Managing US–Mexico “border health”: An organizational field approach

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Abstract

During World War II Mexican and US health professionals and organizations constructed a transnational organizational field to manage the border’s public health problems. Despite barriers to inter-organizational cooperation, including disparate administrative structures and North–South stratification, the field’s transnational approach to health on the border has continued for 60 years. Using archival data to track changes in the number and types of organizations, this article argues that the field practitioners call “border health” reconfigured during the North American Free Trade Association (NAFTA) decade from an era of loosely organized professionals to a specialized bureaucracies era. This change brought new vitality to border health, with transnational ties increasing and diversifying, but has not weakened entrenched cross-border inequalities. The organizational history of the US–Mexico border health field demonstrates how macro-politics and inter-organizational stratification shape transnational public health problems.

Keywords: Mexico; USA; Borders; Public health; Transnational organizational field

Introduction

There is growing recognition that national public health programs inadequately protect populations from public health threats that are increasingly transnational. An important variant of global health is the emergence of transnational public health programs designed for border regions in Latin America, Africa, Asia, and Europe since the 1990s. In this paper I focus on the US–Mexico border, where health professionals, administrators, and academics belonging to non-government and government organizations have formally worked together to manage shared problems like tuberculosis, diabetes, and environmental health since 1942, long before other regions supported cross-border public health projects. These actors constitute a public health field, which practitioners call “border health.” In this paper, I analyze this sector’s organizational history, and argue that insights about stratification and cooperation may be generalizable to fledgling border health projects in other regions. Analyzing the emergence and transformation of this field allows us to understand how social systems of power and inequality as well as macro-political events shape the prioritization of public health problems and the institutional resources for managing them.

US–Mexico border health has had two distinct eras, both coinciding with major political and economic policy changes. The first era began during
World War II and spans five decades. This era was a time of loosely organized professionals: Mexican and American health professionals who periodically convened in groups to discuss common public health problems and work on collaborative projects. The start of serious North American Free Trade Association (NAFTA) discussions sparked the current era, which is dominated by a new US population of formal organizations: specialized bureaucracies which are specifically devoted to border health.

I show how the health workers of the organized professionals era created structures and practices that facilitated Mexican and US involvement in the field, creating a durable arena for transnational public health activity. In this era, the model of both Mexican and US organizations was similar, consisting of professionals employed by public health departments who occasionally participated in transnational voluntary groups. I then explore the emergence of an era of specialized bureaucracies, wherein a new population of US border health organizations with full-time staff proliferated from California to Texas in the 1990s. Their activities, including conferences, trainings, research, and cross-border projects, stimulated border health activity in both countries. Today, however, the field has a new asymmetry at the organizational level. Mexico, in contrast to the USA, has few border health bureaucracies, the implications of which I explore in the conclusion.

While scholars have studied morbidity and mortality in border regions, the transnational organizational systems within which health professionals educate, diagnose, and treat patients, as well as monitor, control, and eradicate public health problems have received little attention. This paper begins to fill this gap by focusing on the professionals and organizations that in the aggregate comprise the US–Mexico border health field and in practice manage the region’s public health. Importantly, organizations and professionals from the two countries have continually worked together within the field to address public health problems, cooperation unique in its longevity and relevant to today’s new wave of transnational social policy. However, this is also a cautionary tale that illustrates how power inequalities operate within transnational fields to influence public health agendas, ultimately skewing the definitions of what constitutes public health problems in ways that privilege dominant actors.

**Borders and health**

The US–Mexico border stretches 2000 miles from the Pacific Ocean to the Gulf of Mexico, crossing mountains and deserts, large metropolises and small towns, and six Mexican and four US states (Fig. 1). This border is one of the longest, busiest, and most stratified in the world. The border forms a region at once united by transnational flows but
split by disparate national political economies, forces that affect border residents’ health and shape public health policy.

While the US–Mexico border is undeniably unique, certain contradictory conditions that negatively affect this area’s public health are common to border regions around the world. Borders are places of crossing and containment, hybridity and difference, cooperation and conflict (Lyttleton & Amarapibal, 2002). Despite increased transnational regionalism, exemplified by NAFTA and the EU, geo-political boundaries continue to challenge organized efforts to control disease and promote wellness. Public health and social science research on this topic can be divided into two complementary bodies of literature, one focused on transnational patients and pathogens and the other on cross-border cooperation.

Scholars who study transnational patients and pathogens track flows of people and disease and emphasize the permeability of geopolitical divides. This research is extensive and global. Research on border patients has documented routine transnational utilization of diagnostic and treatment services on North American (Chavez, Cornelius, & Jones, 1985; Guendelman & Jasis, 1992; Katz, Verrilli, & Barer, 1998), African (Salaniponi, Gausi, Chimzizi, & Harries, 2004) and European borders (Hermesse, Lewalle, & Palm, 1997) showing how mobile patients connect health systems, especially on economically stratified frontiers. Scholars that study transnational pathogens find that border regions are “hot zones” for communicable diseases like tuberculosis (Centers for Disease Control and Prevention, 2001), malaria (Singhanetra-Remard, 1993), and HIV/AIDS (Lyttleton & Amarapibal, 2002). The implication of this research is that geopolitical borders are artificial barriers that do not contain patients or public health threats. Indeed, the evidence suggests that borders distort efforts to prevent, monitor, and address these issues.

Given the urgent need to address how to manage these cross-border health issues, researchers have attempted to understand how cross-national cooperative effort can be developed for this purpose. Ironically though, while this literature heralds the benefits of cross-border cooperation, it mainly outlines cooperative barriers. In Europe, the belief that public health should be a national responsibility rather than a transnational one has historically stalled coordination across internal European Union borders and more so on external ones (Coker, Atun, & McKee, 2004; Mossialos, McKee, & Rathwell, 1997). Public health cooperation in South America is challenged by nationalism (Grimson, 2002). Public health policy on the US–Mexico border is similar in that national politics in both countries often trumps transnational projects (Bath, 1982). Other well-known barriers include unequal public health budgets, different public health systems, language, and ethnic discrimination (Barnes, 2002; Homedes & Ugalde, 2003; Hopewell, 1998).

Scholars agree that countries in border regions share common public health threats and that transnational cooperation to address these problems is difficult. Given these problems, we have a great need for understanding existing cooperative efforts: their history, their organizational dynamics, their strengths and their weaknesses. Research on the organizational field of border health—the social system within which health problems are defined and prioritized and solutions are formulated and resources are distributed—gives us purchase on the management and politics of border health today.

A field includes all professionals, organizations, and governance bodies involved in a common activity that in the aggregate create a recognized area of institutional life (DiMaggio & Powell, 1983). Organizational field studies strive to explain how groups of organizations develop collective understandings of appropriate day-to-day professional and organizational behavior, inter-organizational hierarchies, and overarching mission (Scott, 1995). Scholars have found that powerful organizations, states and associations are central in this process (DiMaggio, 1991; Fligstein, 1990). Their influence is partially coercive, in that these entities establish regulations and administer positive and negative sanctions, but it is also normative and cultural. They influence others through setting a powerful example that organizations consciously and unconsciously emulate.

Organizational field studies require researchers to collect organizational population and macro-political data and explain how they are connected. Most field research is historically comparative, contrasting different periods in order to analyze the field’s social construction—a method I use here in my analysis of border health’s two eras. I also compare the Mexican and US sides of the border health field to understand how fields can be heterogeneous and still be cohesive. For transnational institutions, like the border health field, social structures and
relations emerge and change in dynamic relation to one another. Thus the field’s ethos, membership, and day-to-day cooperation are shaped by events, organizations, and governance institutions in both the USA and Mexico.

Data and methods

The data I collected consist of organization population information that I compiled into a database, texts in the form of organizational publications and secondary sources, and notes from field research. I first identified organizations through resource guides and partnership listings published by border health organizations. Then I cross-checked this list with the Catalog of Border Health Institutions (United States-Mexico Border Field Office of the Pan American Health Organization, 2000) and the US–Mexico Border Health Association membership. The database includes all government border health agencies at state and federal levels in the USA and Mexico (N 8) as well as all small voluntary groups, non-governmental organizations (NGOs), and inter-organizational projects at the California/Baja California Norte sub-regional level (N 40). This sub-region does not have the historical cachet of Texas/Mexico but it has the region’s largest trans-border metropolis (San Diego/Tijuana) and its other cities are socio-culturally similar to those found elsewhere on the border (Brown, 1997). In addition, the geo-political boundaries of California/Baja California Norte are congruent (unlike Texas which borders Chihuahua, Coahuila, Nuevo Leon, and Tamaulipas) which facilitates comparative analysis of Mexican and US organizational populations.

The database helped me systematically measure the organizational field and track historical changes. For example, tracking founding dates revealed how the field’s organizational underpinnings have transformed over time. Finally, these data allowed me to identify transnational public health problems that border health organizations do not address revealing the politics of the field’s boundaries. I outline my criteria for including organizations in the database and discuss the specific types of data collected in the Appendix A.

Qualitative analyses reveal how central actors and macro-politics shape the field. I use secondary sources and organizational archives to explain the field’s historical origins and subsequent transformation during the NAFTA decade. I employ content analysis of organizational publications to untangle the transnational, inter-organizational networks that structure border health’s many collaborative projects and to identify who designs, funds, and manages them. Finally, I attended three US–Mexico Border Health Association (hereafter called the Association) annual meetings, collecting 70 h of participant observation data (Chihuahua, Mexico 2001; San Diego, USA 2002; and Ciudad Juarez, Mexico 2003).

Findings

The Organized Professionals Era, 1942–91

W.W.II ushered in dramatic socio-economic changes, new public health concerns, and increased transnational cooperation on the US–Mexico border. Irrigated agriculture, US military bases, and industrialization transformed the area, shifting it from a politically and economically marginalized region to a place marked by cross-border centers of population and economic growth. These changes also created new public health threats. Economic and regional growth strained waste treatment systems and increased air pollution. These pollutants blew and seeped across political boundaries, creating environmental health problems like asthma and water-borne hepatitis.

The region long had transnational population flows and thus shared communicable diseases, but US policies during W.W.II created new border-crossing patterns and public health problems for the USA and Mexico. For example, the US Bracero Program, started in 1942 to fill a war-induced labor shortage in this country, offered temporary work permits to Mexican agricultural workers, attracting Mexicans from southern states north to Ciudad Juarez, a centrally located border city in the state of Chihuahua that neighbors El Paso, Texas. There they would complete the necessary requirements to enter the USA, including taking a tuberculosis test. Migrants who tested positive were excluded from entering the USA legally, but often did not have the money to make the long journey back to their hometowns and thus settled in Ciudad Juarez, ultimately raising the tuberculosis rate in the city (Romero Alvarez, 1975).

US populations were also crossing south into Mexico. Young American soldiers in the border’s new and expanded bases, including Fort Bliss in Texas and Camp Pendleton in California, continued
a tradition that started during the Prohibition era, of traveling to Mexican border towns to pay for alcohol and sex. Venereal disease during wartime, however, was considered a national security threat. The US military worried that they were losing too much of their fighting force to illnesses brought on by sexually transmitted diseases (Bath, 1982). This was the impetus for a new transnational venereal disease campaign that differed from the region’s previous nation-based public health management models.

National sovereignty concerns in both countries prevented the US government from managing a venereal disease control campaign in Mexico, spurring the adoption of an alternative strategy: a transnational public health campaign managed by an intergovernmental organization. At the invitation of the US Public Health Service, the Pan American Health Organization (PAHO) opened a US–Mexico border field office in El Paso, Texas in 1942. The PAHO field office campaigned against syphilis and other venereal diseases for the next decade through education and testing in both countries. They installed new diagnostic laboratories in Ciudad Juarez, Nuevo Laredo, and Mexicali, so that Mexican laboratory work could be processed locally instead of being sent to Mexico City, and trained medical personnel in new detection and treatment practices (Ruiz, 2002). US and Mexican government health authorities were instrumental to the program; indeed, government personnel did the day-to-day health promotion, detection, and treatment work within state health facilities, but their efforts were coordinated through the PAHO field office. This is important because a transnational body was the lead organization, thus creating a new space for cross-border public health activity. Within 1 year, public health professionals from Mexico and the USA started to fill this space and to carve out a niche for an issue they began to refer to as border health.

In 1943 the PAHO field office organized the first border public health convention held in Ciudad Juarez, Mexico. On the second day of the convention, two colleagues, a Mexican doctor and US sanitation engineer, proposed the creation of a new transnational, non-profit, public health membership group, the US–Mexico Border Health Association (PAHO) opened a US–Mexico border field office in El Paso, Texas in 1942. The PAHO field office campaigned against syphilis and other venereal diseases for the next decade through education and testing in both countries. They installed new diagnostic laboratories in Ciudad Juarez, Nuevo Laredo, and Mexicali, so that Mexican laboratory work could be processed locally instead of being sent to Mexico City, and trained medical personnel in new detection and treatment practices (Ruiz, 2002). US and Mexican government health authorities were instrumental to the program; indeed, government personnel did the day-to-day health promotion, detection, and treatment work within state health facilities, but their efforts were coordinated through the PAHO field office. This is important because a transnational body was the lead organization, thus creating a new space for cross-border public health activity. Within 1 year, public health professionals from Mexico and the USA started to fill this space and to carve out a niche for an issue they began to refer to as border health.

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The formation of the Association in 1943 had three important effects. First, the Association developed transnational organizational structures, practices, and symbols. The nationality of the Association president has alternated between Mexico and the USA every year since 1943 and there are two vice-presidents, one Mexican and one from the USA (Romero Alvarez, 1975). The Association’s logo melds the colors of both nations’ flags—red, green, white and blue—and all publications are bilingual. Its annual meeting, the central activity of the Association, rotates between the two countries and has been held in all major Mexican and US border cities. Today, the 4-day meeting starts with an elaborate ceremony including US and Mexican flag processions, both countries’ national anthems, and speeches by Mexican and US health authorities. All presentations are simultaneously translated in English and Spanish, although many members feel comfortable with both languages. Clearly, from the beginning members strove to create a viable, explicitly transnational organization and, demonstrated by the longevity of the Association and its salient transnational character, they succeeded.

The second effect of the Association (and PAHO) was the development of the border health organizational field. These two central organizations acted primarily as transnational brokers, bringing Mexican and US professionals together to exchange information, ideas, and resources, and to collaborate on joint projects. This resulted in new cross-border networks between organizations. Mexicans and Americans learned who their cross-border counterparts were and began to see themselves as involved in a common endeavor: improving the health of people living on a shared border. The Association and PAHO’s broker activities created the conditions identified as fundamental to field crystallization: increased density of inter-organizational networks, increased information flows, and the emergence of a collective definition of a particular arena of activity (DiMaggio & Powell, 1983).

The modal arrangement of US and Mexican participation in the border health field was that of organized professionals. The Association and PAHO developed long-term and temporary transnational voluntary groups (committees, working groups, and regional councils) organized around specific health problems deemed to be of common
concern to both countries and located in all major border cities. Government health departments, universities, hospitals, and clinics were brought into the field through their employees’ participation in these groups. Mexican and US professional participation was similar in that their border health involvement was part-time and sporadic, work separate from their day-to-day obligations. The few actors dedicated to border health full-time were employees of PAHO and the Association, truly transnational organizations run by Mexican and US staff. Participation ebbed and flowed over the next five decades, with some transnational voluntary groups dissolving and others forming. Importantly, the Mexican and US organizational underpinnings of the border health field were congruent, both following the organized professionals model.

Third, the Association broadened the issues addressed. Any public health worker who paid dues could be a member. Mexican and US health professionals, including doctors, nurses, administrators, scientists, sanitation engineers, and policy makers, worked to set up an Association that reflected their diverse health interests, including environmental health, maternal and child health, and a range of communicable diseases (Romero Alvarez, 1975). The Association’s broad mission, to promote public health along the border, shows the Association growing into areas outside of PAHO’s original mandate, sexually transmitted disease. Today the Association’s committee work includes tuberculosis, emergency services, substance abuse, and others. The Association’s annual meeting is organized into three tracks: disease prevention and control; health and environment; and health, community and development. The expanded border health frame was cemented through the Association’s *Journal of Border Health*, established in 1985. Through the Association, border health became defined not by any specific health issue or population, but by a trans-border regional geography.

In sum, transnational public health organizing on the US–Mexico border started small—one concern, venereal disease, and one organization, PAHO. However, it quickly morphed into border health, an umbrella issue that encompassed multiple health concerns and had its own professional association. Although US interests, specifically its desire to protect against venereal disease, catalyzed the border health field’s inception, transnational organizations were its central actors, and they created the trans-border structures and culture that made the field cohere across a national divide. Predictably, the USA wielded more influence than Mexico within the field, as anyone familiar with US–Mexican relations would expect. But Mexican and US participation in the field was relatively level in that neither country had its own complex bureaucracies devoted to the border health issue full-time. For both sides, resources earmarked for border health was scarce. Involvement was organized through participation in voluntary groups and projects affiliated with the Association and PAHO. This meant that in terms of organizational structure, Mexican and US participation within the field was the same. This was the case until NAFTA, when US government and non-government donors began to fund border health projects creating a new population of US bureaucracies that changed the field’s organizational underpinnings.

The era of specialized bureaucracies, 1992–today

When NAFTA was implemented in 1994, the biggest trade bloc in the world was created and Mexican and US governments moved from a nationalist to an integrationist stance. Trade between Mexico and the USA tripled, with a subsequent increase in cross-border truck traffic, capital flows, and Mexican and US professional-class travel (Fry & Bybee, 2002). But NAFTA is a truncated agreement. Unlike the European Union, it is limited to the economic sector (notably excluding the health services industry) and was not conceived to promote regional integration beyond trade (Warner, 1999).

NAFTA, however, understood here as institutions and general public discourse, stimulated cross-border social and political organizing. Many labor and environmental groups saw NAFTA as a threat and mobilized first to block the legislation, then to make sure the agreement included mechanisms to protect their interests, and finally to manage its influence (Brooks & Fox, 2002). Despite the potential negative health effects associated with increased trade—primarily air pollution from cross-border truck travel, toxic waste from *maquiladoras*, and inadequate sanitation infrastructure for growing populations—border health professionals, unlike labor and environmental activists, did not actively mobilize against the legislation. Given the scant anti-NAFTA organizing around health, it is not surprising that public health measures were left out of the agreement.
Despite this, the border health field entered a period of increased funding and overall growth in the 1990s. By tracking inceptions of the entire population of organizations (including bureaucracies, voluntary groups, and transnational projects) that self-label as “border health” in California and Baja California Norte, I found that while six border health organizations were founded between 1942 and 1991, 34 new organizations were formed between 1992 and 2002. Widespread adoption of the phrase border health to identify and describe public health projects is more than just words, as has been pointed out by sociologists who argue that the diffusion and adoption of organizational language indicates legitimacy (Meyer & Rowan, 1977).

Because field theory suggests that we should analytically connect organizations to their external environment, this approach is useful for explaining why the border health organizational population grew so dramatically in the 1990s. Fields are usually stable, but external events can spark periods of significant change where professionals and organizations see new opportunities for advancing their interests (McAdam & Scott, 2002). Evidence from parallel border health research I am conducting suggests that field members, especially those from the USA, explicitly drew on NAFTA discourse and took advantage of growing interest in the border to promote new cross-border public health agreements and projects. It is important to note that the impetus for this activity was not epidemiological—although to be sure, border residents in the USA and Mexico face egregious health problems—but politically opportunistic. Health troubles have plagued the region for decades but only recently have national policy makers started to dedicate new resources to support efforts to manage border health.

Donors earmarked much of these funds for bureaucracies, a term that has negative connotations but here is used non-pejoratively to identify formal, rule-based organizations. Comparative analysis reveals that the USA has developed many border health bureaucracies while Mexico has few and these US bureaucracies manage most Mexican involvement in border health projects.

Border health bureaucracies in the USA

Specialized bureaucracies—formal, hierarchical organizations that revolve around border health—proliferated at the US side of the US–Mexico border during the 1990s. At the federal level the Health Resources and Services Administration began their Border Health Program in 1996, the Centers for Disease Control started the Border Infectious Disease Surveillance program in 1997, the Substance Abuse and Mental Health Services Administration opened their Border Center in the same year, and Congress funded the US–Mexico Border Health Commission in 1998. At the state level, the California Office of Binational Border Health, the Texas Border Health Office, and the New Mexico Border Health Office all opened in 1993 and the Arizona Office of Border Health opened in 1994.

Local border health bureaucracies also proliferated. Focusing on California as an illustrative case, we see considerable changes in the state’s two border counties, coastal San Diego and its inland neighbor Imperial. Between 1992 and 2002, 12 new border health bureaucracies were established in California. These bureaucracies come from a wide organizational spectrum including county health departments, international NGOs, community-based organizations, and universities. For example, in 1997, San Diego County opened its border health office followed by Imperial County the next year. In the non-profit sector, Project Concern International leveraged funding in 1996 to begin the multi-million dollar Border Health Initiative. Smaller non-profit organizations formed around HIV/AIDS and substance abuse. California universities entered the border health arena in 1997 with the University of California Border Health Education Network.

The data suggest that in the USA the border health issue garnered political support, demonstrated by the growth of governmental border health programs, most of which are the product of legislation. Private philanthropist organizations also supported the issue: the Carnegie Foundation and other major foundations donated funding to finance the development of border health programs throughout the region. In the appropriately titled report the “The Growing Issue of Border Health,” a foundation think tank reported over 49 million dollars in grants to the California and Texas border regions alone (Grantmakers in Health, 2001). The proliferation of specialized bureaucracies dedicated to border health in federal, state, and local governments and throughout the non-profit sector reflects how border health moved from the margins to the mainstream during the NAFTA decade and in this process became recognized as an important
public health issue in the USA. These developments enhanced the capacity of the USA to manage border health’s transnational field of professionals and organizations.

Salud fronteriza in Mexico

In Mexico, the data reveals a different pattern: a near absence of specialized bureaucracies. Few formal organizations use the phrase salud fronteriza (border health) to identify themselves or describe their work. At the federal level, Mexico has one specialized border health organization, the Comisión de Salud Fronteriza México-Estados Unidos, which legislators created in 2000 (the Commission established Mexican regional offices in 2004). There are no other salud fronteriza government bureaucracies at the federal or state level. Looking closely at the entire range of public and private organizations in the state of Baja California Norte, including smaller municipal and community based programs, only four salud fronteriza bureaucracies opened during the NAFTA decade and the US influence on their origin is clear. They include a hospital linked to a California foundation, a family planning organization that grew out of a partnership with a US organization, and two subsidiaries of a California-based NGO.

The infrequency of the term salud fronteriza was surprising given its ubiquity in the USA and lead me to search for an alternative phrase that Mexican organizations might use to capture border health’s meaning. The Association’s Mexican membership records, articles in Mexican public health journals, fieldnotes, and organizational archives revealed no substitute.

The sources listed above were crosschecked with PAHO’s 2000 Catalogo de Instituciones de Salud Fronteriza (Catalog of Border Health Institutions), a publication that includes Mexican and US federal, state, and municipal organizations as well as NGO’s (United States-Mexico Border Field Office of the Pan American Health Organization, 2000). The document’s Mexican government section lists public health departments located in border cities but no specific salud fronteriza government programs. The NGO section documents the entire population of Mexican community-based organizations, listing for example the Asociación de Lucha Para Evitar La Crueldad Con Los Animales (an animal rights organization). Using the PAHO catalog as a guide, all government health institutions in border munici- palities and any NGOs are border health organizations. This inclusiveness contrasts with the specific border health listings in the publication’s US sections. In sum, the data show that salud fronteriza in Mexico has not crystallized into a significant population of specialized bureaucratic organizations. Instead, the organized professionals model prevails. Professionals primarily from government agencies, but also some academics and community members participate in various transnational projects. This work, if voluntary, is usually above and beyond day-to-day professional obligations and if paid, is often through a subcontract from a specialized bureaucracy based in the USA.

The question is why are there so many border health bureaucracies in the USA and so few in Mexico? Uniquely organized national health systems contribute to some variance between the two countries organizational populations. Mexico’s public health system is centralized and comprised primarily of government agencies while the US system is decentralized and non-government organizations are an important part of the system (Bath, 1982; Hopewell, 1998). In terms of organizational populations, these differences make it likely that the USA will have more specialized public health bureaucracies than Mexico because local government agencies and non-profit organizations swell this country’s total numbers. However, Mexico’s public health system has not precluded the development of specialized public health bureaucracies as the country has devoted resources to public health organizations focused on other public health problems. An unintended result of researching Mexican salud fronteriza bureaucracies was the discovery of one such population, salud del migrante (migrant health) organizations. Although these organizations sometimes participate in border health events, they are not specialized border health bureaucracies. Migrant health is not part of the bilateral agenda for health promotion in the border region (United States-Mexico Border Health Commission, 2003).

In the government sector, Mexico has targeted resources to salud del migrante programs like Salud y Apoyo al Migrante (Health and Support for Migrants) and Vete Sano Regresa Sano (Go Healthy Return Healthy). In the non-profit sector, a variety of indigenous NGO’s have emerged around salud del migrante, which provide shelter and mobile medical services. Mexican salud del migrante bureaucracies resemble US border health bureaucracies.
in that they emerged for the most part since NAFTA, they have full-time staff, brick-and-mortar offices, transnational ties, and dense inter-organizational networks. Thus, the scarcity of Mexican *salud fronteriza* bureaucracies is not due to limits in the country’s capacity or propensity for developing specialized health organizations. The evidence suggests that in contrast to the USA, *salud fronteriza* does not enjoy recognition as a pressing public health problem in Mexico.

**Transnational influence within an asymmetrical field**

Today border health is characterized by a new field-level organizational asymmetry. The US side has experienced a growing population of specialized bureaucracies and the Mexican side continues to mainly organize through professional participation in border health voluntary groups and projects. With this divergence in organizational form, why then is today’s era one of specialized bureaucracies? Simply put, bureaucratic organizations exert an inordinate influence on the entire field and enable US professionals to manage the border health issue.

Fields are relational, meaning that organizations that comprise a field are shaped by their contact with each other. Some actors, however, have more influence than others, with the most powerful members constructing fields in ways that further their interests (Fligstein, 1990). Border health bureaucracies have the directives to conceive, promote, and manage border health projects, many of which are transnational, making them very effective field builders. These organizations often include Mexican professionals in their planning sessions; however, Mexicans are often participants while US organizations lead the meetings and set the agenda. US organizations are able to operate projects in Mexico through offering mini-grants and subcontracts to Mexican professionals. Scholarships help Mexicans attend training seminars in the USA where they learn US public health practice.

Because specialized bureaucracies are embedded within the USA, they often promote the interests of this nation. For example, at one border health meeting a plenary session was dedicated to a US border health bureaucracy’s proposal for a new program that would allow Mexican nurses to secure temporary US work permits to fill border (meaning US border) health professional shortages. The US presenter called it a “win–win” project; however, it clearly favored the USA, as Mexico’s nursing shortage is more severe than the shortage in the US border region. Although Mexican nurses may appreciate the chance to work in the USA because of higher wages and Mexico would benefit from remittances, the policy would likely exacerbate the well-documented “brain-drain” of public health and medical professionals from poorer to richer countries; thus the USA would benefit disproportionately (Chen & Boufford, 2005).

Specialized bureaucracies have brick and mortar offices, brochures and other promotional materials, cash to purchase goods and services, and, most importantly, bodies doing the bureaucracies’ work day-in and day-out. This creates organizational heavyweights. In contrast, organized professionals constitute ephemeral bodies. They juggle multiple commitments beyond border health and transnational projects are often sporadic and short lived. The sheer physical mass of bureaucratic organizations and their trappings tips the balance towards the USA, leaving Mexico, with its more nebulous organized professionals model, sliding towards US goals and priorities.

Admittedly, US-directed activities in Mexico are not inherently negative. Mexican professionals participate in the organizational field and enter into relationships with their northern neighbors because they perceive benefits for doing so, like for example, training in new infectious disease surveillance techniques (Weinberg et al., 2003). Along the same line, the US professionals that run border health bureaucracies are primarily Mexican-American, and most genuinely feel solidarity for their Southern counterparts, for example, calling Mexicans “brothers” and “sisters.” The danger, however, is twofold. First, Mexican efforts may be redirected away from Mexican public health priorities. Second, the USA has disproportionate power to define public health problems and prioritize them. The case of injury and mortality outcomes related to undocumented migration illustrates the power of the USA to recast a public health problem as a political problem.

As the organizational underpinnings of the border health field were changing, the number of undocumented Mexican migrants dying while trying to cross into the USA began to increase. On the US–Mexico border, clandestine border crossing has long been dangerous. Migrants die from a variety of causes including suffocation while hiding in the trunks of cars, drowning while trying to cross canals, being hit by cars while running across...
interstate highways, and hyperthermia, dehydration, and hypothermia while trying to cross deserts and mountains. In the mid-1990s the number, causes, and spatial concentration of border crossing deaths changed due in part to new US border patrol policies that increased border enforcement in urban areas, driving migration into more remote and hazardous regions (Cornelius, 2001; Eschbach, Hagan, Rodriguez, Hernandez-Leon, & Bailey, 1999).

A physical manifestation of these new policies is the eight-foot tall steel fence that stretches 14 miles from the Pacific Ocean to San Diego's coastal foothills. Looking through the fence from Tijuana to San Diego, the militarized border provokes the senses with the low rumble of patrol aircraft; the solid feel of the thick rusty metal barrier, and the green uniformed border patrol agents perched on their all-terrain vehicles. The view, however, is partially blocked by the hundreds of white crosses, named and unnamed, that signify the policy’s human toll.

The total number of migrant border-crossing deaths is difficult to measure because some bodies in remote regions are never found. While the causes of death are usually clear, determining indirect causes correlated to border-crossing mortality—like migration rates, border enforcement policies, unusually high temperatures, and floods—takes careful study (Eschbach, Hagan, & Rodriguez, 2001). Social scientists, however, are beginning to provide a clear picture of the danger of undocumented border crossing. Border-wide, 1700 deaths were reported to Mexican consulates between 1994 and mid-2001 (Cornelius, 2001). In California, deaths of unauthorized border crossers increased 509 percent between 1994 and 2000, reaching a peak of 147 deaths in 1998 (Cornelius, 2001). Scholars agree that policies like Operation Gatekeeper, implemented in San Diego in 1994, have deflected clandestine migrant streams away from cities and into deserts and mountains, where migrants are more likely to die from exposure to intense heat and cold, and to drown in agricultural canals (Cornelius, 2001; Eschbach et al., 2001).

Border-crossing injury and death could logically be a focus of border health organizations. The phenomenon’s deadly upswing coincides with the field’s growth and border health organizations have the resources to address it. The problem is well documented, urgent, and timely—all conditions that public health donors appreciate in the areas they fund. It would also require trans-border cooperation to be effectively addressed, concurring with border health’s transnational logic. Most importantly, the problem is inextricably tied to the US–Mexico border itself.

Yet in 3 years of attending Association annual meetings, talking to border health professionals, and reading organizational publications, the migrant border-crossing death problem was scarcely mentioned. No US, Mexican, or transnational organizations that identified as “border health” focused on the issue. A Mexican administrator with a border health organization explained the absence of the issue as a political concern telling me, “Si te metes con politica luego muchas cosas se pueden trabar” (If you get involved in politics many things can get hung up later). Observation of and conversations with Mexican and US professionals suggest that self-censorship around “political” issues combined with the co-optive effects of US funding often make overt coercion unnecessary. Instead, professionals understand the rules of the game and follow them.

Addressing border-crossing injury and death is left to human rights groups from both countries, Mexican migrant welfare agencies, and the US border patrol (Magana, 2006). Volunteers from human rights groups in the USA search for migrants in uninhabited stretches of desert during the summer months, when temperatures often climb well over 100°F (38°C), to treat dehydration, blisters, lesions, and other injuries. While the main goal of the US border patrol is to capture and detain undocumented migrants, this agency has recently begun to frame their activities as rescue and emergency medical work (Magana, 2006). In Mexico, government agencies conduct public health education campaigns about the dangers of crossing, hand out water for the dangerous journey and rescue migrants. One such agency reported 3000 rescues in 2003 (Hendricks, 2004).

Opposition to issue expansion does not explain the problem’s absence from the border health field. Several new concerns have been put on the border health agenda during the specialized bureaucracies era, including cross-border drinking by US youth—an issue that is similar to the migrant problem in that it is not part of the field’s historical foci—communicable diseases and environmental health. Notably, however, curtailing cross-border underage drinking enjoys popular and political support in the USA and little opposition in Mexico. Migrant
border-crossing injury and death, on the other hand, is a politically charged issue linked to US policy. Thus, what differentiates issues entering and excluded from the border health agenda is not their relationship to the border, their severity, or their transnational nature but whether or not they coincide with US interests. In this case, US actors frame migrant death and injury as a problem of criminal migration, not public health.

Conclusion

Many public health problems in border regions do not recognize political geography. National boundaries do not stop sewage, air pollution and toxic contaminants that can seep or blow across borders, causing environmental health risks. Communicable diseases freely travel across frontiers as microscopic infectious organisms easily outmaneuver even the most sophisticated border control technology by settling, undetected, in a variety of hosts. Professionals and organizations on borders around the world have begun to form fields organized around transnational public health problems like these. These fields emphasize public health interdependency and may have potential benefits over nation-based public health policies.

Border health fields meld public health professionals and organizations into new transnational communities organized around sets of public health problems. However, these fields of organizations, like most other groups, are internally stratified and they set up boundaries that exclude some issues, professionals and organizations. How transnational public health fields are constructed then managed as a result of relations within social systems built on inequality of resources and political power is an important question that has not been sufficiently answered.

The history of the US–Mexico border health field provides some answers to this question. The case demonstrates that interdependence can justify bringing professionals and organization together across borders and that developing transnational membership, organizational, and governance structures contributes to field cohesion and longevity. The field’s history also shows that transnational networks and structures do not ensure cross-border equity, as they can channel influence within fields. The end result may be one country’s priorities being subsumed by another’s, resulting in framing issues in ways that reflect powerful countries’ interests. Thus, cross-border integration, often touted as a way to solve transnational social problems, can have the unintended consequence of furthering power inequality.

The US–Mexico border health field continues to change. The most notable developments are the institutionalization of a new intergovernmental organization, the US–Mexico Border Health Commission in 2000, and the field’s new focus on bio-terrorism since the World Trade Center attack on September 11, 2001. The Commission has usurped the older organizations, PAHO and the Association, becoming the central player in the field. It has also begun to institutionalize border health in Mexico. The Commission has created regional offices there and more specialized border health bureaucracies may follow.

In bio-terrorism, we see the continued impact of US interests on the issues that make up border health. Though Mexican professionals and organizations see a potential bio-terrorist attack as marginally important in the scope of the border region’s current public health problems, in just a few years transnational bio-terrorism preparedness networks and projects have sprung up all along the border due to the fact that the USA has prioritized the issue and devoted considerable resources to its management.

Importantly, the field’s flux means that it is currently in a stage where there are unprecedented openings for new ideas to be made into policy. Field members, both Mexican and US alike, have long requested more resources for Mexico and a recent 5.4 million dollar grant from the US government to develop Mexican border-states’ infectious disease surveillance laboratories indicates that this request is gaining a responsive audience. But for border health to be equitable, training and investment in Mexican bio-medical technological capacity is not sufficient; policy makers who are genuinely interested in cross-border partnerships need to also address the field’s durable institutional inequalities that manifest at the organizational level.

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Appendix A. Database inclusion criteria

Organizations included in the database are limited to those that:

- Define in their name, mission statement, or scope of work that the organization wants to improve public health on the US–Mexico border.
- Be from California, Baja California Norte, or a border wide organization.
- Have a minimum amount of information available including some information on the purposes of the organization.
  - Here “organization” includes stand-alone entities and also programs or projects within larger organizations. For example: the California Office of Binational Border Health is part of a larger government organization, the California Department of Health Services.
  - Transnational organizational structures are not required.
  - Location in a border city is insufficient as this would include ALL health organizations in the border region making “border health” meaningless.

Data collected from each organization includes:

- Organization name
- Founding date
- Activities (e.g. professional training)
- Issue areas (e.g. tuberculosis)
- Organizational sector (e.g. government)
- Organizational type (e.g. voluntary group)
- Location
- National affiliation

References


