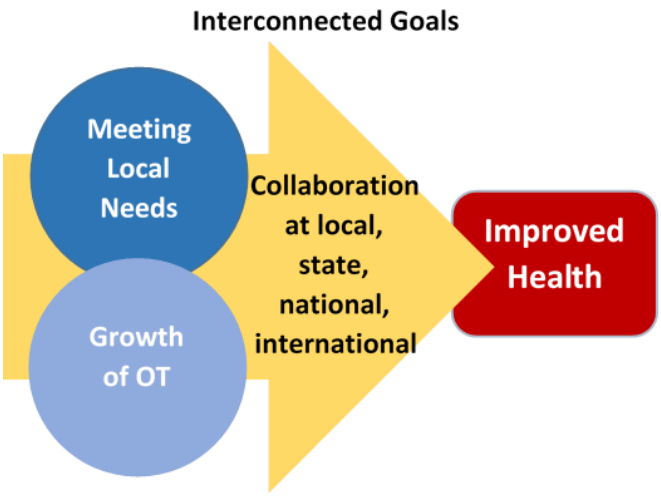
Global partnership projects also benefit the occupational therapy (OT) profession. Historically, occupational therapists around the world helped each other to advance the professional status by sharing occupational therapy skills and competencies (Higman, 2008). International knowledge exchanges, such as student service learning, educational lectures, and volunteering, have been an essential component for the development of the OT profession across international borders. In recent years, global growth of the profession is becoming more important than ever as organizations, such as World Federation of Occupational Therapist (WFOT) and American Occupational Therapy Association (AOTA), are actively pursuing the internationalization of the profession (AOTA, 2006; WFOT, 2011).

The importance of global partnership projects on both practitioners and the OT profession is evident. However, the literature also brings attention to the need of a more comprehensive perspective to global partnerships. For example, typical occupational therapy global partnership projects may focus on skill transfers, targeting a specific local community (Gallagher, Broderick, & Tynan, 2008; Morgan & Kinnealey, 2005). While locally-oriented services are beneficial, it is becoming more important to engage in global partnership projects with multiple stakeholders beyond meeting local needs. Although it focused on a non-occupational therapy public health project, one study reported that efforts involving different stakeholders at multi-levels (i.e., from local to national levels) were found to have more meaningful changes in host countries (Elmusharaf et al., 2016).

Key Ideas:
Occupational Therapists to Promote

- Services beyond local needs
- Strengthening the profession
- Activities involving multi-level stakeholders

The broader, comprehensive perspective is also important for the growth of the profession. Occupational therapists who engage in global partnerships may not necessarily choose workforce development or growth of the OT profession as the primary goal of their projects although partnership activities to strengthen the profession have critical implication for host countries. According to WHO (2006), the growth of health



workforce is required to improve the quality of health among people in host countries. This idea, workforce development as the backbone to good health, is important because it helps visitors see the importance of strengthening the profession for the greater good (i.e., improved health). WHO (2006) also asserts that the participation and cooperation of multi-stakeholders, from local, national, and international level, are critical when strengthening health workforce. These ideas highlight the importance of making a deliberate effort to link stakeholders from multi-levels, so that visitors can support the people in need in local communities and contribute to the growth of the OT profession in host countries for sustainable changes.

B. HUMBLE AND SENSITIVE APPROACHES TO GLOBAL PARTNERSHIPS

There is a shift in the way health care professionals should engage in global health projects. People have started to recognize that service provided to host countries without careful considerations often leads to failure (Welling, Ryan, Burris, & Rich, 2010), and such concerns are more prominent in short-term service activities which have been criticized as medical tourism (Suchdev et al., 2007). In response to these issues in global partnerships, ethical guidelines have recently been proposed for the short-term visits (Crump et al., 2010). The occupational therapy global partnership literature is also changing, and it has started to place its emphasis on the concept of mutuality and a more humble approach to global partnership development (Tupe, Kern, Salvant, & Talero, 2015; Witchger Hansen, 2015).

Cultural humility is an emerging approach to cultural diversity that compliments the humble approach to global partnerships. It is defined as a continued process of learning about others with different cultural backgrounds while focusing on power relations and inequalities derived among diverse social and cultural groups (Beagan, 2015; Chang, Simon, & Dong, 2012; Tervalon & Murray-Garcia, 1998). Its strength is the basic beliefs about culture; culture is fluid and non-static which discourages stereotypes and categorization, and challenges one's own assumptions through self-reflection (Beagan, 2015; Loue, 2012; Tervalon & Murray-Garcia, 1998). The approach encourages a person to reach new perspectives by respecting the partners as experts of their culture, instead of becoming content with having the cultural knowledge or expertise about others with different cultural backgrounds (Chang et al., 2012; Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998)

Reflective Questions

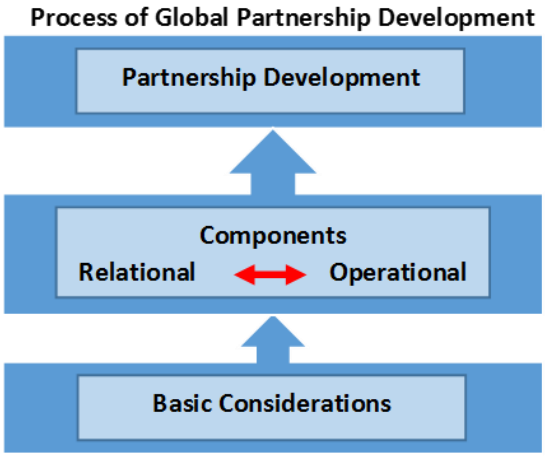
1. How same or different is your current approach to cultural diversity, compared to cultural humility?
2. How do you ensure you are sensitive to different cultures when culture is defined fluid?
3. What are the elements placing you in the position of power in current relationships?

Becoming aware of power relations may be particularly important because imbalance and inequality are common in global partnership projects (Hague et al., 2015). It may be seen as Western vs non-Western theoretical ideologies (Hammell, 2013), financial inequalities, such as funding (Larkan, Uduma, Lawal, & van Bavel, 2016), and hierarchal relations in learner and teacher roles. The fact that visitors are able to make a trip to host countries may demonstrate the power and privilege on the visitor side (Cleaver, Carvajal, & Sheppard, 2016). Visitors need to be aware that the humble approach would be helpful to bridge the cultural differences and alleviate the tensions or issues related to power in the partnership process.

C. PROCESS OF GLOBAL PARTNERSHIP DEVELOPMENT

This document will focus primarily on the components vital for the process of developing global partnerships. Past literature has heavily focused on procedural components and outcomes of global partnerships (Beran et al., 2016; Larkan et al., 2016). However, the development of personal relations is considered a critical contributing factor in collaborative projects (Beran et al., 2016; Pechack & Thompson, 2009). Focusing on the partnership process is important as it may encourage visitors to adopt a more humble and sensitive approach to global partnership projects.

The following section will introduce the basic considerations required when engaging in global partnership activities and explore the components important for partnership development. Using the framework by Larkan et al. (2016), the components were divided into two groups; relational and operational aspects of partnerships which helps simplify the complex, interdependent concepts of global partnerships. It is important to be aware, however, that both components are equally important, and no one component is superior over the other (Larkan et al., 2016).



1. BASIC CONSIDERATIONS

Visitors need to be aware of certain underlying considerations when engaging in global partnerships. They are neither the attitudes nor the actions that visitors need to adopt, but they may be the standard expectations for global partnerships.

a) Global Partnership is Complex

Often times, partnership activities place their strong focuses on clinical skill exchange. However, global partnerships are not only about knowledge transfer and sharing skills (Larkan et al., 2016). Engagement in global partnerships requires visitors to have broader knowledge beyond occupational therapy clinical expertise, including, but not limited to the information about making safe international

Reflective Questions
1. How do these basic considerations influence your planning? 2. How same or different are your assumptions about the visit compared to that of the host?

travels and interpersonal strategies for successful partnership development. All knowledge and skills are equally important in order to ensure development of sustainable projects and ethical engagement with partners in the host country.

b) Preparation is Needed Prior to visits

The literature described that visitors need to make adequate preparations prior to their visits (Kraeker & Chandler, 2013; Hague et al., 2015; Suchdev et al., 2007). Preparation may include activities related to logistics planning to goal setting, and may include understanding history, culture, language, sociopolitical and economic factors of the host country, ideas of health and status of the OT profession, and the needs of the specific community in the host country (Larkan et al., 2016; Leffers & Mitchell, 2010; Witchger Hansen, 2015; Suarez-Balcazar, Hammel, Mayo, Inwald, & Sen, 2013). Understanding all aspects of host countries is not necessary, and some learning will occur once visitors arrive in the country with the help of local partners.

c) Sustainable Change Takes Time

Global partnerships take many forms (e.g., service learning, volunteers, etc.); however, the general understanding is that the process of developing partnerships takes time. Long-term relationships and continued visits are essential for mutually beneficial partnerships, and project success and sustainability (Kraeker & Chandler, 2013; Pechak & Thompson, 2009). This is not to say single or occasional visits do not lead to tangible outcomes, but these visits have the risk of only having short-term local solutions that often focus on client outcomes. The long-term commitment to the host county is recommended because it may lead to development of stronger mutual partnerships and systematic changes, such as the growth of the OT profession in host countries.

Key Ideas:
Basic Considerations

Successful global partnership development requires:

1. Knowledge beyond technical skills
2. Pre-visit preparation
3. Time commitment

2. RELATIONAL COMPONENTS

The relational components include the intangible aspects of partnerships. However, they are considered important because they can facilitate the partnership development. They include personal attributes, understanding host's contexts, mutuality, and common goals. They are difficult to measure, although partnership building is impossible without them. Some global projects were developed from informal personal encounters with colleagues (Witchger Hansen, 2015) rather than official alliances, such as formal inter-institutional projects. Regardless of the way partnerships were established, many view relationship building as the foundation for global partnerships (Beran et al., 2016; Leffers & Mitchell, 2010; McKinnon & Fealy, 2011; Pechak & Thompson, 2009).

a) Personal Attributes

Certain personal qualities and readiness are considered enabling factors when engaging in global health experience. These attributes are described as compassion, openness to learn, desire to help, and willingness to develop equal partnerships (Kraeker & Chandler, 2013; Leffers & Mitchell, 2010; McKinnon & Fealy, 2011; Witchger Hansen, 2015). Most importantly, caring and commitment to support both the clients and occupational therapy colleagues may be some of the most important elements that drive the development of partnerships.

b) Understanding Host's Contexts

Understanding contextual factors is paramount in partnership process. One study revealed that the host country negatively perceived (e.g., offensive) the visit by international health care professionals when they did not have adequate understanding about host's culture and context (Kraeker & Chandler, 2013). Additionally, the knowledge about the host's context benefit not only the host partners, but also the visitors. The literature suggested that visitors may need to be ready to adapt to an environment where the level of personal comfort and personal space may be different from their expectations (Leffers & Mitchell, 2010), and that preparation for visits or knowledge about host countries would alleviate cultural shock (Hague et al., 2015). This type of knowledge should not be taken lightly because being unable to adapt to the local environment may adversely influence a visitor's capacity during their visits. This information suggests that adequate contextual knowledge would benefit both the host partners and visitors.

c) Mutuality in Working and Learning

Mutuality in working and learning is essential in global partnerships, and is often described as reciprocity (Pechack & Thompson, 2009), collaboration (Leffers & Mitchell, 2010), and/or sharing power (Witchger Hansen, 2015). Teaching may be often mistakenly perceived as the primary task for visitors. However, it is important to be aware that hosts contribute to the learning process as much as visitors do because they play valuable roles in teaching and sharing with the visitors about their culture and practice (Kraeker & Chandler, 2013; Suarez-Balcazar et al., 2015). In mutual partnership process, visitors' adopting the attitude of accepting local solutions (Witchger Hansen, 2015) becomes integral. Mutuality also lays the foundation where the sense of trust and respect develops (Tupe et al., 2015; Witchger Hansen, 2015). Sense of mutuality, trust, and respect constantly influence each other during the partnership process, and one cannot be fostered without the others.

Interdependent Components

d) Common Goals

Goals reflective of the host partner's needs also contribute to the promotion of meaningful and reciprocal partnerships. Relevance to partner's contextual factors and needs are important because good ideas without relevance to local contexts could only cause frustrations among the host partners (Kraeker & Chandler, 2013). Goals should be developed cooperatively, and adapted according to the

changing needs during the visit (Leffers & Mitchell, 2010). The information indicates that goals should be flexible and developed mutually, reflecting the needs of both host partners and visitors.

3. OPERATIONAL COMPONENTS

The operational components include task-oriented items and are the practical aspects of the partnerships, including communication, language barriers and communication methods, and evaluation and follow-up. Depending on the goals of global partnership projects, however, there are other operational components visitors may need to consider.

a) Communication

Communicating with host partners is an indispensable component that moves forward the partnership process. Good communication is required throughout the partnership process as insufficient communication may have a negative impact on the partnerships (Hague et al., 2015). Communication needs to be carefully approached because it is not only about expressing ideas clearly, but also about listening to the partner (Witchger Hansen, 2015). Good communication is often described as honest, open, and transparent (Larkan et al., 2016; Witchger Hansen, 2015), and both the visitors and host partners need to establish the optimum method (e.g., email) and frequency of communication (Suarez-Balcazar et al., 2013; Witchger Hansen, 2015). These communication strategies play essential role in partnership building.

b) Language Barriers and Communication Methods

Often times, the dominant language in host countries is different from that of the visitors. English, which may be visitors' language, is considered a universal language, however, it may not be ideal to assume that local colleagues and clients would speak in English. The level of language skills required at the host country among visitors depends on the nature of the project (e.g., visiting lecturers may have an access to interpreters while they may not be easily accessible for visiting volunteers to community organizations).

It is, therefore, imperative to establish some reliable methods to communicate during the visit with consultation with the host partners because language barriers influence all aspects of the visit, including the quality of the services. Learning the host partner's language is one way to solve this problem. If this is not feasible, prior arrangement to secure interpreters and translators may be necessary. Non-verbal communication could effectively be used to compensate the language barriers (Humbert, Burket, Deveney, & Kennedy, 2011). However, understanding culturally appropriate non-verbal communication is highly recommended (see the Communication section on page 21, and review the resources for the beliefs about traditional illness in Appendix E to understand important concepts in Mexico).

Reflective Questions

1. How do you ensure your contributions are relevant for the host country?
2. How do you ensure if your support is beneficial for the growth of occupational therapy in the host country?

c) Evaluation and Follow-Up

Either formal evaluation or informal follow-up after the visit will ensure whether or not the visitor's

program or activities resulted in meaningful outcomes. Evaluation is also beneficial in order to identify the areas of improvement (Suchdev et al., 2007). Informal follow-up may also be useful to foster further personal relationships that may lead to future projects. Much of the current literature generally report the outcomes perceived by visitors, and it less frequently explores the opinions of host countries (Elobu et al., 2014; Kraeker & Chandler, 2013). Evaluating outcomes from the host partner's perspective are of particular importance in order to develop long-term partnership relationships.

D. SUMMARY OF GLOBAL PARTNERSHIPS

Global partnerships have potential to benefit occupational therapists and the OT profession. Partnerships are complex activities requiring occupational therapists to have a wide array of knowledge beyond clinical skills. Ensuring tangible outcomes is important; however, meaningful global projects benefiting both the host partners and visiting occupational therapists are only possible when a strong, but caring relationship is formed. Such relationships must be supported by good communication, and fostered continuously by a sense of trust, respect, and mutuality. Additionally, an open, humble, and culturally sensitive attitude would contribute to the development of such conducive relationships.

Without a doubt, all visiting occupational therapists have a genuine desire to help host countries. However, it may be important to be aware that their efforts, if provided with little attention to the host contexts and culture, could unknowingly have a negative impact on local colleagues, and possibly the growth of the profession. This makes gaining the basic knowledge about the host partners a priority when preparing to visit the host country.

Linking visiting occupational therapists' efforts among multi-level stakeholders within the host country is also important. This idea will have critical implications if the OT profession in a host country is struggling to grow, and the profession is neither well protected by regulations nor vulnerable to contextual influences. Networking with occupational therapists at local and national levels would help visiting occupational therapists navigate the challenging contexts, and they can help local colleagues and be part of the growth of the OT profession in host countries. Such efforts are difficult, but important when considering the sustainable benefits of well-established health care professionals/programs on people in the host country. Strong partnerships, knowledge about the host country, and multi-level efforts are some of the core ideas that lead to successful global partnership projects.

II. GENERAL CONTEXTUAL FACTORS IN MEXICO

Mexico is a country with a diverse culture, language, and geographic features. This chapter will introduce some of the important aspects of Mexico, including the political structure, economic growth, health systems, and culture of the country. In the last 15 to 20 years, the country made attempts towards democratization, which has resulted in some improvements in their health systems and other infrastructures. It is important to note that the information provided here will help visitors understand the subsequent chapter about occupational therapy practice in Mexico.

Flag of Mexico

(Gabino, 2001)

A. CLIMATE AND GEOGRAPHY

Many may believe that Mexico is warm all year round, but the country has varied climate depending on the region. Ecologically, Mexico enjoys a wide variety of landscapes, from the dry regions in the north to tropical rainforests in the south (Shaw, n.d.). These geographic differences influence the climate: The northern part of the country has cooler temperature during the winter while the south has hot weather with relatively constant temperature throughout the year (Hanratty, 1997). During the winter months, for example December and January, in Mexico City, the temperature may drop to six degrees Celsius or lower 40s Fahrenheit (Barbezat, 2016). The two distinct seasons in Mexico are rainy and dry seasons, and depending on the region, the rainy season may be between June and October (Hanratty, 1997).

B. BRIEF HISTORY

Mexico is a country with a rich history, and the historical beginning dates back at least a few thousand years. Many advanced civilizations, which were built by indigenous people of Mesoamerica, including Olmecs, Maya, Teotihuacan, Toltec, and Aztec, rose and fell since before the current century (History of Mexico, 2016). One of the notable civilizations, Maya, peaked between 250 BCE to 900 CE, covering large territory from southern Mexico to the northern Central America, and some of their greatest achievements included development of sophisticated calendar and ancient pyramids (Haggerty, 1997; Maya Civilization, 2016). Another key native civilization, Aztec, gained prominence in 1300s, and established its capital in the modern day Mexico City. The Aztec empire flourished based on the social class

Pyramid of Chichen Itza by Maya

(Ostertag, 2006)

President Benito Juárez

(Anonymous, n.d.)

system, and the tribute system - provision of goods, such as produce and precious metals from conquered cities (History of Mexico, 2016).

The 300-year Spanish control began when the Spanish conquistador, Hernán Cortés arrived in Mexico in 1591 (Haggerty, 1997; History of Mexico, 2016). The fall of the capital in 1521 marked the end of Aztec rule and the gradual emergence of the modern Mexican national identity, the blended culture between the native civilization and Spanish culture (Haggerty, 1997; History of Mexico, 2016).

After the 1821 independence from Spain, Mexico faced conflicts with foreign nations for 40 years, including the Mexican-American War and French intervention of Mexico City. Under the leadership of President Benito Juárez, Mexico regained its control from the French in 1867. Upon Juárez's death, Porfirio Díaz, who was known for modernization and industrialization of Mexico, rose to power as the president. However, he was considered a dictator who ruled Mexico for over 30 years. People revolted against Díaz, and Mexico underwent yet another armed conflict known as the Mexican Revolution. Although it was difficult 10 years, the conclusion of the war brought Mexico together to establish the first constitution, the constitution of 1917 (Haggerty, 1997; History of Mexico, 2016; Palazuelos & Capps, 2013).

After the revolution, Mexico entered into a relatively stable period in terms of armed conflicts. However, the country struggled to establish a democratic regime. Since 1934 for approximately 70 years, Mexico was ruled and dominated by a single political party. Some of the major events during this 70-year period were the economic crisis in 1980s, the North American Free Trade Agreement by President Salinas in 1994, and the Zapatista uprising in Chiapas for the right of indigenous people in 1994 (Haggerty, 1997; Palazuelos & Capps, 2013).

Mexico made efforts in transitioning itself to a more democratic and decentralized government over the past few decades (Álvarez Tovar, 2013). One of the notable events that characterized the transition was the end of the single-party domination when Vincente Fox from the opposing political party became the president in 2000 (History of Mexico, 2016; Palazuelos & Capps, 2013). The next candidate, Felipe Calderón, from the same party as Fox took over the office in 2006 (History of Mexico, 2016). However, this transition did not last. The party that dominated the government for 70 years returned to power in 2012 when Enrique Peña Nieto became the president (History of Mexico, 2016). Despite some improvement, political struggles towards democratization and decentralization continues to this day.

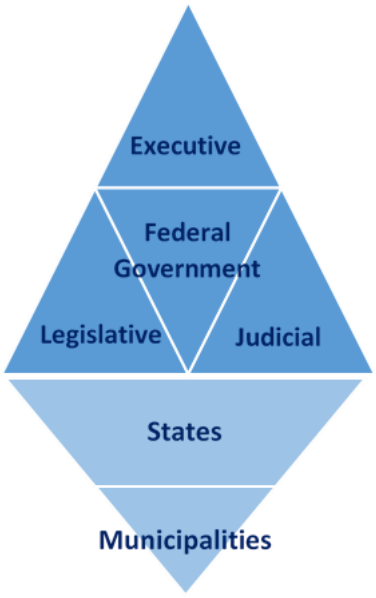
Reflective Questions

1. What are the differences between your knowledge about Mexico and the information provided here?
2. How might the information influence the way you approach your partners in Mexico?

C. GOVERNMENT STRUCTURE

Mexico, officially the United Mexican States, is composed of 32 federal entities. The federal

Government Structures



government consists of three branches: (a) the executive branch, led by the president who is elected every six years; (b) the legislative branch, composed of Senate and Chamber of Deputies (similar to House of Representative in the US); and (c) the judicial branch, organized at the federal and state levels, with the highest court being the Supreme Court of Justice (Brás, 1997). Under the federal system, each state has its own government, which is comprised of local governing bodies, the municipality (Brás, 1997).

Mexico adopted the federal system for over several decades. However, the political system in Mexico had been considered a highly centralized authoritarian regime until the presidential election in 2000 (Schiavon, 2006). One of the causes for centralization was that the state and municipal governments were financially dependent on the federal government (Brás, 1997). Another cause was the power of the executive branch. Under the single-party rule, it dominated the other two branches, and its power was extended to the state and municipal levels, creating the government without checks and balances (Schiavon, 2006).

The democratic changes over the years, especially the transition to the multi-party system, were positive, and society's pressure on the government to combat corruption promoted transparency. However, issues remnant of the past political challenges are still persistent in Mexico. Corruption Perceptions Index represents the perceived level of corruption in the public sector among 176 countries around the world, and countries are evaluated between zero and 100 with zero being considered highly corrupted (Transparency International, 2017). The value of Mexico in 2016 was 30 compared to the global average of 43 (Transparency International, 2017). This below-average level by Mexico highlights the challenge Mexico faces despite the changes in the past few decades.

D. ECONOMY AND GROWTH

Mexico experienced some economic ups and downs in last few decades. The major downturns were the recessions in the 1980s, the mid-1990s, and the 2009 recession influenced by the global economic crisis (Goodman, 1997; Villarreal, 2010). Mexican economy has been growing since the last recession (see Quick Fact 1 on this page); however, it has only experienced moderate growth in recent years. The current economy relies on private consumptions because the external environment is not necessarily favorable for its economic growth (World Bank, 2016d). The growth of manufacturing sectors had a positive impact on the economy: Manufacturing in automotive, electronic, plastics, and aerospace industries has noted to be especially strong in recent

Quick Fact 1:
Economy and Growth in Mexico

Economy

- GDP:
  2nd largest economy in Latin America
  15th largest economy out of 195 countries

Growth

- HDI: 74th out of 188 countries
- Difference between GNI and HDI: - 4

(Word Bank, 2016b; World Bank, 2016c; UNDP, n.d.)

years (Stratfor, 2015). In addition to the manufacturing sector, tourism has been considered important for Mexico (Goodman, 1997).

The Human Development Index (HDI) is used to evaluate social and health development of a given country in the areas of health and longevity, education, and standard of living (United Nations Development Programme [UNDP], 2015). According to UNDP (n.d.), Mexico was ranked as a country with high human development (see Quick Fact 1 on page 11), indicating that the government has been supporting the system and infrastructure important for its people in the given areas. On the other hand, the same UNDP data showed that Mexico has a low value (-4) when comparing the Gross National Income (GNI) per capita rank and the HDI rank (see Quick Fact 1 on page 11). The difference between GNI and HDI is often used to measure how well the economic growth is contributing to the life of the people in the given country (World Bank, 2004). The low value in Mexico in 2014 means that the economic growth might not have been fully utilized for human development despite recent economic status.

E. HEALTH CARE

Similar to other countries, health care issues continue to be a difficult challenge in Mexico. Unequal quality of care remains a problem despite Mexico's significant efforts to ensure the rights of all people and efforts in providing health coverage to all people.

Quick Fact 2:
Health Coverage in Mexico

Programs	Employment	Funding Sources
IMSS	Private companies	Employee, employer, & government
ISSSTE	Government	Employee & government
Special Programs	Military/navy, & energy	Employee & government
Popular Health	Non-salaried (e.g., self-employed)	Federal/state governments & participants

(Knaul et al., 2012; Hanratty, 1997; ManattJones Global Strategies, 2015)

1. HEALTH SYSTEM

The health care coverage in Mexico and health systems are characterized as unequal and fragmented (ManattJones Global Strategies, 2015; Whyte, 2009). Only a small percentage of people in the upper to middle class has an access to private insurance (Whyte, 2009), and the majority of the people use the government-sponsored health programs. Those who have formal employment and their families making up approximately 50% of the population are covered by employment-based programs: the Mexican Social Security Institute (IMSS), the Institute for Social Security and Services for State Workers (ISSSTE), or special programs for other formal employment sectors (Hanratty, 1997; ManattJones Global Strategies, 2015). Until 2003, the rest of the people were left without adequate health care support (Knaul et al., 2012).

The 2003 reform led to the development of universal coverage, Popular Health Insurance or *Seguro Popular*, which aims to provide an access to health services to the people who were in the non-salaried employment sector (Knaul et al., 2012). The program especially benefits many low-income families because these families are not required to make contributions if they fall under the low-income exemption (Knaul et al., 2012).

Key Idea:

The majority of the health services in Mexico is provided under the public health care system, which is typically affiliated to the government programs.

These government-based programs improve access to health care for many people in Mexico, however, not without problems. The programs are dictated by inflexible and fragmented service delivery as each program has its own network of facilities (hospitals, pharmacies, etc.) and providers, and patients have access to services only within the specific network (ManattJones Global Strategies, 2015). For example, a person who has the IMSS coverage can only see a doctor within the IMSS network. This fragmented service delivery can be problematic as each program is run according to its own standards, and resources are used inefficiently among the divided programs, potentially leading to lower quality of care (ManattJones Global Strategies, 2015).

2. COST OF HEALTH CARE

The health care in Mexico is relatively inexpensive (see Quick Fact 3 on this page), but Mexico's health care spending is rapidly increasing as the average in 1995 was only $172, compared to that of $677 in 2014 (World Bank, 2016e). The availability of health care programs and low expenditures do not mean people can easily afford health care. Compared to the OECD countries, Mexico had higher percentage of out-of-pocked medical spending: 45% of the spending were out-of-pocket in 2013 in Mexico while that of the OECD average was 19% (OECD, 2016a). Although the average health expenditure may be low, the financial impact of the out-of-pocket expense may be significant especially for those who live in poverty (see Quick Fact 6 and 7 on page 15 for the data about poverty).

Quick Fact 3: Average Expenditure per Capita in 2014 (US$)

Mexico: $677
vs.
USA: $9,403

(World Bank, 2016e)

3. RIGHTS OF PEOPLE WITH DISABILITIES

Similar to other countries, Mexico has been working over the years to update the laws and regulations, and develop programs and agencies to protect the right of people with disabilities. In Mexico, the federal constitution guarantees the health protection of all people (Gutiérrez, 2014); however, the most significant events took place relatively recently.

One of the notable event was the enactment of the General Law for People with Disabilities in 2005, which protects the rights of the people with disabilities (Prieto Armendáriz & Saladin, 2012). This law was eventually updated into the landmark law, the new General Law, General Law for the Inclusion of Persons with Disabilities in 2011 (Office of the United Nations High Commissioner for Human Rights. [OHCHR], 2014; Prieto Armendáriz & Saladin, 2012). The 2011 General Law was significant because it specified the monitoring agencies, such as CONADIS, to ensure the enforcement of the law (Prieto Armendáriz & Saladin, 2012). Another important event was the ratification of the UN Convention of Persons with Disabilities of 2007, which was initially proposed by Mexico during the international conference in 2001 (Schulze, 2009). It is evident that numerous efforts have been made to protect the rights of people with disabilities. However, enforcement of the law continues to be a challenge in Mexico (United States Department of State, 2015). Providing detailed history and functions of all laws

Quick Fact 4:
Major Events
Rights of People with Disabilities
(Abbreviated)

1970s: National System for Integral Development of the Family (DIF)
1995: National Coordination Commission for the Welfare of People with Disabilities (CONVIVE)
2001: Office for the Promotion and Social Integration of People with Disabilities
2000s: National Council for People with Disabilities (CONADIS)
2005: General Law for People with Disabilities
2007: UN Convention of Persons with Disabilities
2011: General Law for the Inclusion of Persons with Disabilities
(Diario Oficial de la Federación, 2014; Prieto Armendáriz & Saladin, 2012)

and agencies was not possible, but some of the major events relate to the important laws and agencies are provided in this document (See Quick Fact 4 on this page).

In addition to the basic rights, accessibility is also protected by the law in Mexico. Designated parking spots and ramps for the people with disabilities are seen in many buildings in Mexico. Various laws and regulations to ensure accessibility for the people with disabilities have been mandated at multiple governmental levels (Michailakis, 1997). However, in reality, limited accessibility to buildings continue to be a challenge in Mexico (Crowe, Picchiarini, & Poffenroth, 2004). Many public buildings are difficult to access because of noncompliance (United States Department of State, 2015), and some older buildings may not be easily upgraded because their historical value limits such changes (Crowe et al., 2004). Additionally, many rural areas are difficult to navigate because these roads have uneven pavement or rough unpaved paths, and are not well-maintained. These problems can be seen in towns and cities, and the accessibility continues to be a challenge.

4. PEOPLE WITH DISABILITIES

Demographics of people with disabilities in Mexico may be similar to most countries. According to the national statistics (Instituto Nacional de Estadística y Geografía. [INEGI], 2015a), in 2014, 7.2 million people reported to have difficulty or not able to do some of the basic activities (i.e., people with disabilities) and about 15.9 million had mild or moderate difficulty performing the same activities out of the total population of 120 million people. There were no large discrepancies in prevalence of disabilities by gender while the older population was identified as having higher prevalence of disabilities (INEGI, 2015a). Types of disabilities identified by the general population are provided in the box here (See Quick Fact 5 on this page), and the data for pediatric and geriatric population is available in Appendix B.

Quick Fact 5:
Types of Disabilities
(General Population: 2014)

Most Frequently Identified to Least			
1	Ambulation / lower extremity (64%)	5	Upper extremity (33%)
2	Vision (58%)	6	ADL (24%)
3	Cognition (39%)	7	Psychological (20%)
4	Hearing (34%)	8	Speech/ communication (18%)

* Some people reported more than one area of difficulties.

(INEGI, 2016)

Quick Fact 6:
Percentage of Poverty

	Poverty	Extreme poverty
% to the total population	37.7%	9.8%

Approximately 47% (53 million people) live in poverty

(Wilson & Silva, n.d.)

5. SOCIOECONOMIC STATUS AND HEALTH DISPARITIES

No society is without inequalities, and there are marginalized groups that experience health disparities. The following sections will describe the situations in Mexico based on some of the WHO definitions of contextual determinants of health (WHO, 2016).

a) Social Class

In Mexico, social class has significant importance on poverty and health disparity. Generally speaking, attributing wealth distribution to race is not common in Mexico (Martinez & de la Torre, 2011). Race has some impact on class, however, race alone is not the dominant factor for social stratification because other factors, such as class origins (e.g., parent's occupations) is considered more important in Mexico (Flores & Telles, 2012). A family with abundant of resources is able to offer better opportunities for children, such as having better education, which possibly leading to higher level of schooling and income (de la Calle & Rubio, 2012). The impact of parents' background on their children may be commonly seen in other countries. However, what sets apart Mexico from other countries is social mobility. Mexico has a limited social mobility (de la Calle & Rubio, 2012), and people cannot easily move upward within the social class.

b) Economic Inequality and Poverty

Economic inequality and poverty remain serious challenges in Mexico. Latin American countries, including Mexico, generally have high level of income inequality although the growth rate of economic inequality in Mexico has declined in recent years (Lustig, 2015). Although economic inequalities may be improving, the differences in income is concerning. For example, in 2014, 64% of the wealth was generated only by the wealthiest 10% in Mexico (Credit Suisse, 2014). The middle class is growing in Mexico, and percentage of middle class and beyond has almost doubled from 2000 to 2015 (Credit Suisse, 2015), however, the recent economic growth is enjoyed primarily by the upper, elite class (Flannery, 2013). This data indicates that unequal distribution of wealth is not only a problem for the people in poverty, but has pervasive effects on all people in Mexico.

Poverty is a serious problem in Mexico as nearly half the population lives in poverty (See Quick Fact 6 and 7 on this page). Some people living in poverty experience serious problems, such as difficulty securing food. In 2012, nearly 20% of the population experienced food poverty in that people could not afford food even spending their total earnings (Wilson & Silva, n.d.). As described in the Health System section (page 12), the employment status determines one's health insurance program in Mexico.

Quick Fact 7:
Income Per Month among People in Poverty in 2012 (US$)

	Poverty	Extreme poverty
Urban	$177	$85
Rural	$113	$60

(Wilson & Silva, n.d.)

Reflective Questions

What are the similarities and differences in terms of health disparities compared to your home country?

This indicates that the level of income certainly influence the quality and level of health services a person could access.

c) Education

A level of education plays an important role in determining the type of work and the income a person can attain, and subsequently inequality. According to the 2013 data, Mexico has been doing well with early childhood education, and participation in the education program at this level was nearly 100% (OCED, 2013). However, Mexico is not doing well with the education beyond the age 15 group. The same data reported that the graduation rate at upper secondary school was 47% (as opposed to the OECD average of 84%), and the rate of tertiary education attainment between age 25 and 34 was 23% (the OECD average of 39%). Educational attainment can be an important factor that influences a person's health status because of its relationship to occupational attainment and the social class.

d) Supportive Living Environment

A supportive living environment is an important factor for health. Some people have difficult living conditions in Mexico. According to the national statistics, 3.6 % of the homes had dirt floors, 20.4 % had access to water, but plumbing was available outside the house, and 6.1% of the homes were not hooked up to the drainage system in 2012 (INEGI, 2015b). The same report indicated that some homes did not have some of the helpful appliances: approximately 15 % of the homes did not have refrigerators and 30% did not have washing machines (INEGI, 2015b). It is possible people's health can be compromised without a supportive living environment.

e) Access to Health Services

Popular Health Insurance certainly increased the access to health services for those who were not previously entitled to the employment-based health programs. Although it is considered the universal health care, Popular Health Insurance requires voluntary participation among users (Knaul et al., 2012). Therefore, not all the people utilize the program. Approximately 18 % of the population still did not identify themselves to be affiliated with any health program according to the 2015 census (INEGI, 2015b). Popular Health Insurance provide affordable care; however, the limited types of medical service continue to be a source of inequality. Guerrero Cantera et al. reported that the Popular Health Insurance only covers the pre-determined interventions, and patients are required to cover the cost if it falls outside of the coverage (as cited in Gutiérrez, 2014).

The access to quality health care services is also a problem in rural areas. For example, physicians are unequally

Key Idea:
Factors Influencing Health Disparities

1. Social class & mobility
2. Poverty among 50% of the population
3. Low education attainment beyond age 15
4. Difficult living environment for some people
5. Unequal access to health services, including rurality
6. People with indigenous background

distributed throughout Mexico, in which urban areas, such as the Federal District, enjoy high density of physicians while a remote state, such as Chiapas, does not (OECD, 2016a). In addition to limited access to basic care, specialty care may not be readily available in rural areas (Gutiérrez, 2014). Access to health services are not equal within the segmented Mexican health care systems, and between the urban and rural settings.

e) Cultural Factors

People in Mexico may not always heavily emphasize race and ethnicity as issues. However, people with indigenous background experience disparities at more profound level because of their language and cultural differences. People with indigenous background are primarily concentrated in southern states, including Oaxaca, Yucatán, Campeche, Quintana Roo, Chiapas, Puebla, and Guerrero (INEGI, 2015b), and some of the southern states are considered having limited access to health services (National Council for the Evaluation of Social Development Policy [CONEVAL], 2012a). The inadequate access to health services in rural areas is due to the fact that some areas are so marginalized that there are no health centers that meet the criteria of national welfare programs (Servan-Mori et al., 2014). The living conditions among some people with indigenous background may also be less favorable. According to the 2015 census, some of them lived in homes with dirt floor: 14% compared to the national average of 3.6% (INEGI, 2015b). Only 38.4% of them had water plumbing inside the house while that of the national average was 74.1% (INEGI, 2015b).

People with indigenous backgrounds are also challenged with a higher incidence of poverty and lower education level compared to the rest of the population. For example, nearly 80 % of the people who speak indigenous languages lived in poverty in 2010 (CONEVAL, 2012b). The average length of schooling among the people who speak indigenous languages was 5.7 years compared to 9.1 years for the national average (INEGI, 2015b). Some of the reasons for limited participation to educational services among people with indigenous background in Mexico were lack of teachers and teaching materials utilizing indigenous language (United States Department of State,2015).

Similar health disparities due to social inequality may also be seen in other countries. The information provided in this section exemplifies the complex nature of the challenges experienced in Mexico, especially among the people with indigenous backgrounds.

F. CULTURE

This section will introduce some aspects of culture in Mexico that may be useful for visitors. As previously described in the Humble and Sensitive Approaches to Global Partnerships section (page 3), it is important for visitors to remember that culture is fluid, and simple categorization would not be sufficient to understand a person (Beagan, 2015; Loue, 2012; Tervalon & Murray-Garcia, 1998). Generalized characteristics of a specific group may be helpful when initiating dialogues with a person with a different cultural background, but such knowledge should only be used as a reference point for visitors, so that they can develop their own knowledge and understanding about unique values and beliefs of their partners.

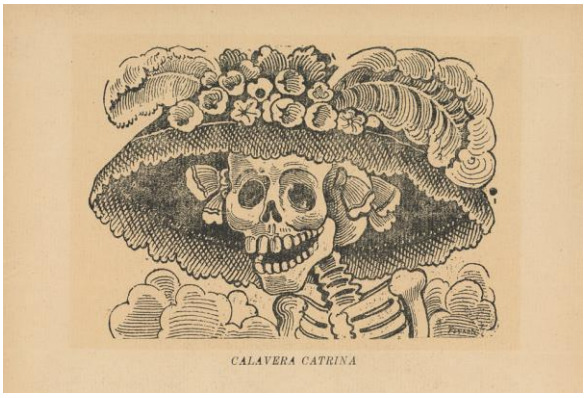
Key Idea:

Culture is ever-changing, and no one person has the same culture

1. PEOPLE

The population of Mexico in 2015 was approximately 127 million people (World Bank, 2016a) which, due to its complex history, consists of people with diverse racial and cultural backgrounds. The ethnic groups include mestizo, indigenous people, and other groups (Hanratty, 1997; Demographics of Mexico, 2016). Statistically, mestizo, the people with mixed heritage between European and indigenous backgrounds, is the largest group and includes 62% of the population (Central Intelligence Agency [CIA], 2016). According to the same CIA data, 28% of the population is characterized as predominantly indigenous or indigenous people, and 10% of the population (classified as "other groups") may include people with European, Arabian, African, and Asian backgrounds (CIA, 2016; Demographics of Mexico, 2016).

La Calavera Catrina (Elegant Skull)



(Posada, 1913)

2. LANGUAGE

The dominant and national language in Mexico is Spanish, however, Mexico is a multilingual country. Approximately 93% of the people speak only Spanish (CIA, 2016), and different dialects of Spanish are spoken, depending on the region (Mackenzie, 2013). In 2015, 6.5% of the people spoke in indigenous language (INEGI, 2015b). More than 90 indigenous languages exist, which are used predominantly in the southern states (Hanratty, 1997; INEGI, 2015b) where many indigenous people reside. In 2015, approximately 910,000 people were indigenous language speakers who did not use Spanish (INEGI, 2015b). Two of the most spoken native languages are Náhuatl (the language used by the Aztec) and Maya (Hanratty, 1997; INEGI, 2015b). It is also important to note that not all the people in Mexico speak English.

3. CULTURAL VALUES AND BELIEFS

Mexico has an interesting culture emerging from indigenous people and Spanish. Mexican culture is diverse as each region of Mexico enjoys its own distinctive culture. For example, cuisine in Mexico is a blended dish between the traditional cooking of Mexico and that of Europe, and has developed over the centuries since the Spanish arrival in Mexico in 1500s (Mexican Cuisine, 2016). Dishes also developed based on the specific characteristics of the regions: *machaca* (a dish with dried meat) in the north where the livestock industry is prominent due to the dry climate, to *cochinita pibil* in Yucatán peninsula that is influenced by the Maya (Mexican Cuisine, 2016). Each region is also known for its specialty product, such as cheese in Oaxaca and vanilla in Veracruz (Mexican Cuisine, 2016). Mexican food is strongly tied to everyday life of people in Mexico, and continue to be one of the important aspects of Mexican culture (Mexican Cuisine, 2016).

Many states also have traditional clothes to represent their regions. For example, one of the smallest states in Mexico, Aguascalientes, has its own traditional clothing (Campos Espino, 2016) that reflect what the state is known for, embroidery work. These regionally different traditional clothes were profoundly influenced by their histories (McFeaters, n. d.). Although people wear contemporary clothes

Dress with Traditional Features of Aguascalientes

(Linares Garcia, 2015)

every day, they still value traditional clothing and embrace their cultural heritage. This may be seen among children who dress up with traditional clothing during cultural celebrations, such as the Independence Day in September and the Revolution Day in November.

Another important factor influencing Mexican culture is the religion as it influences people's values and beliefs. The majority of the population identify themselves with Christianity, and over 82% of the population were Roman Catholics in 2010 (CIA, 2016). Similar to food and clothing, religion is part of people's daily lives as people in Mexico customarily attend churches and celebrate religious holidays.

a) Family System

Generally speaking, people in Mexico are considered collectivists (Hofstede, n.d). Collectivists tend to value cooperation and harmony (Goncalo & Staw, 2005) over individual interests, and this characteristic may be represented in the strong values people in Mexico place on their family (Hernández Pozas, 2013). People in Mexico are known to take extra care to protect and sacrifice for their family because of their strong sense of responsibility for their families, and this value is called *familismo* (Santana & Santana, 2001).

Within the family dynamics, traditional gender roles may be seen: the man as a protector and provider of the family and a woman as a caretaker (Santana & Santana, 2001). Within the family system, a father may take the primary responsibility in making important decisions for the family; however, the mother's opinions as well as those of other family members are also valued (Santana & Santana, 2001). It may be common to see that decisions are being made as a family (Santana & Santana, 2001), which may include medical decision-making. Consideration for collectivism may be necessary when working with colleagues in Mexico as visitors who value individualism may have different attitudes and expectations within a work setting. Additionally, the central value placed on a family is critical when interacting with clients, and visitors' understanding of the strength of the family is paramount.

b) Beliefs about Disabilities

The view on disability in Mexico may be different from that of visitors. In some countries where a person's independence is valued, it is common that the goals of rehabilitation are to enable the person by remediating and restoring lost functions. However, in Mexico, interdependence may be considered more important than independence. The idea that a person becoming functional with the help of family members may be more important than functional independence of the individual (Santana & Santana, 2001). This view (interdependence) when being combined with *familismo*, could pose a challenge because families sometimes may overprotect the person who is disabled. The need to protect children and the elderly may be particularly strong due to the family responsibility and the sense of respect towards the elderly. It may be possible to see family members attempt to provide all assistance to those who have disabilities without encouraging their functional independence.

Additionally, religious and traditional beliefs may influence their views on illness and disabilities. Some people in Mexico may consider that the health issues as God's will and may incorporate religious approaches to their illnesses (Santana & Santana, 2001; Vela, 2011). Because of the traditional beliefs, some people in Mexico have different beliefs about illnesses, such as *mal de ojo* or evil eye (Santana & Santana, 2001; Tafur, Crowe, & Torres, 2009; Vela, 2011), and may take the traditional approach to health issues. For example, people in Mexico may use a c*urandero* or *curandera* (a traditional Mexican healer) and value the hot and cold dichotomy in the treatment process (Santana & Santana, 2001; Tafur et al., 2009; Vela, 2011). It is important to acknowledge that these views can be important for people in Mexico, and visitors may need to further review the relevant information, depending on the goals of their visits (Appendix E).

Reflective Questions

What are the differences in rehabilitation goals between your country and your colleagues and/or clients?

c) Gender Roles

Gender roles are typically well-defined in Mexico, and influence various aspects of the society (e.g., gender-based roles within a family, as described in the Family System section in page 19). The gender roles between males and females are *machismo* and *marianismo* respectively (Santana & Santana, 2001; Vela, 2011), and people commonly take up on gender-based expectations within these roles (Schmitz & Diefenthaler, 1998). These gender-based distinctions may contribute to Mexico being characterized as a male-dominant society.

Although the roles of women in workplace have evolved and women have made advancement in society over the years, gender inequality is still observed today. The statistical data about females working in Mexico reported that they are less likely to occupy managerial positions and make less salary compared to the male counterpart (World Economic Forum, 2016). Visitors may need to be sensitive about the situations where the gender roles and expectations influence their colleagues as well as clients, such as during the decision-making process.

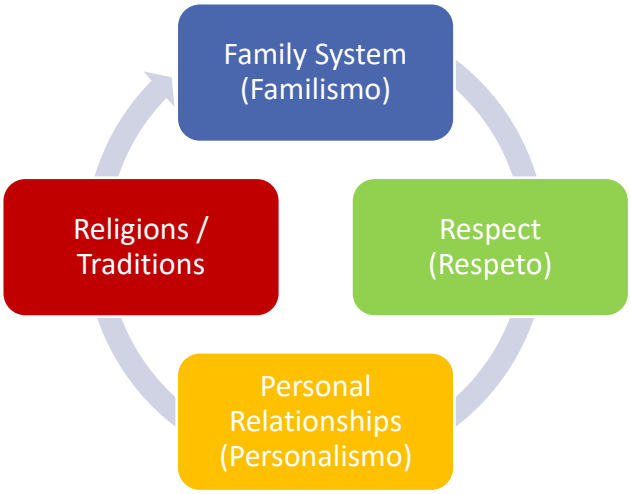
4. RELATIONSHIPS AND COMMUNICATION

Generally speaking, people in Mexico are warm and welcoming, and most people are very sociable and appreciative of visitor's help. Such generalization, although positive, may not accurately represent individuals as their behaviors and actions are strongly influenced by their own unique values, beliefs, and personal experiences. Despite the danger of stereotyping, this section will explore some of the important ideas that may be helpful for the visitors when they start developing relationships with their partners in Mexico.

a) Personal Relationships

People in Mexico are known to emphasize personal connections. The collectivistic view, as previously described, has significant influence on this value that people place on relationships (Hernández Pozas, 2013). People consider it important to develop the trust and sense of caring which are fostered through personal relationships (Canada. Centre for Intercultural Learning, 2014; Real Embajada de Noruega, n.d.). This value is also prevalent within a work setting. While some countries may prefer a direct approach (i.e., get to the point), people in Mexico often make it a point in sharing personal matters, such as asking about family (Real Embajada de Noruega, n.d.). This value, emphasizing

Some of the Important Values



warm and personal interaction, is called *personalismo* (Santana & Santana, 2001), and is one of the important ideas in Mexico.

Another important aspect in relationships is that Mexico is a hierarchal society (Hofstede, n.d). In Mexico, important decisions are typically made by people who are ranked high in the hierarchy at the workplace (Canada. Centre for Intercultural Learning, 2014). However, even within a hierarchical relationship, the people in higher status need to take a personable approach to their subordinates (Canada. Centre for Intercultural Learning, 2014). The same is true for the clinical environment. Generally, health care professionals are highly regarded (Santana & Santana, 2001) and an authority figure; however, being personable and respectful is extremely important in client-practitioner relationships (Santana & Santana, 2001; Smith, 2003).

The idea related to a hierarchical relationship is also connected to another important value in Mexico, respect or *respeto* (Schauber, 2001). The visitors may need to understand that respect must be paid mutually (Santana & Santana, 2001). People in Mexico show respect by being cordial and formal, such as addressing a person by the last name with an honorific prefix, such as Señor or Señora (Canada. Centre for Intercultural Learning, 2014; Santana & Santana, 2001; Smith, 2003). It is also important to recognize that respect may be automatically granted for a person in the higher rank simply because of his or her superior position (Schauber, 2001). The hierarchal nature of Mexican society may make it important for visitors to be sensitive about their inherent power when interacting with both colleagues and clients.

b) Communication Style

Communication style of people in Mexico may be greatly different from that of visitors. They are considered having high-context culture (Georgakopoulos & Guerrero, 2010). The seminal work by Edward T. Hall defined that people in high-context culture prefer a less explicit communication style with nonverbal expression (as cited in Georgakopoulos & Guerrero, 2010). For example, "reading between the lines" would become more important when communicating with people in Mexico as they may not necessarily say what is in their mind. Within a work setting, it is common that communication is indirect, and people may not openly show disagreement to avoid being viewed as confrontational (Kopp, 2012). This tendency may be more pronounced in a hierarchal relationship. In some cases, they do not ask questions

Reflective Questions

1. How do you ensure you understand the partner's needs when they do not explicitly express their needs?
2. How is your position as a visitor influencing relationship-building and communication?

Key Idea:
Cultural Aspects to Consider

1. Diversity by geographic areas, ethnicity, and languages
2. Traditional values (family, being personable, respect, and gender roles)
3. Religious and traditional beliefs about health
4. Value on personal relationships while considering hierarchy
5. Interdependence as an attitude towards disabilities
6. A subtle and indirect communication style
7. Preference on neat appearance

because they do not want to appear they don't understand instructions from superiors (Kopp, 2012; Schauber, 2001). However, indirectness does not equate with low emotional affect as display of emotion is considered important in Mexican culture (Canada. Centre for Intercultural Learning, 2014). The difference in communication style suggests that it is important for visitors to read the partners' cues carefully. It also suggests the need to pay attention to the way visitors convey themselves because people in Mexico may find visitors' assertive, direct communication style offensive (Kopp, 2012; Schauber, 2001).

Another characteristics is that Mexico is considered to have contact oriented culture (Georgakopoulos & Guerrero, 2010). According to the work by Hall, people in this culture tend to have closer personal space (as cited in Georgakopoulos & Guerrero, 2010). Communication with people in Mexico often involves physical contacts, such as kissing or touching. Women may greet each other by kissing on a cheek and shaking hands while men may only hug and handshake (Canada. Centre for Intercultural Learning, 2014). Even in a business setting, personal touch is common, and avoiding physical contact will not be well-received (Real Embajada de Noruega, n.d). However, greeting approach could vary depending on the contexts, such as social vs. business, closeness of the relationship, genders, etc., and it is probably wise to observe the host's approach and follow their cues (Canada. Centre for Intercultural Learning, 2014) instead of assuming what is normal.

c) Appearance

People in Mexico are conscious about their appearance and presentation. In general, they prefer formal and conservative dress code in a work setting (Canada. Centre for Intercultural Learning, 2014; Real Embajada de Noruega, n.d.). Dressing appropriately according to the specific context is important because people may make judgments about others based on how they dress (Canada. Centre for Intercultural Learning, 2014). Dressing out of context is not well-regarded (e.g., wearing jeans and shorts at work), and untidiness is never accepted well (e.g., messy hair). The way visitors present themselves is important, and it is a good idea to ask about the dress code at the host institution prior to visits.

G. SUMMARY OF CONTEXTS AND CULTURE OF MEXICO

This section explored the diverse nature of Mexico, in terms of people, language, and culture, as well as a brief history and government structure, so that visiting occupational therapists will become familiar with some of the important elements influencing the life of people in Mexico.

Mexico's complex history gave rise to political struggles and led to the structure that made democratization very difficult in the past. However, especially in recent decades with the help of economic growth, Mexico has been making some advances towards democratization and decentralization, which contributes to improving the quality of life for its people, such as enactment of

the law protecting the rights of people with disabilities and provision of universal health care. Despite some improvement, the marginalized population, such as people in poverty and those with indigenous backgrounds, continue to experience health disparities due to social and structural barriers. The issues in Mexico should not be sensationalized because similar issues may be present in other countries, but perhaps experienced in a different manner due to different social and cultural contexts. It is important to acknowledge that visiting occupational therapists' countries may have more profound challenges in some areas.

Key Idea:
Danger of Stereotyping

Although each section of this chapter was carefully developed, it is still influenced by this author's biases.

Mexico has a fascinating culture blended between the indigenous people and Spanish. It is a country with diverse groups of people with different ethnic and linguistic backgrounds, and characterized by beautiful and colorful regional traditions. Many people in Mexico are warm, welcoming, and courteous who value personal connections, especially their families. However, some of the ideas, such as beliefs about disabilities and gender roles, may be different from those of visiting occupational therapists. Understanding some of the basic values, beliefs, and expectations influenced by the cultural norms would be valuable when trying to decipher why and how people behave in a certain way. Consideration and respect for these cultural aspects will be important when developing global partnership projects and working with colleagues and clients in Mexico. Difference in communication styles may be particularly important, and visiting occupational therapists' tactful and culturally humble approaches may be helpful for successful implementation of partnership projects (e.g., finding ways to obtain honest feedback during service evaluation).

It is important to note, however, that the information in this chapter could only provide extremely abbreviated information, and it is only a "snap shot" of the contexts and culture of Mexico. For example, some of the sections in this chapter were developed based on statistical data. It is important to note that statistical data can only provide the overall trend, and what visitors observe may be different from the local reality. Culture is constantly changing, and even within the groups of people who share the same culture could identify differences among them, such as a generation gap. It is also important to be aware that the information is not free from the author's biases although the content was developed based on the existing resources. Visiting occupational therapists are encouraged to seek further information depending on the nature and goals of their projects, and to form their unique understanding of the country with the help of their local partners.

III. PRACTICE CONTEXTS SURROUNDING OCCUPATIONAL THERAPISTS IN MEXICO

The following section will cover some ideas about the status and progress of occupational therapy in Mexico, which may be similar or different in its professional development compared to the visiting occupational therapists' home countries. It will be important to remember that the culture of occupational therapy differs among countries. Perhaps, it is also different even within the country because each occupational therapist or group of therapists may have unique values and ideas about the profession. For example, in the United States, there are different views about what constitutes best practice or what the entry point should be for occupational therapy education (e.g., masters vs. doctorate). Visiting occupational therapists may need to be flexible to understand competing ideas about the directions and goals for the profession, and determine the best course of action that contributes to the growth of the OT profession in Mexico.

A. OCCUPATIONAL THERAPY IN MEXICO

Mexican occupational therapists are proud of their profession. The meanings they derive from their work and their desire to serve the people in need are no different from those of any other occupational therapists around the world. The following section will provide some of the basic information about the OT profession in Mexico, such as a brief history of the profession, educational programs, legal requirements, and common practice areas.

1. BRIEF HISTORY

Occupational therapy is not a young profession in Mexico. The history can be traced back as early as 1860s during the presidency of Benito Juárez (Torices Rodarte, 2012), and craft activities were provided as early form of occupational therapy by 1910 (Colegio de Terapeutas Ocupacionales de México [COTEOC], 2013b) for the psychosocial rehabilitation of people. Since this period until 1940s, the growth of the profession was somewhat stagnant. Therapeutic activities continued to be used to treat patients. However, these services were provided by professionals in psychology and special education teachers for the treatment of people with psychosocial disabilities (Torices Rodarte, 2012).

Amate and Vázquez reported that rehabilitation medicine made advancement in 1940s to 1950s during WWII and the polio epidemic (as cited in Torices Rodarte, 2012). During this period, the first occupational therapy school was founded (Torices Rodarte, 2012) under the physical therapy supervision. Nurses became the first physical therapists and occupational therapists in 1950s in Mexico (Cromwell, 1977). Since the growth of rehabilitation medicine and establishment of the school, occupational therapists started to become more visible in the rehabilitation clinics.

Despite the growth of the profession in1940s to 1950s, the number of occupational therapists did not grow considerably. Florence Cromwell, an occupational therapist from the US, visited Mexico three times from 1971 to 1974 at the request of the Pan American Health Organization (Cromwell, 1977). According to Cromwell (1977), at the time, approximately 30 occupational therapists practiced in nine hospitals and

Reflective Questions

How different and similar is the development of the profession compared to your home country?

Quick Fact 8:
Major Events
(Abbreviated)

1910s: Use of craft activities as a therapeutic medium
1940s: Growth of the profession by emergence of physical medicine during WWII
First occupational therapy school
1950s: Nurses becoming first occupational therapists
Growth of the profession during the polio epidemic
1970s: Establishment of Asociación Mexicana de Terapia Ocupacional
1990s: Establishment of APTO and COTEOC
Becoming Associate Member of WFOT
2000s: Becoming Full Member of WFOT

(COTEOC, 2013b; Cromwell, 1977; Torices, 2012)

rehabilitation centers in Mexico, and three occupational therapy schools (two governmental schools and one private school) were available.

Although the number of occupational therapists did not grow significantly, the visits by Cromwell was beneficial for the growth of occupational therapy in Mexico. Cromwell provided intensive courses to strengthen the occupational therapy clinical practice and educational programs (Cromwell, 1977). According to Bolaños, the courses focused on introducing the new practice areas that had not been taught in Mexico, including mental health, pediatrics, and return to work (as cited in Torices Rodarte, 2012). The courses also included the training for educational programming, administrative practices, and professional development (Cromwell, 1977).

During the same period, professional organization emerged. When Cromwell visited, the first professional association, Asociación Mexicana de Terapia Ocupacional was established (Cromwell, 1977). However, it was in 1990s when the current association and regulatory body were formally founded: Asociación de Profesionales en Terapia Ocupacional (APTO) in 1993 (APTO, 2016a), and Colegio de Terapeutas Ocupacionales de México (COTEOC or College of Occupational Therapists of Mexico) in 1999 (COTEOC, 2013a). Mexico became an Associate Member of World Federation of Occupational Therapists (WFOT) in 1998, and subsequently a Full Member in 2004 (WFOT, 2016b) after the first occupational therapy educational programs were accredited by WFOT.

Some positive changes occurred in 2000s. In 2004, the first occupational therapy master's program, which was approved by both the Secretaría de Educación Pública (SEP or the Ministry of Education) and WFOT, was established (Serrano Hernández, 2013). Another activity includes the efforts to reduce the gap among occupational therapy practitioners who have the associate's degree. In 2007 to 2008, the special program was implemented to bring up the level of occupational therapy practitioners who had the associate degree to the bachelor's level (Serrano Hernández, 2013). These efforts had positive impact on the growth of the profession.

It appears occupational therapy in Mexico made steady progress. However, there were some challenges. Occupational therapy in Mexico struggled with limited autonomy in establishing their own educational programs because non-occupational therapy professionals, such as physical rehabilitation physicians and physical therapists controlled many occupational therapy programs (Bolaños & Armendáriz, 2009). Additionally, a focus on physical rehabilitation had been historically prevalent in Mexico. These issues significantly impacted the profession's growth in the areas of occupational therapy curricula and professional identity. However, in the 1990s, a movement to incorporate occupational therapy theories into practice was seen (e.g., an occupation-based approach), and numerous efforts, including collaboration with international occupational therapy lecturers, had been made to improve

the educational programs and to generate new generation of occupational therapists with new roles and identities (Bolaños & Armendáriz, 2009).

Although the historical information described here highlighted only a few events, it shows that the OT profession has had steady growth in Mexico over the years. Their growth was supported by diligent efforts by occupational therapists in Mexico and with the positive impact by visiting occupational therapists through international knowledge exchange.

Useful Links 1

APTO:

http://www.apto.org.mx

COTEOC

http://www.coteoc.org/

* Check Facebook pages for more information

2. OCCUPATIONAL THERAPY ASSOCIATIONS AND RELEVANT ORGANIZATIONS

As described above, Mexico has two national occupational therapy organizations working to promote the growth of the profession. It is important to note that Mexico is a member of the Latin American Occupational Therapy Association (CLATO) that aims to provide opportunities for networking and knowledge sharing among Latin American countries (CLATO, 2013). The organizations often mentioned as relevant among Mexican occupational therapists are Asociación de Profesionales en Terapia Ocupacional (APTO) and Colegio de Terapeutas Ocupacionales de México (COTEOC).

a) National Associations

Asociación de Profesionales en Terapia Ocupacional (APTO or Professional's Association of Occupational Therapists) strives to promote the growth of the profession by providing courses (APTO, 2016a) and sponsoring an annual national congress. The association is also important as it provides the delegate to WFOT (APTOb).

Colegio de Terapeutas Ocupacionales de México (COTEOC or College of Occupational Therapists of Mexico) is a regulatory body registered by SEP or the Ministry of Education. Its goal is to establish the standard of practice for the profession, and its effort included the development of official documentation, such as the history of occupational therapy (COTEOC, 2013b) and the ethical code (COTEOC, n.d.-a). The organization also provides the standard of education, and its format to revise occupational therapy educational programs has been accepted by WFOT.

b) State Organizations

There are no state-level civil organizations for the OT profession in Mexico. It is possible, however, that informal, interest groups may exist in some regions.

B. DEMOGRAPHICS

As is true in other countries, occupational therapy in Mexico is a female-driven profession, and 85% of occupational therapists in Mexico were female in 2013 (WFOT, 2016c). Currently, the number of occupational therapists in Mexico is very small (See Quick Fact 9 on page

Quick Fact: 9:
Comparison of Demographics Occupational Therapists

	Population in 2015	Number of OT in 2015
Mexico	127 million	447
US	321 million	132,660

(WFOT, 2016c; World Bank, 2016a)

26). The shortage is accentuated when comparing to the US data - the difference in the population is only three-fold while the number of occupational therapists in the US, which still considered as having growth potential, is 296 times more than that of Mexico. However, it is important to note that Mexico may have more occupational therapists than 447. This is because census data from some of the universities were not available at the time of data collection (V. Arzate González, personal communication, June 1, 2017).

The number of occupational therapists in Mexico is significantly smaller than that of other health care professionals. Mexico had 3,057 physical therapists in 2013 (World Confederation for Physical Therapy, 2017), 303,519 physicians, and 417,665 nurses/midwifes according to the 2011 report (WHO, 2011).

C. EDUCATION SYSTEMS

Generally speaking, the education system in Mexico is complex, and there are different types of institutions of higher education. These institutions need to be accredited by the government, and each has various policies and is overseen by different administrative bodies, including the federal entity, such as the Secretaría de Educación Pública (SEP or the Ministry of Education), the state ministries, or other bodies (Magaziner, 2016).

Useful Links 2

License Verification:

http://www.cedulaprofesional.sep.gob.mx/cedula/indexAvanzada.action

Registration with SEP for foreigners:

http://www.sep.gob.mx/es/sep1/Estudios_Obtenidos_en_el_Extranjero_yo_Por_Extanjeros

Over the years, occupational therapy programs have grown and expanded. Currently, there are one associate degree program, 10 occupational therapy bachelor's programs, and one master's program (Appendix C). Occupational therapy doctoral programs are presently not available in Mexico. Occupational therapy bachelor's programs in Mexico grant *título* or the degree upon graduation. The length of the program may vary. However, most programs would require five years of study, which typically include four years of academic work and one year of *servicio social* or fieldwork. In addition to the year-long fieldwork, short-term clinical experiences may be offered throughout the academic coursework. For example, one program offers shorter clinical assignments during the academic years (Centro Mexicano Universitario de Ciencias y Humanidades, n.d.). Most of the programs are taught by occupational therapists; however, other educators from different disciplines, such as physical therapists, may be part of the occupational therapy educational programs.

Some improvement has been made to occupational therapy educational programs over the years towards more holistic approach. However, the main focus of occupational therapy education tends to be physical rehabilitation in many of these institutions. Despite challenges, these programs have been producing a steady number of graduates each year.

D. LICENSE AND QUALIFICATION REQUIREMENT

Occupational therapists are licensed professionals in Mexico. Upon graduation, the therapists can apply to SEP to be registered as a professional and obtain *cédula professional* (professional license). Candidates apply for the license according to the level of certification or degree they obtain (SEP, 2016). Upon completing the registration process, the government assigns a license number unique to each

Key Idea:

Follow appropriate legal requirements according to the nature of the visit

- Visiting occupational therapists who obtain a paid position will require:
  - Professional license (Cédula)
  - Working visa (e.g., FM3)
  - Registration with the federal tax agency (RFC No.)
- Consult with the national OT organizations and/or host institutions if in doubt

applicant, and the public can verify the license number through the federal web site (see Useful Links 2 on page 27). Occupational therapists in Spanish is *terapeuta ocupacional*, and abbreviated as T.O. Licensed occupational therapists may use L. T. O. or Lic. in front of their names for documentation in Mexico. For example, it may appear as L.T.O. Ana Maria Rodriguez Sánchez.

Occupational therapists in Mexico do not need to be registered with the occupational therapy associations neither at the national nor state level (WFOT, 2015). This is because Mexico does not have a mandate for a national board exam or a state-level occupational therapy regulatory body. However, as previously mentioned, the occupational therapists in Mexico must be registered through the federal government.

Currently, there is no requirements for a working visa or a professional license for those who provide unpaid volunteer services (WFOT, 2015). Generally, the same rules apply to lecturers who visit Mexico for conferences and continuing education courses. However, a visiting occupational therapist, who intends to have a paid employment position in Mexico, must have a working visa through an employer. The most prominent visa is called FM3, and the application process requires the employer to provide a support letter (Kihn, n.d.). Additionally, visiting occupational therapists, who plan to have such a position, must register themselves with the federal tax agency, and obtain the occupational therapy license through SEP. The general instructions for visiting occupational therapists could be found on the SEP website (see the Useful Links 2 on page 27). This document does not provide legal advice, and visiting occupational therapists who are interested in this type of position may resolve legal issues with prospective employers.

E. PRACTICE AREAS

Similar to current dominance in rehabilitation model within the university-level occupational therapy programs, physical rehabilitation is the most common practice area among Mexican occupational therapists. In Mexico, the rehabilitation services are mainly provided through public services, such as Instituto Mexicano del Seguro Social (IMSS or the Mexican Social Security Institute) and Sistema Nacional para el Desarrollo Integral de la Familia (DIF or National System for Integral Development of the Family). IMSS, the social security programs, is one of the important rehabilitation service providers, and the system offers its services to over 50 million people across the country (Guzmán González, 2012). DIF is another governmental agency that is available in most communities, and provide rehabilitation services to children and adults (Guzmán González, 2012).

Among physical rehabilitation services, pediatric practice is one of the popular practice areas. Centros de Rehabilitación e Inclusión Infantil Teletón (CRIT or Teleton Children's Rehabilitation Centers) are private organizations, and they offer pediatric services focusing on physical rehabilitation through their nationwide network of 21 facilities (Guzmán González, 2012; Teleton México, 2015). Although pediatric physical rehabilitation within a clinic setting is prevalent, occupational therapists are working in other settings; rehabilitation centers for adults, including IMSS and DIF, and specialty clinics, such as brain injury clinics and neurorehabilitation clinics. Other practice areas may include private practice,

Additional Information Related to a Professional Status:

The levels of academic degrees are supposed to differentiate the professional status.

- Graduates with bachelor's degree: occupational therapists
- Graduates with associate degree: occupational therapy assistants

Both are simply called as "occupational therapists," regardless of the degree obtained.

especially in the area of sensory integration. Community and mental health practice is emerging, although these two practice areas are not common.

Some occupational therapists may also have dual roles. For example, some of the occupational therapists in Mexico work on their full-time position during the day, and take additional responsibility, such as private practice or teaching positions in the late afternoons or evenings. Other occupational therapists also take educator and researcher roles.

F. CHALLENGES FACED BY OCCUPATIONAL THERAPISTS IN MEXICO

This section explores some of the difficulties experienced by occupational therapists in Mexico. The information previously described in this document, such as culture and sociopolitical contexts of Mexico, and current occupational therapy practice environment, is helpful to understand their challenges.

1. DIFFICULTY WITH ENFORCEMENT

Although occupational therapists are licensed professionals, there is not a strong enforcing body that protect the title of an occupational therapist from misuse. For example, occupational therapy students in Mexico are required to fulfill certain requirements (e.g., a thesis), so that they will be awarded with the occupational therapy degree upon graduation. Unfortunately, some students do not complete these final requirements. These students are called as a *pasante* – one who completed class work, but does not have the adequate degree necessary to apply for a professional license (Magaziner, 2016). In Mexico, a *pasante* could find employment in his or her specialized area (Magaziner, 2016) without a professional license. This means that a person, who attended occupational therapy program but does not have an occupational therapy license, can work as an occupational therapist. The problem intensifies as the activities by an occupational therapy *pasante* are not well regulated. Additionally, this issue (lack of an enforcing body) goes beyond a *pasante.* In some cases, some people in Mexico simply call themselves occupational therapists, and provide "occupational therapy" services despite having neither formal academic coursework nor trainings.

Weak professional boundaries within clinical practice are another challenge. Professional encroachment is common, and other health care professionals may dominate the techniques that were specifically designed to support the practice of occupational therapy. In one case, physical therapists own a sensory room to treat their clients with sensory integration. In other case, occupational therapy may be viewed as a technique, not as a profession. One Mexican nursing journal, reporting the outcome of a group program among the elderly, described that a psychologist used

Reflective Questions

1. How does the physician-centered model influence the partnership and client care?
2. What are the differences in approaches in how evaluation and interventions are being provided?

occupational therapy as his or her intervention approach (Maldonado-Guzmán, Carbajal-Mata, Rivera-Vázquez, & Castro-García, 2015).

The system to monitor the conduct of occupational therapy practitioners in Mexico may not be same as what visiting occupational therapists are familiar with. This is perhaps because the idea of litigation, such as lawsuits against malpractice, is different in Mexico (Tena-Tamayo & Sotelo, 2005) where there is a culture of respecting authority. However, the system to report and dispute medical malpractice is available in Mexico. The malpractice is overseen by the federal government agency, the Comisión Nacional de Arbitraje Medico or the National Medical Arbitration Commission (Tena-Tamayo & Sotelo, 2005). Additionally, COTEOC has an arbitrary function, and disputes can be reported to the organization (COTEOC, n.d.-b.).

Limited enforcement poses a problem because people who do not have proper credentials can provide "occupational therapy" services without worrying too much about legal consequences. This can hinder the growth of occupational therapy because these people do not always accurately represent the profession, and may negatively influence the ways the other health care professionals and the public perceive the OT profession.

2. CENTRALIZATION

Mexico has been moving towards a more democratic system; however, it still has a centralized and hierarchal system. Centralization is considered a hurdle because health research cannot easily influence policy changes within the Mexican government (Trostle, Bronfman, & Langer, 1999). Navigating within the hierarchy in Mexico is also difficult. According to the literature, maintaining personal relationships between health researchers and decision-makers is necessary for policy changes, but difficult in Mexico because of the frequent government personnel changes every six years with the advent of each new presidency (Trostle et al., 1999). These characteristics of Mexico may influence many aspects of occupational therapy practice and make it difficult for the national occupational therapy organizations to advocate for the profession and policy changes.

Unequal distribution of occupational therapists is another challenge. Many occupational therapists work in Mexico City and the State of Mexico, but this is not necessarily the same in other regions. One of the contributing factor to this problem may be due to the fact that occupational therapy educational programs are also concentrated in Mexico City and the State of Mexico. Occupational therapists are present in other regions, however, may be most prevalent in the areas where occupational therapy academic programs are offered. These non-central regions, especially the areas without occupational therapy schools, are generally struggling to recruit occupational therapy practitioners.

This situation creates a problem - licensed occupational therapists are not readily available in some regions of Mexico. In one simplified example, some community centers and organizations that support people with disabilities may choose to hire people who does not have formal occupational therapy education, and train them internally with occupational therapy techniques in order to compensate for the occupational therapist shortage.

3. LIMITED PRACTICE AREAS

As described in the Practice Areas section (page 28), DIF and IMSS are some of the important public health agencies to provide rehabilitation services in Mexico. However, occupational therapy is

not always part of these health systems. Lack of presence within these critical systems is a problem because they sometimes hire non-occupational therapy professionals in place of properly educated and trained occupational therapists to provide "occupational therapy" services. Although rurality may play a role (i.e., occupational therapists are not present or are scarce in some regions), it is not necessarily the only reason. DIF or IMSS in regional cities, including small metropolitan cities with nearly one million inhabitants, may choose to hire non-occupational therapy professionals even though licensed occupational therapists are locally available.

Another challenge relates to the focus placed on physical rehabilitation, which are prevalent both in clinical practice and occupational therapy academic programs. The focus on physical rehabilitation inevitably narrows down the areas where occupational therapists could practice, and the problem may be further intensified by the lack of occupational therapy presence within the major health systems of Mexico.

Despite these issues, stronger interests in expanding occupational therapy practice beyond the physical rehabilitation practice are emerging in Mexico. These areas include, but are not limited to mental health, geriatrics, school system, and community. Additionally, a few university-level occupational therapy educational programs are working to expand their curricula, so that they could have programs other than physical rehabilitation, which will be necessary when expanding the practice areas.

4. INFLUENCE OF PHYSICIANS AND THE PUBLIC

In many countries, occupational therapists struggle with professional autonomy under physicians who take on a gatekeeper role in the rehabilitation process. In Mexico, physicians, especially physical medicine and rehabilitation physicians, are encouraged to take a central role in organizing and supervising the rehabilitation service delivery (Guzman & García-Salazar, 2014). In some cases, physicians may influence an occupational therapy plan of care. This is a difficult issue to address within the culture of respecting authority (i.e., physicians). For example, under the direction of physicians, occupational therapists may not independently conduct full evaluations (e.g., functional evaluation, ROM, standardized evaluation, etc.), but only conduct general intake interviews prior to occupational therapy treatment. Professional autonomy is certainly an issue. However, diminished professional autonomy is not only the case with occupational therapists, but also can be seen among other allied health care professionals in Mexico, such as physical therapists and nurses.

Reflective Questions

1. What are the consequences of teaching and training a person who is not an occupational therapist under current practice context?
2. Who are the major occupational therapy players in the geographical areas where you are visiting?
3. What does the best support look like when considering to meet the need of local organizations while ensuring the growth of the profession?

Another challenge is lack of understanding about the OT profession by the public. Generally speaking, occupational therapy is not a well-recognized profession in Mexico, and not too many people know the scope of occupational therapy practice. This is a problem because the public would not seek occupational therapy services because they do not know the extent of the services that occupational therapists could offer. Because of the lack of recognition and visibility of occupational therapy, physicians may be the first contacts that introduce the occupational therapy services to the

Useful Link 3

Ethical Code:

http://www.coteoc.org/index.php/quienes-somos/normatividad/codigo-etica

public while physicians' understanding of occupational therapy services can be limited and are not necessarily correct. These issues perhaps have a compounding effect on the occupational therapy practice: the practice areas are not expanding well because of lack of recognitions about the occupational therapy services among potential service users (i.e., supply and demand).

Influence by physicians and the public on the growth of the profession is a challenge; however, clients, and their families/acquaintances who received the occupational therapy services in the past understood what occupational therapy could offer relatively well. They also appreciated occupational therapists and continued seeking occupational therapy services as needed. This, perhaps, signifies the competent and quality service provided by occupational therapists in Mexico, and the importance of increasing accurate understanding of the profession within the Mexican health care system.

5. BODY OF KNOWLEDGE

Development of unique occupational therapy body of knowledge is another challenging area for Mexico. Currently, there is no professional journal in Mexico that is dedicated for Mexican occupational therapy scholars and practitioners. Additionally, occupational therapy textbooks developed in Mexico are scarce. It is common that the occupational therapy theories and concepts from different countries are translated and adopted to be used in Mexico. Only a limited number of published documents, delineating the profession and the professional identity (e.g., ethical code), is currently available (see Useful Link 3 on this page).

Development of occupational therapy knowledge certainly appears an issue for Mexico; however, occupational therapists in Mexico are making steady efforts to develop their body of knowledge. For example, ethical code became available in the past few years, and some Mexican occupational therapists developed or have been developing standardized assessment tools. Additionally, an online occupational therapy scholarly archive, contributed by occupational therapy students, recently became available for registered users (Instituto de Terapia Ocupacional, 2014).

G. PRODUCTS FROM VISITOR'S COUNTRY AND FINANCIAL CONSIDERATIONS

Visiting occupational therapists may have become accustomed to enjoying financial privilege and benefits compared to their partners in Mexico. It may be important to consider the availability of resources, both financial and material, before deciding to introduce possibly cost-prohibiting products developed outside of Mexico. Sustainability, the socioeconomic status of clients, and financial availability of the host organizations

Key Question:

What does it mean for Mexican partners to have products from your home country?

When considering;

Average wage in 2015 (US$)
Mexico: $15,000
vs.
US: $59,000

(OECD, 2016b)

What does the $150 product mean for low income families?

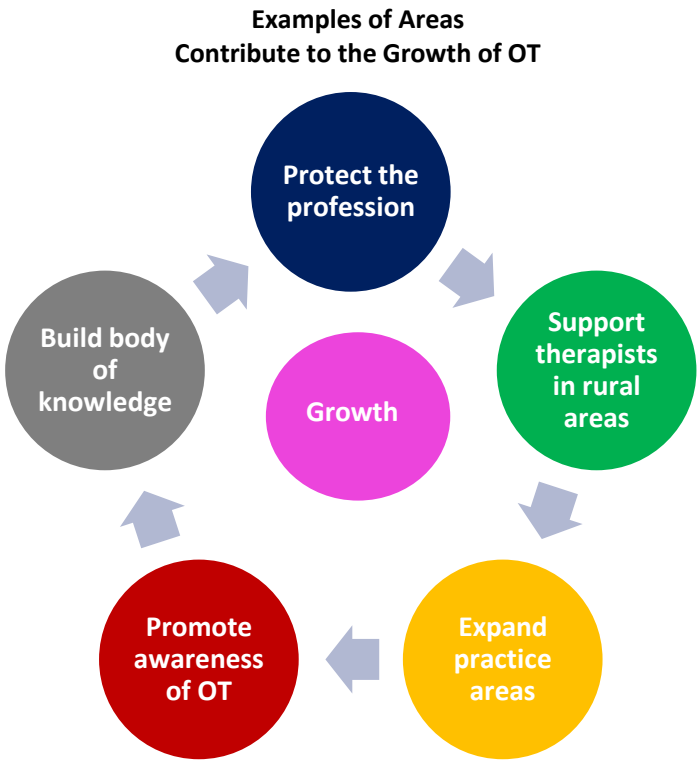
are some of the important factors to consider when planning to introduce new assessment tools or assistive devices.

Contextual understanding and discussions with hosts will help this process. When indicated by the local partners, it may also be important to consider the use of local materials and local services, such as carpenters and handymen to fabricate necessary items.

H. SUMMARY OF OCUPATIONAL THERAPY PRACTICE CONTEXT

This section presented the basic information related to the occupational therapy practice in Mexico, and introduced some of the difficult issues experienced by occupational therapists in Mexico. Looking at these issues, visiting occupational therapists may have noticed that these issues are not necessarily exclusive to Mexico, but may be common among other countries. Some issues may appear serious because they are influenced by the social and cultural environment unique to Mexico. This demonstrated the importance of obtaining contextual knowledge about the country.

As you may have noticed, many of the issues related to growth of the profession have complex correlational relationships (e.g., practice areas do not expand because of limited perceptions about occupational therapy, but perceptions cannot be improved without being visible within health systems). These issues require continuous long-term efforts by all relevant stakeholders, including visiting occupational therapists, through global partnership activities focusing on knowledge exchanges. This is not to say that visiting occupational therapists provide solutions for local colleagues' challenges, but they find the way to be part of the solutions. Any activities leading to the growth of profession, whether small or large, can be valuable, and visiting occupational therapists are encouraged to network with occupational therapists in Mexico, and to expand their efforts beyond transferring clinical knowledge and locally-oriented support. The information provided here may help visiting occupational therapists start looking for ways in how they could contribute to the growth of occupational therapy and the places where they could collaborate through the existing infrastructure, such as occupational therapy schools and national organizations in Mexico.



IV. LOGISTICAL PREPARATION

Good logistical preparation backed by accurate information about host countries is important for successful global partnership projects. The knowledge may help eliminate visitors' unrealistic expectations during the visit (e.g., unexpected living environment and accommodations), and facilitate visitors to adopt the local culture and customs.

Each visitor should consult with host institutions and national organizations to make the arrangement specific to the goals of his or her visit. Visitors may use the following table, which was developed based on the existing guidelines, to search relevant information, and initiate important dialogues with host institutions for safe and productive visits. The table is not exhaustive, and reading the resources listed in this section and identifying further resources are highly recommended.

Topics

Logistical preparations (1, 2, 5)
 	
• Make travel arrangements, such as booking flights
• Make living arrangement
  ○ Find the place to stay
  ○ Understand the cost of living
• Make transportation arrangement
  ○ Find out who to pick you up at the airport
  ○ Find out how to get to workplace every day
• Establish communication arrangement, such as finding out the availability of internet access
• Make financial arrangement
  ○ Understand how to withdraw funds, such as ATMs
  ○ Open local bank accounts, if taking the paid position
  ○ Handle tax issues within the host country and your home country, if taking the paid position
 	
Tip Some foreign credit cards may be used in Mexico, however, many small businesses may only accept cash, Mexican pesos (the currency of Mexico) – Be familiar with the exchange rate

Working arrangement (1, 2, 5)
 	
• Prepare to work
  ○ Find the position
  ○ Understand and obtain job description
  ○ Make arrangement for compensation: salary vs. volunteer
  ○ Coordinate work schedule, such as work hours
• Understand the professional liability insurance, and obtain it if needed

Topics

Working arrangement (Continued; 1, 2, 5)

- Develop network and professional relationships both in the host country and home country
  - Find people who supervise/coach/ mentor you for personal and work issues
  - Find people who previously visited the country to gain some knowledge about the host country
- Understand legal requirements, such as obtaining occupational therapy license and working visa, as needed

> Tips See page 27, "License and Qualification Requirement" section of this document
> See the "Mexico" section of the WFOT document, "*Working as an occupational therapist in another country*" (the link provided at the end of this table)

Personal health (1, 2, 3, 5)

- Obtain all necessary vaccines
- Understand local diseases that you may be in danger of contracting

> Example: See the website of Center for Disease Control and Prevention for vaccination and local disease information in Mexico (e.g., malaria, typhoid, zika, etc.)
> https://wwwnc.cdc.gov/travel/destinations/traveler/none/mexico

- Confirm the types of poisonous snakes and insects prevalent in the area you will be visiting

> Example: See the general information
> http://hubpages.com/travel/Poisonous-and-Venomous-snakes-and-animals-in-Mexico

- Prepare to bring necessary routine medication or find out how you will procure it during the visit
- Obtain health/travel insurance for yourself, and consider obtaining Medivac
- Find out available local medical services, such as the name of a local physician
- Ensure psychological well-being and physical health
  - Identify the support system, such as supervision and mentoring
  - Take care of your health, such as establishing a new routine, and ask for medical help before problems become serious
- Understand daily living tips to maintain health safety, such as how to clean fruits and vegetables before consumption

> Tip Generally speaking, bottled water is needed for drinking and cooking, and fruits and vegetables need to be sanitized. In some areas, bottled water may be needed when brushing teeth - Ask local people for advice in this matter

Topics

Personal safety (1, 4, 5)

Further readings and consultation with host institutions are strongly encouraged to ensure your safe visits

- Take common precautions in accordance with local norms and customs
  - Do not wear clothing that does not fit the local context. It is important to wear conservative clothes when the situation calls for it
  - Do not visit neighborhoods considered dangerous by locals on your own or without taking proper safety measure
- Plan for emergency
  - Understand the types of available insurance coverage during medical emergency
  - Identify the method of how emergency funds are transferred
  - Develop lists of emergency contacts in both the home country and host country
  - Identify people who are notified of your plans, such as a local friend who knows of your plans for vacation and outings

> Tip Mexico recently adopted 911 as the emergency call number. However, it is probably a good idea to have contact numbers for local friends and colleagues if you do not speak Spanish

- Understand local laws

> Tips Foreigners are prohibited from participating in demonstrations and political activities in Mexico.
> Foreigners are expected to carry a valid visa when obtaining a visa is a requirement.
> Example: General overview related to legal issues
> https://mx.usembassy.gov/u-s-citizen-services/
> https://travel.state.gov/content/passports/en/country/mexico.html

- Establish connections with government agencies
  - Register yourself with nearest embassy or consulate and receive travel advisory/warnings
  - Know the location of the embassy and consulate responsible for the area you are visiting

> Example 1: Register at U.S. Department of State
> https://travel.state.gov/content/passports/en/go/step.html/
>
> Example 2: Location of the US embassy and consulate in Mexico
> https://mx.usembassy.gov/u-s-citizen-services/find-your-consular-location/

Topics

Personal safety (Continued; 1, 4, 5)

- Understand crime and drug-related violence of the area you will be visiting

  Example 1: Crime data by Peace Corps
  http://files.peacecorps.gov/manuals/countrydata/mexico.pdf

  Example 2: Crime data by World Bank
  http://data.worldbank.org/indicator/VC.IHR.PSRC.P5

  Example 3: Travel alert in Mexico
  https://travel.state.gov/content/passports/en/alertswarnings/mexico-travel-warning.html

Other (1, 3, 5)

- Understand your diverse background may be viewed differently in Mexico because people may take more conservative perspectives on gender, sexual orientation, and ethnic/racial issues, depending on the areas you will be visiting

  Example: Experience by Peace Corps volunteers who have culturally diverse backgrounds
  http://files.peacecorps.gov/manuals/welcomebooks/mxwb510.pdf

- Be cognizant about the international news and host country's news and data. The sources may include:
  - Access World News
  - World News Connection
  - Google News' international editions
  - WHO
  - World Bank
  - UNICEF

1. Anderson, K., & Bocking, N. (2008). *Preparing medical students for electives in low-resource settings: A template for national guidelines for pre-departure training.* Retrieved from http://www.old.cfms.org/downloads/Pre-Departure%20Guidelines%20Final.pdf
2. Gillon, L., Barker, C., & Boggs, D. (2014). *Working abroad: Guidance for allied health professionals.* Retrieved from http://www.otfrontiers.co.uk/downloadable-resources/
3. Peace Corps. (2015). *The Peace Corps welcomes you to México: A Peace Corps publication for new volunteers.* Retrieved from http://files.peacecorps.gov/manuals/welcomebooks/mxwb510.pdf
4. Rana, G. K. (2014). Information empowerment: Predeparture resource training for students in global health. *Journal of the Medical Library Association, 102*(2), 101-104. doi: http://dx.dol.org/10.3163/1536-5050.102.2.008
5. World Federation of Occupational Therapists. (2015). *Working as an occupational therapist in another country.* Retrieved from http://www.wfot.org/ResourceCentre.aspx

V. FINAL THOUGHTS

Many occupational therapists in Mexico are eager to engage in mutual learning experiences with visiting occupational therapists during knowledge exchanges. Visiting occupational therapists may perhaps find themselves grateful for the warm and welcoming nature of occupational therapists in Mexico as these characteristics may make it easy to form a personal relationship. This is critical because the personal relationships are considered important in Mexican culture and the foundation for all global health projects. Visiting occupational therapists are encouraged to utilize the knowledge gained from this document, including, but not limited to:

- Emphasizing personal relationship building
- Being sensitive about cultural values, power relationships in a hierarchy and preference to a non-assertive communication style
- Being considerate about the difficult contexts where occupational therapists in Mexico must practice

The knowledge in this document was primarily provided to develop partnership relationship with occupational therapy colleagues in Mexico. However, some information could be used when working with other partners, such as clients within a clinical setting.

Preparation for global partnership projects are complex as it requires visiting occupational therapists to have broader knowledge, from the logistical preparation, technical knowledge, to knowledge about hosts. Different types of knowledge have their own values, and are important in distinctive ways. This document could only provide some basic, limited information about Mexico and occupational therapy practice in Mexico, and further research by visiting occupational therapists are warranted. However, the author hopes the information will be helpful for visiting occupational therapists who are planning to teach, volunteer, and work in Mexico.

The author believes that all visiting occupational therapists have something to offer, and is confident that they will find working in Mexico a meaningful and delightful experience.

VI. REFERENCES

Álvarez Tovar, J. A. (2013). Why has the transition to democracy led the Mexican presidential system to political instability? A proposal to enhance institutional arrangements. *Mexican Law Review, 5*(2), 277-304. Retrieved from http://dx.doi.org/10.1016/S1870-0578(16)30026-9

American Occupational Therapy Association. (2006). *AOTA's centennial vision.* Retrieved from https://www.aota.org/-/media/Corporate/Files/AboutAOTA/Centennial/Background/Vision1.pdf

Anderson, K., & Bocking, N. (2008). *Preparing medical students for electives in low-resource settings: A template for national guidelines for pre-departure training.* Retrieved from http://www.old.cfms.org/downloads/Pre-Departure%20Guidelines%20Final.pdf

Anonymous. (n.d.). *Benito Pablo Juárez García.* Retrieved October 31, 2016 from https://commons.wikimedia.org/wiki/File:Benito_Pablo_Ju%C3%A1rez_Garc%C3%ADa.png

Asociación de Profesionales en Terapia Ocupacional (2016a) *¿Quiénes somos?* [About us]. Retrieved from http://www.apto.org.mx/quienes-somos-2/

Asociación de Profesionales en Terapia Ocupacional (2016b). *Consejo Directivo.* [Board members]. Retrieved from http://www.apto.org.mx/consejo-directivo/

Barbezat, S. (2016, October 26). *The weather in Mexico.* Retrieved from http://gomexico.about.com/od/planningandinformation/ss/weather.htm#showall

Beagan, B. L. (2015). Approaches to culture and diversity: A critical synthesis of occupational therapy literature. *Canadian Journal of Occupational Therapy, 82*(5), 272 - 282. doi: 10.1177/0008417414567530

Beran, D., Perone, S. A., Alcoba, G., Bischoff, A., Bussien, C.-L., Eperon, G., . . . Chappuis, F. (2016). Partnerships in global health and collaborative governance: Lessons learnt from the division of tropical and humanitarian medicine at the Geneva University Hospitals. *Globalization and Health, 12*(14), 1-13. doi:10.1186/s12992-016-0156-x

Bolaños, C., & Armendáriz, L. (2009). Experiencia educativa centrada en la ocupación. Un reporte de caso [Educational experience centered on the occupation. A case report]. *World Federation of Occupational Therapists Bulletin, 59,* 25-29.

Brás, M. (1997). Government structure. In T. M. Merrill & R. Miró (Eds.), *Mexico: A country study* (pp. 229-278). Washington: Library of Congress. Federal Research Division.

Campos Espino, J. (2016). *Typical costume.* Retrieved from http://www.aguascalientes.gob.mx/idiomas/ingles/turismo/tradiciones/traje.aspx

Canada. Centre for Intercultural Learning. (2014). *Cultural information – Mexico.* Retrieved from https://www.international.gc.ca/cil-cai/country_insights-apercus_pays/ci-ic_mx.aspx?lang=eng#cn-2

Central Intelligence Agency. (2016). Mexico. *In The world fact book.* Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/mx.html

Centro Mexicano Universitario de Ciencias y Humanidades. (n. d.). *Licenciatura en terapia ocupacional* [Occupational therapy degree]. Retrieved from http://www.cmuch.edu.mx/files/LTO.pdf

Chang E.-S., Simon, M., & Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advance in Health Science Education, 17*, 269-278. doi: 10.1007/s10459-010-9264-1

Cleaver, S. R., Carvajal, J. K., & Sheppard, P. S. (2016). Cultural humility: A way of thinking to inform practice globally. *Physiotherapy Canada, 68*(1), 1-2. doi: 10.3138/ptc.68.1.GEE

Colegio de Terapeutas Ocupacionales de México. (2013a). *Historia de COTEOC.* [History of COTEOC]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/historia-coteoc

Colegio de Terapeutas Ocupacionales de México. (2013b). *Historia de la terapia ocupacional en México.* [History of occupational therapy in Mexico]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/historia-terapia-ocupacional-mexico

Colegio de Terapeutas Ocupacionales de México. (n.d.-a.). *Código de ética.* [Code of ethics]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/normatividad/codigo-etica

Colegio de Terapeutas Ocupacionales de México. (n.d.-b.). *Estatutos.* [Statute]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/normatividad/estatutos

Confederación Latinoamericana de Terapeutas Ocupacionales. (2013). *Quienes somos* [About us]. Retrieved from http://www.terapia-ocupacional.org.ar/quienes-somos/

Covarrubias, A. (2007). *Mexico states map w names.* Retrieved March 30, 2017 from https://commons.wikimedia.org/wiki/File:Mexico_states_map_w_names.png

Credit Suisse. (2014). *Global wealth report 2014.* Retrieved from https://publications.credit-suisse.com/tasks/render/file/?fileID=60931FDE-A2D2-F568-B041B58C5EA591A4

Credit Suisse. (2015). *Global wealth report 2015.* Retrieved from https://publications.credit-suisse.com/tasks/render/file/?fileID=F2425415-DCA7-80B8-EAD989AF9341D47E

Cromwell, F. S. (1977). Occupational therapy in Mexico. *American Journal of Occupational Therapy, 31*(8), 512-515.

Crowe, T. K., Picchiarini, S., & Poffenroth, T. (2004). Community participation: Challenges for people with disabilities living in Oaxaca, Mexico, and New Mexico, United States. *OTJR: Occupation, Participation and Health, 24*(2), 72–80.

Crump, J. A., Sugarman, J., & the Working Group on Ethics Guidelines for Global Health Training. Guidelines for Global Health Training (WEIGHT) (2010). Global health training: Ethics and best practice guidelines for training experiences in global health. *American Journal of Tropical Medicine and Hygiene, 83*(6), 1178–1182. doi:10.4269/ajtmh.2010.10-0527

de la Calle, L., & Rubio, L. (2012). *Mexico: A middle class society.* Retrieved from https://www.wilsoncenter.org/sites/default/files/Mexico%20A%20Middle%20Class%20Society.pdf

Demographics of Mexico. (2016). Retrieved September 9, 2016 from the Mexico Wiki: https://en.wikipedia.org/wiki/Demographics_of_Mexico

Diario Oficial de la Federación. (2014). *Programa nacional para el desarrollo y la inclusión de las personas con discapacidad. 2014-2018* [National Program for the Development and Inclusion of Persons with Disabilities. 2014-2018.]. Retrieved from http://www.dof.gob.mx/nota_detalle.php?codigo=5343100&fecha=30/04/2014

Elliot, M. L. (2015). Critical ethnographic analysis of "doing good" on short-term international immersion experiences. *Occupational Therapy International, 22*(3), 121-130. doi:10.1002/oti.1390

Elobu, A. E., Kintu, A., Galukande, M., Kaggwa, S., Mijjumbi, C., Tindimwebwa, J., . . . Lipnick, M. (2014). Evaluating international global health collaborations: Perspectives from surgery and anesthesia trainees in Uganda. *Surgery, 155*(4), 585-592. doi: http://dx.doi.org/10.1016/j.surg.2013.11.007

Elmusharaf, K., Tahir, H., O' Donovan, D., Brugha, R., Homeida, M., Abbas, A. M. O., & Byrne, E. (2016). From local to global: A qualitative review of the multi-leveled impact of a multi-country health research capacity development partnership on maternal health in Sudan. *Globalization and Health, 12*(20), 1-14. doi:10.1186/s12992-016-0153-0

Flannery, N. P. (2013, July 23). What's the real story with modern Mexico's middle class? *Forbes.* Retrieved from http://www.forbes.com/sites/nathanielparishflannery/2013/07/23/whats-the-real-story-with-modern-mexicos-middle-class/#12348bd3d536

Flores, R., & Telles, E. (2012). Social stratification in Mexico: Disentangling color, ethnicity, and class. *American Sociological Review, 77*(3), 486–494. doi: 10.1177/0003122412444720

Gabino, J. M. (2001). *Flag of Mexico.* Retrieved October 31, 2016 from https://commons.wikimedia.org/wiki/File:Flag_of_Mexico.png

Gallagher, F., Broderick, E., & Tynan, G. (2008). Occupational therapy in developing countries: Our Moldovan experience. *Irish Journal of Occupational Therapy, 36* (2), 34-38.

GDJ. (2015). *United Globe*. Retrieved October 31, 2016 from https://openclipart.org/detail/233143/united-globe

Georgakopoulos, A., & Guerrero, L. K. (2010). Student perceptions of teachers' nonverbal and verbal communication: A comparison of best and worst professors across six cultures. *International Education Studies, 3*(2), 3-16.

Gillon, L., Barker, C., & Boggs, D. (2014). *Working abroad: Guidance for allied health professionals.* Retrieved from http://www.otfrontiers.co.uk/downloadable-resources/

Goncalo, J. A., & Staw, B. M. (2006). Individualism–collectivism and group creativity. *Organizational Behavior and Human Decision* Processes 100, 96–109. doi:10.1016/j.obhdp.2005.11.003

Goodman, T. (1997). The economy. In T. M. Merrill & R. Miró (Eds.), *Mexico: A country study* (pp. 141-228). Washington: Library of Congress. Federal Research Division.

Gutiérrez, N. C. (2014). *Mexico: Availability and cost of health care – Legal aspects, U.S. Department of Justice* (LL File No. 2014-010632), Retrieved from https://www.justice.gov/sites/default/files/eoir/legacy/2014/07/14/2014-010632%20MX%20RPT%20FINAL.pdf

Guzman, J. M., & García-Salazar, E. (2014). Disability and rehabilitation in Mexico. *American Journal of Physical Medicine and Rehabilitation, 93*(1), S36-s38. doi: 10.1097/PHM.0000000000000019

Guzmán González, J. M. (2012). Rehabilitation in Mexico: A dream come true. *Physical Medicine and Rehabilitation, 4,* 770-772. doi: 10.1016/j.pmrj.2012.09.577

Hague, B., Sills, J., & Thompson, A. R. (2015). An evaluation of the benefits to a UK health care trust working in a partnership with a hospital in northern Uganda: International partnership working in mental health. *Globalization and Health, 11,* 1-8. doi:10.1186/s12992-015-0134-8

Haggerty, R. (1997). Historical setting. In T. M. Merrill & R. Miró (Eds.), *Mexico: A country study* (pp. 1-76). Washington: Library of Congress. Federal Research Division.

Hammell, K. R. W. (2013). Occupation, well-being, and culture: Theory and cultural humility. *Canadian Journal of Occupational Therapy, 80*(4), 224-234. doi: 10.1177/0008417413500465

Hanratty, D. M. (1997). The society and its environment. In T. M. Merrill & R. Miró (Eds.), *Mexico: A country study* (pp. 77-140). Washington: Library of Congress. Federal Research Division.

Hernández Pozas, O. (2013, September 27). *Let´s talk about the Mexican culture.* Retrieved from http://www.oliviahdzp.com/2013/09/27/let%C2%B4s-now-talk-about-the-mexican-culture/

Higman, P. (2008). International exchange of knowledge. *British Journal of Occupational Therapy, 71*(4). 168-170.

History of Mexico. (2016). Retrieved October 23, 2016 from the Mexico Wiki: https://en.wikipedia.org/wiki/History_of_Mexico

Hofstede, G. (n.d.). *What about Mexico?* Retrieved from https://geert-hofstede.com/mexico.html

Humbert, K. T., Burket, A., Deveney, R., & Kennedy, K. (2011). Occupational therapy practitioners' perspectives regarding international cross-cultural work. *Australian Occupational Therapy Journal, 58,* 300-309 doi: 10.1111/j.1440-1630.2010.00915.x

Instituto de Terapia Ocupacional. (2014). *Encuentra* [Archive]. Retrieved from http://www.ito-edu.org.mx/encuentra-repositorio-del-instituto-de-terapia-ocupacional

Instituto Nacional de Estadística y Geografía. (2015a). *Estadísticas a propósito del día internacional de las personas con discapacidad (3 de diciembre): Datos nacionales* [Statistics related to the International Day of Persons with Disabilities (December 3): National data]. Retrieved from http://www.inegi.org.mx/saladeprensa/aproposito/2015/discapacidad0.pdf

Instituto Nacional de Estadística y Geografía. (2015b). *Encuesta intercensal 2015: Principales resultados* [2015 Census: Main results]. Retrieved from http://www.inegi.org.mx/est/contenidos/proyectos/encuestas/hogares/especiales/ei2015/doc/eic_2015_presentacion.pdf

Instituto Nacional de Estadística y Geografía. (2016). *La discapacidad en México, datos al 2014* [Disability in Mexico, data to 2014.]. Retrieved from http://internet.contenidos.inegi.org.mx/contenidos/productos//prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/702825090203.pdf

Kihn, S. (n.d.). *Foreigners considering working in Mexico, what you need to know.* Retrievevd from http://careerminer.infomine.com/foreigners-considering-working-in-mexico-what-you-need-to-know/

Knaul, F. M., González-Pier, E., Gómez-Dantés, O., García-Junco, D., Arreola-Ornelas, H., Barraza-Lloréns, M., … Frenk, J. (2012). The quest for universal health coverage: achieving social protection for all in Mexico. *Lancet, 380*, 1259–1279. doi: 10.1016/S0140-6736(12)61068-X

Kopp, R. (2012, December 6). *Working effectively with Mexicans – What Japanese companies need to know.* Retrieved from http://www.japanintercultural.com/en/news/default.aspx?newsID=230

Kraeker, C., & Chandler, C. (2013). "We learn from them, they learn from us": Global health experiences and host perceptions of visiting health care professionals. *Academic Medicine, 88*(4). 483-487.

Krasnoff, M. J. (2013). Introduction. In M. J. Krasnoff (Ed.), *Building partnerships in the Americas: A guide for global health workers* [ebrary]. Hanover, New Hampshire: Dartmouth College Press.

Larkan, F., Uduma, O., Lawal, S. A., & van Bavel, B. (2016). Developing a framework for successful research partnerships in global Health. *Globalization and Health, 12*(17), 1-9. doi: 0.1186/s12992-016-0152-1

Leffers, J., & Mitchell, E. (2010). Conceptual model for partnership and sustainability in global health conceptual model for partnership and sustainability in global health. *Public Health Nursing, 28*(1), 91 – 102. doi: 10.1111/j.1525-1446.2010.00892.x

Linares Garcia, A. (2015). *Poplin Dress Embroidered with Grape Vines from Aguascalientes.* Retrieved October 31, 2016 from https://en.wikipedia.org/wiki/Poplin#/media/File:MAPElNorte078.JPG

Loue, S. (2012). Sandplay therapy: Identity, diversity, cultural humility. *Journal of Sandplay Therapy, 21*(2), 105-110.

Lustig, N. (2015, September). Most unequal on earth. *Finance & Development,* 52(3), 14-16. Retrieved from http://www.imf.org/external/pubs/ft/fandd/2015/09/lustig.htm

Mackenzie, I. (2013). *The linguistics of Spanish: Mexican Spanish.* Retrieved from https://www.staff.ncl.ac.uk/i.e.mackenzie/mexico.htm

Magaziner, J. (2016, August 16). *Current issue: Education in Mexico.* Retrieved from http://wenr.wes.org/2016/08/education-in-mexico

Maldonado-Guzmán, G., Carbajal-Mata, F. E., Rivera-Vázquez, P., & Castro-García, R. I. (2015). Beneficios que percibe el adulto mayor al integrarse a un grupo de ayuda dirigido por personal de enfermería [Benefits perceived by elderly members from a support groups directed by nursing]. *Revista de Enfermería del Instituto Mexicano del Seguro Social,* 23(1), 31-6. Retrieved from http://revistaenfermeria.imss.gob.mx/editorial/index.php/revista_enfermeria/rt/printerFriendly/22/219

ManattJones Global Strategies. (2015). *Mexican health care system challenges and opportunities.* Retrieved from https://www.wilsoncenter.org/sites/default/files/mexican_healthcare_system_challenges_and_opportunities.pdf

Martinez, R., & de la Torre, C. (2011). Mexico's resilient cast system: Managerial implications for foreign firms. *International Business and Economics Research Journal, 2*(5), 97-104. Retrieved from http://www.cluteinstitute.com/ojs/index.php/IBER/article/download/3802/3846

Maya Civilization. (2016). Retrieved October 23, 2016 from the Maya sites Wiki: https://en.wikipedia.org/wiki/Maya_civilization

McFeaters, B. (n. d.). *Mexico: The other melting pot.* Retrieved from http://www.houstonculture.org/mexico/ballet.html

McKinnon, T. H., & Fealy, G. (2011). Core principles for developing global service-learning programs in nursing. *Nursing Education Perspectives, 32*(2), 95-101.

Mexican Cuisine. (2016). Retrieved October 23, 2016 from the Mexico Wiki: https://en.wikipedia.org/wiki/Mexican_cuisine#Northern_Mexico

Michailakis, D. (1997). *Government action on disability policy. A global survey part II - Government replies as country profiles: Mexico*. Retrieved from http://www.independentliving.org/standardrules/UN_Answers/Mexico.html

Morgan, M. J., & Kinnealey, M. (2005). Promoting occupational therapy service development in Vietnam. *WFOT Bulletin, 51,* 31-34.

National Council for the Evaluation of Social Development Policy. (2012a). *Report of poverty in Mexico 2010: The country, its states and its municipalities.* Retrieved from http://www.coneval.org.mx/Informes/Coordinacion/INFORMES_Y_PUBLICACIONES_PDF/REPORT_OF_POVERTY_IN_MEXICO_2010.pdf

National Council for the Evaluation of Social Development Policy. (2012b). *Evaluation report on social development policy in Mexico 2012. Retrieved* from http://www.coneval.org.mx/Informes/Coordinacion/INFORMES_Y_PUBLICACIONES_PDF/Info_Eval_Pol_Des_Soc_2012sbiblio.pdf

OECD. (2013). *Education policy outlook: Mexico.* Retrieved from http://www.oecd.org/mexico/EDUCATION%20POLICY%20OUTLOOK%20MEXICO_EN.pdf

OECD. (2016a). *OECD health policy overview: Health policy in Mexico.* Retrieved from http://www.oecd.org/mexico/Health-Policy-in-Mexico-February-2016.pdf

OECD. (2016b). *Average annual wage.* Retrieved September 30, 2016 from https://stats.oecd.org/Index.aspx?DataSetCode=AV_AN_WAGE

Office of the United Nations High Commissioner for Human Rights. (2014, September 17). *Committee on the Rights of Persons with disabilities considers initial report of Mexico.* Retrieved October 23, 2016 from http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15046&LangID=E

Ortega, R. M., & Faller, K. C. (2011). Training child welfare workers from an Intersectional cultural humility perspective: A paradigm shift. *Child Welfare, 90*(5), 27-49.

Ostertag, R. (2006). *Chichen Itza*. Retrieved October 31, 2016 from https://commons.wikimedia.org/wiki/File:Chichen_Itza_2006_08_15.JPG

Palazuelos, D., & Capps, L. (2013). Mexico. In M. J. Krasnoff (Ed.), *Building partnerships in the Americas: A guide for global health workers* [ebrary]. Hanover, New Hampshire: Dartmouth College Press.

Peace Corps. (2015). *The Peace Corps welcomes you to Mexico: A Peace Corps publication for new volunteers.* Retrieved from http://files.peacecorps.gov/manuals/welcomebooks/MXWB510.pdf

Pechak, C. M., & Thompson, M. (2009). A conceptual model of optimal international service-learning and its application to global health initiatives in rehabilitation. *Physical Therapy, 89*(11), 1192-1204.

Posada, J. G. (1913). *La Calavera Catrina* [Elegant Skull]. Retrieved October 31, 2016 from https://en.wikipedia.org/wiki/File:Posada2.Catrina.jpeg

Prieto Armendáriz, E. S., & Saladin, S. P. (2012). A Comparison between the Ley General para la Inclusión de las Personas con Discapacidad and the Americans with Disabilities Act. *Revista Perspectivas Sociales* [Social Perspectives Journal], 14(2), 31-43. Retrieved from https://dialnet.unirioja.es/descarga/articulo/4703948.pdf

Rana, G. K. (2014). Information empowerment: Predeparture resource training for students in global health. *Journal of the Medical Library Association, 102*(2), 101-104. doi: http://dx.dol.org/10.3163/1536-5050.102.2.008

Real Embajada de Noruega. (n.d.). *Introduction to the Mexican market and business culture.* Retrieved from http://www.noruega.org.mx/Norsk/Business-i-Mexico/Making-business-in-Mexico/#.V_u5t2zrvb1

Santana, S. & Santana, F. O. (2001). Mexican culture and disability: Information for U.S. service providers. [Monograph]. *CIRRIE Monograph Series.* Retrieved from http://cirrie.buffalo.edu/culture/monographs/mexico.pdf

Schauber, A. C. (2001). Proceedings from the 5th Western Dairy Management Conference: *No see ums: Hidden aspects to communicating with your Mexican workers.* Las Vegas, NV. Retrieved from http://wdmc.org/2001/WDMC2001p133-138.pdf

Schiavon, J. A. (2006). The central-local division of power in the Americas and renewed Mexican federalism: Old institutions, new political realities. *International Journal of Constitutional Law, 4*(2), 392-410. doi: 10.1093/icon/mol010

Schmitz, K. & Diefenthaler, S. (1998). An examination of traditional gender roles among men and women in Mexico and the United States, *University of Wisconsin-La Crosse Journal of Undergraduate Research,* 139-143. Retrieved from https://www.uwlax.edu/urc/jur-online/PDF/1998/Schmitz_and_Diefenthaler.pdf

Schulze, M. (2009). *Understanding the UN Convention on the Rights of Persons with Disabilities.* Retrieved from http://iddcconsortium.net/sites/default/files/resources-tools/files/hi_crpd_manual_sept2009_final.pdf

Secretaría de Educación Pública. (2010). Autorización y Registro Profesional [Authorization and Professional Registry]. Retrieved from http://www.sep.gob.mx/wb/sep1/sep1_Registro_de_Titulo_y_Ex_cedula

Serrano Hernández, M. P. (2013). Historia de la terapia ocupacional en México [History of Occupational therapy in Mexico]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/historia-terapia-ocupacional-mexico

Servan-Mori, E., Torres-Pereda,P., Orozco, E., & Sosa-Rubí, S. G. (2014). An explanatory analysis of economic and health inequality changes among Mexican indigenous people, 2000-2010. *International Journal for Equity in Health, 13*(21), 1-8. doi: 10.1186/1475-9276-13-21

Shaw, E. (n. d.). *The environment & climate in Mexico.* Retrieved from http://traveltips.usatoday.com/environment-climate-mexico-59810.html

Smith, A. B. (2003). *Mexican culture profile.* Retrieved from https://ethnomed.org/culture/hispanic-latino/mexican-cultural-profile

Stratfor. (2015, April 8). Mexico's manufacturing sector continues to grow. *Forbes.* Retrieved October 23, 2016 from http://www.forbes.com/sites/stratfor/2015/04/08/mexicos-manufacturing-sector-continues-to-grow/#5d7d47c83c9e

Suarez-Balcazar, Y., Hammel, J., Mayo, L., Inwald, S., & Sen, S. (2013). Innovation in global collaborations: From student placement to mutually beneficial exchanges. *Occupational Therapy International, 20*(2), 94-101 8p. doi:10.1002/oti.1341

Suarez-Balcazar, Y., Witchger Hansen, A. M., & Muñoz, J. P. (2015). Transformative nature of global partnerships. *Occupational Therapy International, 22*(3). 117-120. doi: http://dx.doi.org.pearl.stkate.edu/10.1002/oti.1406

Suchdev, P., Ahrens, K., Click, E., Macklin, L., Evangelista, D., & Graham, E. (2007). A model for sustainable short-term international medical trips. *Ambulatory Pediatrics, 7*(4), 317–20.

Teleton México. (2015). *Centro de Rehabilitación Infantil Teletón.* Retrieved from http://www.teleton.org/home/contenido/centro-de-rehabilitacion-infantil-teleton

Tena-Tamayo, C., & Sotelo, J. (2005). Malpractice in Mexico: Arbitration not litigation. *BMJ, 331,* 448–451. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1188117/pdf/bmj33100448.pdf

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, (9)*2, 117 – 125.

Torices Rodarte, I. (2012). *Historia de la Terapia Ocupacional en México: Una aproximación a los contextos que han definido la identidad profesional de terapeutas ocupacionales* [History of occupational therapy in Mexico: An approach to the contexts defined the professional identity of occupational therapists.], *Instituto de Terapia Ocupacional,* 1-125. Retrieved from http://www.ito-edu.org.mx/0/view_bl/77/tesis-resena-de-documentos/34/historia-de-la-terapia-ocupacional-en-mexico-una-aproximacion-a-los-contextos-que-han-definido-la-identidad-profesional-de-terapeutas-ocupacionales?is_show_data=1&tab=getmybooksTab

Transparency International. (2017). *Corruption Perceptions Index 2016.* Retrieved from http://www.transparency.org/news/feature/corruption_perceptions_index_2016

Trostle, J., Bronfman, M., & Langer, A. (1999). How do researchers influence decision-makers? Case studies of Mexican policies. *Health Policy and Planning, 14*(2), 103-114.

Tupe, D. A., Kern, S. B., Salvant, S., & Talero, P. (2015). Building international sustainable partnerships in occupational therapy: A case study. *Occupational Therapy International, 22*, 131-140. doi: 10.1002/oti.1407

United Nations Development Programme. (2015). *Human development report 2015: Work for human development.* Retrieved from http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf

United Nations Development Programme. (n.d.). *Human development reports - Table 1: Human development index and its components.* Retrieved October 4, 2016 from http://hdr.undp.org/en/composite/HDI

United States Department of State. (2015). *Mexico 2015 human rights report executive summary.* Retrieved from http://www.state.gov/documents/organization/253239.pdf

Vela, L. (2011). Latino. In L. A. Cartwright & R. R. Shingles (Eds.), *Cultural competence in sports medicine* (pp. 161-184). Champaign, IL: Human Kinetics

Villarreal, M. A. (2010). *The Mexican economy after the global financial crisis, Congressional Research Service* (CRS Report No. R41402). Retrieved from. https://www.fas.org/sgp/crs/row/R41402.pdf

Welling, D. R., Ryan, J. M., Burris, D. G., & Rich, N. M. (2010). Seven sins of humanitarian medicine. *World Journal of Surgery, 34,* 466-70. doi: 10.1007/s00268-009-0373-z

Whyte, S. (2009, May 4). How Mexico's health system works. *CBC News.* Retrieved from http://www.cbc.ca/news/technology/how-mexico-s-health-system-works-1.777348

Wilson, C., & Silva, G. (n.d). *Mexico's latest poverty stats.* Retrieved from https://www.wilsoncenter.org/sites/default/files/Poverty_Statistics_Mexico_2013.pdf

Witchger Hansen, A. M. (2015). Crossing borders: A qualitative study of how occupational therapy educators and scholars develop and sustain global partnerships. *Occupational Therapy International, 22*(3), 152-162. doi:10.1002/oti.1401

World Bank. (2004). *Beyond economic growth student book - XV. Composite indicators of development.* Retrieved from http://www.worldbank.org/depweb/english/beyond/global/chapter15.html

World Bank (2015a). *Population, total.* Retrieved from http://data.worldbank.org/indicator/SP.POP.TOTL

World Bank. (2016b). *Mexico.* Retrieved from http://www.worldbank.org/en/country/mexico

World Bank. (2016c). *Gross domestic product 2015.* Retrieved from http://databank.worldbank.org/data/download/GDP.pdf

World Bank. (2016d). *Overview.* Retrieved from http://www.worldbank.org/en/country/mexico/overview#1

World Bank. (2016e). *Health expenditure per capita (current US$).* Retrieved from http://data.worldbank.org/indicator/SH.XPD.PCAP

World Confederation for Physical Therapy. (2017). *Mexico: A profile of the profession.* Retrieved from http://www.wcpt.org/node/24069/cds

World Economic Forum. (2016). *Economies: Mexico.* Retrieved from http://reports.weforum.org/global-gender-gap-report-2015/economies/#economy=MEX

World Federation of Occupational Therapists. (2015). *Working as an occupational therapist in another country.* Retrieved from http://www.wfot.org/ResourceCentre.aspx

World Federation of Occupational Therapists. (2016a). *Fundamental beliefs.* Retrieved from http://www.wfot.org/aboutus/fundamentalbeliefs.aspx

World Federation of Occupational Therapists. (2016b). *Country and Organisation Profiles.* Retrieved from http://www.wfot.org/Membership/CountryandOrganisationProfiles.aspx

World Federation of Occupational Therapists. (2016c). *WFOT human resources project 2016.* Retrieved from http://www.wfot.org/ResourceCentre.aspx

World Health Organization. (2006) *The world health report 2006: Working together for health.* Retrieved from http://www.who.int/whr/2006/whr06_en.pdf?ua=1

World Health Organization. (2011). *World health statistics 2011.* Retrieved from http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf

World Health Organization. (2016). *The determinants of health.* Retrieved from http://www.who.int/hia/evidence/doh/en/

VII. APPENDICES

A. REFLECTIVE QUESTIONS WORKSHEET

Chapter 1: Global Partnerships

	Questions	Your Answers
1	How same or different is your current approach to cultural diversity, compared to cultural humility (page 3)?	
2	How do you ensure you are sensitive to different cultures when culture is defined fluid (page 3)?	
3	What are the elements placing you in the position of power in current relationships (page 3)?	
4	How do these basic considerations influence your planning (page 5)?	
5	How same or different are your assumptions about the visit compared to that of the host (page 5)?	
6	How do you ensure your contributions are relevant for the host country (page 7)?	
7	How do you ensure if your support is beneficial for the growth of occupational therapy in the host country (page 7)?	

Chapter 2: General Contextual Factors in Mexico

	Questions	Your Answers
1	What are the differences between your knowledge about Mexico and the information provided here (page 10)?	
2	How might the information influence the way you approach your partners in Mexico (page 10)?	
3	What are the similarities and differences in terms of health disparities compared to your home country (page 16)?	
4	What are the differences in rehabilitation goals between your country and your colleagues and/or clients (page 19)?	
5	How do you ensure you understand the partner's needs when they do not explicitly express their needs (page 20)?	
6	How is your position as a visitor influencing relationship-building and communication (page 20)?	

Chapter 3: Practice Contexts Surrounding Occupational Therapists in Mexico

	Questions	Your Answers
1	How different and similar is the development of the profession compared to your home country (page 24)?	
2	How does the physician-centered model may influence the partnership and client care (page 29)?	
3	What are the differences in approaches in how evaluation and interventions are being provided (page 29)?	
4	What are the consequences of teaching and training a person who is not an occupational therapist under current practice context (page 31)?	
5	Who are the major occupational therapy players in the geographical areas where you are visiting (page 31)?	
6	What does the best support look like when considering to meet the need of local organizations while ensuring the growth of the profession (page 31)?	

B. DATA RELATED PEOPLE WITH DISABILITIES

Common Type of Disabilities by Specific Groups - 2014

	Pediatric (0 to 14)	%[a]	Geriatric (60 and beyond)	%
1	Speech / communication	46	Ambulation / lower extremity	81
2	Cognition[b]	41	Vision	67
3	Activities of daily living[c]	37	Hearing	47
4	Ambulation / lower extremity[d]	36	Cognition	45
5	Vision[e]	27	Upper extremity	43
6	Psychological[f]	27	Activities of daily living	29
7	Upper extremity[g]	14	Psychological	16
8	Hearing[e]	13	Speech / communication	14

Note. The types of disabilities by vulnerable groups. Adapted from "La Discapacidad en México, Datos al 2014" by Instituto Nacional de Estadística y Geografía, 2016, p. 30. Copyright 2016 by Instituto Nacional de Estadística y Geografía. Data for the other groups is available in the original data by INEGI.

[a]Some people reported more than one area of difficulties. [b]Cognitive difficulties were described as "learning, remembering, or concentrating." [c]Activity of daily living difficulties were described as "bathing, dressing, or eating." [d]Ambulation and lower extremity difficulties were described as "walking, climbing up or down, or use of legs." [e]Vision or hearing difficulties even with devices, such as eye glasses or hearing aide. [f]Psychological difficulties were described as "emotional and mental problems." [g]Upper extremity difficulties were described as "use of arms and hands."

C. OCCUPATIONAL THERAPY PROGRAMS IN MEXICO

Master's Program

Names	Locations	Type of Institution & Program		Program Length (Years)	Approved by	
		Public	Private		SEP[a]	WFOT
Instituto de Terapia Ocupacional	Mexico City		Yes	2	Yes	Yes

Bachelor's Programs (Entry-level)

Names	Locations	Type of Institution & Program		Program Length (Years)	Approved by	
		Public	Private		SEP[a]	WFOT
Benito Juárez Autonomous University of Oaxaca (UABJO)	Oaxaca	Yes		5	Yes	
Centro Mexicano Universitario de Ciencias y Humanidades (CMUCH)	Puebla		Yes	5	Yes	Yes
Centro Nacional Modelo (Gaby Brimmer)	Mexico City	Yes		5	Yes	
Centro Nacional Modelo (Iztapalapa)	Mexico City	Yes		5	Yes	
Centro de Rehabilitación y Educación Especial (Puebla)	Puebla	Yes		5	Yes	
Centro de Rehabilitación y Educación Especial (Toluca)	Near Mexico City	Yes		5	Yes	
Instituto National de Rehabilitacion (INR)	Mexico City	Yes		5	Yes	
Instituto de Terapia Ocupacional	Mexico City		Yes	4	Yes	Yes
Universidad de Autonoma del Estado de México (UAEM)	State of Mexico	Yes		5	Yes	
Universidad Teletón	State of Mexico		Yes	5	Yes	

Associate's Program

Names	Locations	Type of Institution & Program		Program Length (Years)	Approved by	
		Public	Private		SEP[a]	WFOT
Instituto Mexicano del Seguro Social (IMSS)	Mexico City	Yes		3	Yes	

Note. The list of occupational therapy programs by the degree awarded.

[a]SEP is the abbreviation for Secretaría de Educación Pública (the Ministry of Education) of Mexico.

D. RELEVANT ORGANIZATIONS AND ABBREVIATIONS

English	Spanish	Abbreviations
College of Occupational Therapists of Mexico	Colegio de Terapeutas Ocupacionales de México	COTEOC
General Law for People with Disabilities	Ley General para las Personas con Discapacidad	
General Law for the Inclusion of Persons with Disabilities	Ley General para la Inclusión de las Personas con Discapacidad	
Institute for Social Security and Services for State Workers	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado	ISSSTE
Latin American Occupational Therapy Association	Confederación Latinoamericana de Terapeutas Ocupacionales	CLATO
Mexican Social Security Institute	Instituto Mexicano del Seguro Social	IMSS
Ministry of Education	Secretaría de Educación Pública	SEP
National Council for People with Disabilities	Consejo Nacional para las Personas con Discapacidades	CONADIS
National Coordination Commission for the Welfare of People with Disabilities	Comisión Nacional Coordinadora para el Bienestar y la Incorporación al Desarrollo de las Personas con Discapacidad	CONVIVE
National Council for the Evaluation of Social Development Policy	Consejo Nacional de Evaluación de la Política de Desarrollo Social	CONEVAL
National Institute of Statistics and Geography	Instituto Nacional de Estadística y Geografía	INEGI
National System for Integral Development of the Family	Sistema Nacional para el Desarrollo Integral de la Familia	DIF
Office of the United Nations High Commissioner for Human Rights		OHCHR
Organization for Economic Cooperation and Development		OECD
Popular Health Insurance	Seguro Popular	
Professional's Association of Occupational Therapists	Asociación de Profesionales en Terapia Ocupacional	APTO
Teleton Children's Rehabilitation Center	Centros de Rehabilitación Infantil Teletón	CRIT
United Nations Development Programme		UNDP
World Federation of Occupational Therapists		WFOT

E. RECOMMENDED RESOURCES

Some of the resources provided such valuable information that visitors are encouraged to read the original sources.

1. Peer-reviewed articles

- **Global partnerships**

Beran, D., Perone, S. A., Alcoba, G., Bischoff, A., Bussien, C.-L., Eperon, G., . . . Chappuis, F. (2016). Partnerships in global health and collaborative governance: Lessons learnt from the division of tropical and humanitarian medicine at the Geneva University Hospitals. *Globalization and Health, 12*(14), 1-13. doi:10.1186/s12992-016-0156-x

Elliot, M. L. (2015). Critical ethnographic analysis of "doing good" on short-term international immersion experiences. *Occupational Therapy International, 22*(3), 121-130. doi:10.1002/oti.1390

Larkan, F., Uduma, O., Lawal, S. A., & van Bavel, B. (2016). Developing a framework for successful research partnerships in global Health. *Globalization and Health, 12*(17), 1-9. doi: 0.1186/s12992-016-0152-1

Leffers, J., & Mitchell, E. (2010). Conceptual model for partnership and sustainability in global health conceptual model for partnership and sustainability in global health. *Public Health Nursing, 28*(1), 91 – 102. doi: 10.1111/j.1525-1446.2010.00892.x

McKinnon, T. H., & Fealy, G. (2011). Core principles for developing global service-learning programs in nursing. *Nursing Education Perspectives, 32*(2), 95-101.

Pechak, C. M., & Thompson, M. (2009). A conceptual model of optimal international service-learning and its application to global health initiatives in rehabilitation. *Physical Therapy, 89*(11), 1192-1204.

Suarez-Balcazar, Y., Hammel, J., Mayo, L., Inwald, S., & Sen, S. (2013). Innovation in global collaborations: From student placement to mutually beneficial exchanges. *Occupational Therapy International, 20*(2), 94-101 8p. doi:10.1002/oti.1341

Tupe, D. A., Kern, S. B., Salvant, S., & Talero, P. (2015). Building international sustainable partnerships in occupational therapy: A case study. *Occupational Therapy International, 22*, 131-140. doi: 10.1002/oti.1407

Witchger Hansen, A. M. (2015). Crossing borders: A qualitative study of how occupational therapy educators and scholars develop and sustain global partnerships. *Occupational Therapy International, 22*(3), 152-162. doi:10.1002/oti.1401

- **Cultural humility**

Beagan, B. L. (2015). Approaches to culture and diversity: A critical synthesis of occupational therapy literature. *Canadian Journal of Occupational Therapy, 82*(5), 272 - 282. doi: 10.1177/0008417414567530

Chang E.-S., Simon, M., & Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advance in Health Science Education, 17*, 269-278. doi: 10.1007/s10459-010-9264-1

Hammell, K. R. W. (2013). Occupation, well-being, and culture: Theory and cultural humility. *Canadian Journal of Occupational Therapy, 80*(4), 224-234. doi: 10.1177/0008417413500465

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, (9)*2, 117 – 125.

2. Ethical codes

- **Guidelines for ethical practice for people who participate in global health projects**

Crump, J. A., Sugarman, J., & the Working Group on Ethics Guidelines for Global Health Training. Guidelines for Global Health Training (WEIGHT) (2010). Global health training: Ethics and best practice guidelines for training experiences in global health. *American Journal of Tropical Medicine and Hygiene, 83*(6), 1178–1182. doi:10.4269/ajtmh.2010.10-0527

- **Ethical codes by the occupational therapy associations**

Colegio de Terapeutas Ocupacionales de México. (n.d.). *Código de ética.* [Code of ethics]. Retrieved from http://www.coteoc.org/index.php/quienes-somos/normatividad/codigo-etica

World Federation of Occupational Therapists. (2016). *World Federation of Occupational Therapists: Code of ethics.* Retrieved from http://www.wfot.org/ResourceCentre.aspx

Ethical code by visitor's country

3. Information about Mexico

- **Cultural and contextual**

Krasnoff, M. J. (2013). *Building partnerships in the Americas: A guide for global health workers*. Hanover, New Hampshire: Dartmouth College Press.

Merrill, T. L., & Miró, R. (1996). *Mexico: A Country Study.* Retrieved from http://countrystudies.us/mexico/

Smith, A. B. (2003). *Mexican culture profile.* Retrieved from https://ethnomed.org/culture/hispanic-latino/mexican-cultural-profile

Vela, L. (2011). Latino. In L. A. Cartwright & R. R. Shingles (Eds.), *Cultural competence in sports medicine* (pp. 161-184). Champaign, IL: Human Kinetics

- **Communication and working in Mexico**

Canada. Centre for Intercultural Learning. (2014). *Cultural information – Mexico.* Retrieved from https://www.international.gc.ca/cil-cai/country_insights-apercus_pays/ci-ic_mx.aspx?lang=eng#cn-2

Kopp, R. (2012, December 6). *Working effectively with Mexicans – What Japanese companies need to know.* Retrieved from http://www.japanintercultural.com/en/news/default.aspx?newsID=230

Schauber, A. C. (2001). Proceedings from the 5th Western Dairy Management Conference: *No see ums: Hidden aspects to communicating with your Mexican workers.* Las Vegas, NV. Retrieved from http://wdmc.org/2001/WDMC2001p133-138.pdf

Santana, S. & Santana, F. O. (2001). Mexican culture and disability: Information for U.S. service providers. [Monograph]. *CIRRIE Monograph Series.* Retrieved from http://cirrie.buffalo.edu/culture/monographs/mexico.pdf

* Santana and Santana also provide information related to traditional illnesses in Mexico.

- **Beliefs about traditional illnesses**

Tafur, M. M., Crowe, T. K., & Torres, E. (2009). A review of curanderismo and healing practices among Mexicans and Mexican Americans. *Occupational Therapy International, 16*(1), 82-88. doi: 10.1002/oti.265

Vela, L. (2011). Latino. In L. A. Cartwright & R. R. Shingles (Eds.), Cultural competence in sports medicine (pp. 161-184). Champaign, IL: Human Kinetics

- **Statistical data**

Central Intelligence Agency. (2016). Mexico. *In The world fact book.* Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/mx.html

Instituto Nacional de Estadística y Geografía. (2015). *Encuesta intercensal 2015: Principales resultados* [2015 Census: Main results]. Retrieved from http://www.inegi.org.mx/est/contenidos/proyectos/encuestas/hogares/especiales/ei2015/doc/eic_2015_presentacion.pdf

Instituto Nacional de Estadística y Geografía. (2016). *La discapacidad en México, datos al 2014* [Disability in Mexico, data to 2014.]. Retrieved from http://internet.contenidos.inegi.org.mx/contenidos/productos//prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/702825090203.pdf

4. Logistical preparation

Anderson, K., & Bocking, N. (2008). *Preparing medical students for electives in low-resource settings: A template for national guidelines for pre-departure training.* Retrieved from http://www.old.cfms.org/downloads/Pre-Departure%20Guidelines%20Final.pdf

Gillon, L., Barker, C., & Boggs, D. (2014). *Working abroad: Guidance for allied health professionals.* Retrieved from http://www.otfrontiers.co.uk/downloadable-resources/

Peace Corps. (2015). *The Peace Corps welcomes you to México: A Peace Corps publication for new volunteers.* Retrieved from http://files.peacecorps.gov/manuals/welcomebooks/mxwb510.pdf

World Federation of Occupational Therapists. (2015). *Working as an occupational therapist in another country.* Retrieved from http://www.wfot.org/ResourceCentre.aspx