Cross-border governance on the U.S.–Mexico border

Institutional challenges and developments in health collaboration

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Abstract: This article examines public policies and development of institutions at the U.S.– Mexico border related to the progression of cross-border health governance. Establishing interlinkages between health and security aspects of the border collaboration, I systematically present a descriptive panorama of the problems inherent to cross-border health governance and analyze institutional perspectives and border typology. As borders continue to change with time, cross-border collaboration continues to be shaped and redefined. In analyzing the challenges facing the border today, what would effective cross-border governance entail? Who are the actors and what are the processes that may facilitate cross-border health governance?

Keywords: borderland, communicable diseases, institutionalization, public health, security

Introduction

"Health knows no borders. But just as the problems flow freely across the globe, knowledge and solutions should too. Many health problems in a globalized world call for complex, multipronged responses. The record shows that even modest investments can go a long way toward achieving better health outcomes and policies."

– David M. Malone
President, International Development Research Centre[1]

The U.S.–Mexico border has long been perceived as complex due to numerous factors such as security, immigration, arms and drug trafficking, and the large disparities that lie between these two border populations.

Particular to this region, in terms of governability, the borders are further complicated by a population that has a unique border identity with historical, cultural, and social processes, separated by two distinct governmental systems, working towards different policy priorities. Health has received less attention among border populations, despite collaborative efforts that date back to 1942.[2] Payan (2006 p. 13) considers the U.S.–Mexico border in a "national security era", redefining border issues a matter of national security, and while health and disease have traditionally not been axiomatic as security questions (Jackson, 2011), health as a security issue is beginning to be identified in public policy making. Therefore, health is an important issue to identify in public policy making and implementation. Borders will continue to change over time as cross-border governance is shaped and redefined. It is likely that health problems on the U.S.–Mexico border will not be solved in the near future (United States–Mexico Border Health Commission [USMBHC], 2010, p. 22).

Assessing the responsiveness and efficacy of the current collaboration involving communicable and noncommunicable diseases,[3] this contribution follows the "disease knows no border" rationale. This approach is relevant to understanding the burdens in the design and implementation of public health policies when a cross-national community constitutes a single zone in terms of containing the spread of communicable diseases (Warner & Jahnke, 2003). While there are obstacles to achieving sustainable cross-border governance, some questions arise: What would effective cross-border governance entail? Who are the actors and what processes facilitate cross-border health governance?

This research involves identifying the problems, actors, and factors in cross-border health governance and looking at institutions and border typology (Payan, 2010). While the analysis focuses on the coordination of problems and asymmetries, I build on the cross-border governance theoretical framework of institutions to establish the interlinkages between health and security aspects of the cross-border collaboration. The evolution towards a deeper binational collaboration may strengthen the communicative channels at the institutional level and improve the monitoring capability and responsiveness on both sides of the border. I argue that lacking or limited collaboration on health issues may result in threats to national security. Furthermore, through cross-border health governance efficacy, it is possible to transform an asymmetrical interdependent border such as that which divides the U.S. and Mexico into a more integrated borderland in terms of Martínez's (1994) models of interaction. My contribution to the existing literature is positioning the lens of research on the issue linkages and institutions in cross-border health governance. I show a mirror effect between health and security, given the potential mutual benefits of politi-

cal, bureaucratic, and social collaboration. Synchronizing bureaucracies may help to achieve political agreements and shape social interaction. As a result, more general problems in cross-border governance can smoothly transition to a more responsive and effective system.

Cross-border governance is a broad field that many scholars have explored from a wide range of perspectives, such as institutions, trends in globalization, processes, and policy changes, in order to identify the evolution of collaboration between nations and the factors that may foster or hinder governance. Payan (2010) analyzes governance capacities in the Paso del Norte region, and identifies the factors that operate against local efforts to produce optimal collaboration efforts. Studying cross-border governance allows readers to understand the different mechanisms that can hinder communication channels through which individuals and institutions can deliver solutions to problems that affect local populations. Other political scientists such as Staudt and Coronado (2002) examine collaboration across borders, focusing on networks, organizations, and issues that require cross-border governance such as environment and health, business and labor, and human rights. Although, when looking at specific fields such as cross-border health governance, one of the biggest gaps in research is that most scholars are largely in the fields of sociology (Collins, 2007; Collins-Dogrul, 2006, 2012), public health (Homedes & Ugalde, 2003; McCormick et al., 2010), social work, and medicine. There are few political scientists who focus on cross-border health research. Yet, a political science perspective may provide an alternative view on the role of institutions in shaping behavior, public policies, and outcomes in cross-border health collaboration.

Governance and communicable diseases on the U.S.–Mexico border

Infectious diseases, also referred to as "communicable diseases" are "caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another" (World Health Organization [WHO] 2013a). Typically, communicable diseases can spread rapidly, become endemic, and put populations at risk. Health status is determined by genetic makeup and access to health services, level of education, socioeconomic status and income inequalities, environmental and employment conditions, and lifestyle (Homedes, 2012).[4] Communicable diseases are a major concern for borderlands and border populations due to the high mobility of people across borders and the inadequate sanitation infrastructure in some parts of border areas. The

Pan American Health Organization (PAHO, 2007 pp. 737–738) identified some of the communicable diseases that have been seen in the U.S.–Mexico border, such as vector-borne diseases (West Nile virus, dengue fever), hepatitis A, intestinal infectious diseases (typhoid fever), chronic diseases (tuberculosis), brucellosis, and HIV/AIDS and sexually transmitted infections (STIs).[5] Some diseases can also be used as weapons for bioterrorist attacks. Examples include anthrax *(bacillus anthracis)*, plague (*yersinia pestis*), tularemia (*francisella tularensis*), and botulism *(clostridium botulinum toxin)* (CDC, 2013a)[6].

In order to understand fully what cross-border governance is, one must understand that its definition has its roots in global governance. "Global governance" refers to the complex roles of formal and informal institutions, processes between and among actors—both intergovernmental and nongovernmental—through which collective interests are expressed, rights and obligations are designated, and differences are mediated (Thakur & Van Langenhove, 2006). Conceptually, global governance branches into different subtopics, such as health governance. This type of governance is focused on actions adopted by society for the protection of the health of its population, regardless whether its mechanisms are formally or informally situated at national, local, regional, or international levels, or whether determinants of health have flowed over borders.[7] Borderland areas are particularly important in terms of global governance, as they contain boundary markers that separate one country from another, and can help or hinder the process of implementing global governance and collaboration in any field of interest to these countries.

Cross-border governance is defined as involving the entire binational community, which requires capable local governments, political leadership, and exclusive systems of administrative control in the area to create joint structures, implement common processes, and to establish mutual issue linkages that produce optimal results in terms of human security, economic prosperity, community political empowerment, and a robust social fabric for their residents (Payan, 2010, pp. 224–226). While Payan's definition of cross-border governance applies broadly to all borderlands and to various fields of mutual issue linkage, this definition can also apply when looking at health issues and the role of multiple actors involved in the prevention, preparedness, and surveillance of communicable and noncommunicable diseases along the borderland. Cross-border governance is understood as an activity or arrangement in the field of health care undertaken by two or more cooperating actors, located in different systems/countries, with the aim of transferring or exchanging patients, providers, products, services, funding or health care knowledge across

the border that separates them (Glinos, 2011, p. 219). Adopting these definitions is vital as identifying the actors in the case of the U.S.–Mexico border may help to determine how effectively they communicate and collaborate with other actors, whether they are at the national, state, or local level.

For example, the effectiveness and responsiveness of cross-border health governance on the U.S.–Mexico border can be analyzed using the case of influenza A (H1N1). The viral epidemic prompted a quick response involving the surveillance of border populations and mitigated the spread of the virus. Mexican health authorities sent samples to both Canadian labs and the United States Centers for Disease Control and Prevention (CDC) in order to confirm the virus. Moreover, Janet Napolitano, United States Secretary of Homeland Security from 2009–2013, commented in a media briefing on her collaboration with her border counterparts (Mexico and Canada), describing "a tri-national approach" based on passive surveillance at border crossings and using CDC teams in Mexico to assist with laboratory capacity and collecting data (U.S. Department of Homeland Security, 2009). Cross-border health governance aiming to help mitigate and respond to health-related issues in an integrated way shows the interdependence of countries when assuring the health and safety of their citizens.[8]

There was, however, opposition to the United States' actions at the time, as people called for closing the borders in order to contain the virus.[9] Shutting down the borders would create what Martínez (1994) refers to as an "alienated borderland" (another of his models of interaction); the model, however, fails in its definition to address the condition of disease containment as a possibility for alienated borderlands.[10] Thus, given the fact that the virus was already present in the United States, sealing the border would halt border populations who commute daily across the border, and damage the interdependent economies deepened by NAFTA. Moreover, a study by McCormick and others (2010), conducted to analyze the response to influenza A (H1N1) virus in a U.S.–Mexico border community, found that state and national preparation plans addressed the need for a comprehensive response, yet the information specifying disease preparedness and response management at the community level was cumbersome. In the case of influenza A, although federal level action was immediate, Texas first learned of the pandemic from media reports rather than direct notification from the U.S. government (USMBHC, 2011, p. 6). It is imperative to look at national, state, and local level initiatives to be able to promote the communication and transfer of knowledge to existing actors to improve the effectiveness of cross-border collaboration.

Interlinkages between health and security

The interlinkages between security and health are relatively new. Understanding the connection between them is important because of the increased effects of globalization felt on the U.S.–Mexico border. Especially the movement of goods and people may imply that diseases can spread through this geopolitical space regardless of set borderlines.[11] One of the most difficult barriers to overcome when working with two countries is the legal impediments that restrict or limit the interaction between these countries. In 1999, Senate Bill 1857 of the Texas 76th Legislature required the Texas Department of Health to conduct a study on federal and state laws that hinder the exchange of information on disease and epidemiological reporting between Texas and Mexico. The report indicated at least six provisions in federal laws and eight provisions in state laws that affect the relationship between Texas and Mexico (Texas Department of Health, 2001).[12] The report reflects the serious problems that influence cross-border health governance. Federal and state laws regarding collaborative efforts should strive for processes that facilitate, rather than impede, attempts to provide health and security to border populations.

Aside from dealing with communicable diseases, the U.S.–Mexico border is also considered a vulnerable area for bioterrorism events. Given the incubation period of an infectious pathogen, it would be easy for terrorists to release agents on the U.S. side and cross the border long before cases of illness were detected (USMBHC, 2010, p. 151). The tragic events of 11 September 2001, changed the direction of many issues related to the border, which included the possibility of attacks through the U.S.–Mexico border, and the U.S.–Canada border. The possibility of attacks with biological pathogens presents deepening concerns for border populations, health, and national security. While governments in both the U.S. and Mexico have taken steps to prepare for such attacks, there still is confusion regarding how nations should prepare and respond as this aspect remains more theoretical than practical (Center for Strategic and International Studies [CSIS], 2004). Yet border security now must include health issues with a collaborative perspective to mitigate threats that may directly or indirectly affect borderland populations and the larger Mexican and U.S. populations.

When looking at new vulnerabilities in the borderland, whether health or bioterrorism, countries may be quick in passing laws without properly assessing federal/state laws with regard to exchanging information. Buzan and Wæver (2009) discuss securitization theory and its links to "institutionalized securitization," and the expression of "watch words," which often generate vivid imagery that can be invoked to move specific

issues into the realm of securitization without much debate. This can be seen in various cases, such as terrorism, the war on drugs, and immigration. One should therefore be wary of the processes of securitization; if the state pursues its own survival needs as the greatest importance, a situation can develop in which the needs of the nation-state supersede the rights of others (Buzan & Wæver, 2009). The idea of labeling as a security issue is becoming increasingly prominent and may justify "othering".[13] The challenge of security and health interlinkages may lie in cross-border health governance where countries can feel more secure, share identities, public policies, and, most importantly, mutual interests in solving health issues.

Theoretical framework

There is a vast literature discussing whether or not institutions matter and how much. The development of this literature has been advancing into a more detailed understanding of the mechanisms through which institutions are able to shape or incentivize the behavior of states as the main actors in international relations. This article argues that institutions do play a role in guiding collaboration. Institutions, formal or informal, play a key role in the effectiveness of cross-border governance. They have the power and ability to shape behavior, enact trust, and incentivize actors and actions toward more cooperation.

Institutional perspectives can be easily understood following Hall and Taylor's (1996) three forms of institutionalism: historical, sociological, and rational choice. The historical approach argues that the decisions made as an institution or policy, and the commitments that the institution manifests, will persist to shape its development (Rackner & Randall, 2011, p. 57).[14] Cross-border health governance and institutions follow the logic of historical institutionalism, because if policies or institutions are built upon uncooperative terms, differing in goals and objectives, it can hinder the processes to be implemented, for example by producing gridlock in programs or research interests and methodological approaches. On the other hand, if institutions are established with proper authority, mutual interests, and interdependence, then the policy outcomes are going to benefit society, or borderland populations in our case.

The second perspective is sociological institutionalism. This school of thought focuses on norms and values that are established in institutions that shape individual behavior and preferences, and thus translate into collective action (Rackner & Randall, 2011, p. 56). However, if norms of distrust are forged—if, for example, professional barriers arise such as nega-

tive perceptions of colleagues working in Mexico or the United States—it can impede collaborative attempts, as Homedes and Ugalde (2003) found in their study on globalization and health. If norms of distrust are commonly found amongst U.S. and Mexican physicians and health officials, it is unlikely that academic or professional alliances will be produced or maintained.

Finally, rational choice institutionalism argues that institutions represent rules that constrain and enable action; "rules reflect the explicit intent and powers of individual actors" (Rackner & Randall, 2011p. 57), and these rules enable actors to undergo a rational calculation persuaded by incentives and self-interest. Both rational and sociological approaches shape behavior, but there are other factors that may incentivize actors and prompt collaborative efforts, which include properly funding of institutions to work effectively and produce research results, under clear conditions of authority and obligations.

People assume that cross-border health governance institutions represent mutual interests in providing a more favorable setting for agreement construction and action. Cross-border health institutions should be able to provide the necessary information on issues pertinent to the populations they serve. Institutions increase their leverages, and in doing so, the likelihood of successful enactment and implementation of policies in response to health security needs. Through collaborative approaches with countries between the borderland areas, institutions would ideally be able to produce the necessary information for developments, thus being prepared to act effectively. However, what is at stake if these institutions cannot function properly or fail to collaborate in providing necessary and reliant information? Health issues become a matter of concern, because if there is failure to act collectively on communicable diseases, or threats of bioterrorism, these issues may quickly evolve to national security threats. If collaboration is limited or reduced, countries are bound to fail in making effective public policy and they may miss opportunities for exchanging security services that may generate mutual benefits (Bronk & González-Aréchiga, 2011). For example, if institutions are not able to come to an accord to provide emergency services (such as vaccinations or responses to disease outbreaks), it could lead to panic, and result in the delegitimization of these institutions as providers of collaboration among different actors on which people depend.

Moreover, Payan's (2010, p. 230) application of cross-border governance and institutions includes an identification of border typology using the following terms: coordination, cooperation, and collaboration. Indeed, many studies and institutions use these words interchangeably, yet the terms differ in types of structures, processes, and aims. Particularly in

health issues, institutions must aim for collaboration, rather than merely coordination and cooperation.[15] According to Payan (2010, pp. 230–231), collaboration entails:

1. Objectives: Same objectives, previously defined as common by all actors.
2. Vision: Shared understanding of interest, meaning and purpose.
3. Acknowledgement of interdependence: High, goals are the same.
4. Mechanisms of interaction: Designed to be permanent and clear; actors are bound by rules and procedures and there is a degree of certainty in the outcome because everyone works toward accomplishing the same goals; the work is synergistic.
5. Purpose of the system: To work together to accomplish the same goals, which the actors defined prior to taking joint action.
6. Requirements: Absolute trust, continual information sharing and ongoing consultation.
7. Physical location of participants: Same physical location or very well-regularized processes of interaction.

This definition provides a holistic approach to identifying good cross-border collaboration.[16] Using these seven identifiers of collaboration, I will look at two major health institutions that address binational health issues along the U.S.–Mexico border: the U.S.–Mexico Border Health Commission (USMBHC)[17] and the Texas Office of Border Health. Identifying the gaps in these institutions will provide insight into developing cross-border collaboration to increase effectiveness.

U.S.–Mexico Border Health Commission

The USMBHC is a good example for the study of the cross-border policy processes discussed above. It took more than 10 years to reach an agreement to establish the USMBHC. Throughout the policy process, legislators in Mexico and United States had different ideas of what constituted border health interests. Collins-Dogrul (2012) argues that when transnational networked governance intersects with domestic politics, there is a struggle between actors to shape policy outcomes. On 22 October 1994, Public Law No: 103-400 established the U.S. Section of the U.S.–Mexico Border Health Commission (Library of Congress, 1994; Collins-Dogrul, 2012). In defense of domestic interests, the law included a clause that would allow the USMBHC to suggest ways to reimburse a public or private entity of one country for the costs of a citizen of another country who is not able

to pay for the health service.[18] In 2000, after a dispute among health advocates, the Mexican Congress passed the agreement (the reimbursement clause was removed), and stated that one of the Commission's goals was to protect migrants living in the U.S. from health threats. The agreement did not make references to migrants, and while "US lawmakers thought migrants were a border health problem, most Mexican lawmakers wanted to protect migrants from border health problems" (Collins-Dogrul, 2012). Despite the USMBHC's rough beginnings, publications from this entity do not include the disagreements mentioned above (the difficulty in addressing mutual interests). Instead they only highlight the 2000 signing.[19]

The historical institutionalism approach adopted by this article contends that collective decisions made as an institution or policy, and the commitments that the institution adopts, will persist to shape its development. So then, looking at the Commission through the lens of historical institutionalism, one can see that its problems/lack of consultation/conflicting interests, etc., persist to shape its development. Because it was founded in difficult political conditions, it has yet to mature institutionally. Perhaps that is why it took over 10 years to finally start the USMBHC. Also, according to Payan's typology of border collaboration, at least in the beginning, the Commission failed according to all seven identifiers[20]: it failed in establishing shared understanding of interests, objectives and goals; it did not acknowledge interdependence nor value ongoing consultation (as Mexico has little input throughout the policy process); and the physical locations of participants were both Washington, DC and Mexico City. This leads to the question: how many border experts and populations were consulted in the institutionalization process? Considering another aspect of the historical analysis, institutionalists have devoted attention to how institutions structure a nation's response to new challenges (Hall & Taylor, 1996). Historical events, such as the terrorist attack of 11 September 2001, shifted U.S. health institutions towards a "new path," one that was more security-based due to the possibility of bioterrorism.

The Commission established the Early Warning Infectious Disease Surveillance (EWIDS) project and the U.S. government assigned the ability to prepare and respond to bioterrorism and outbreaks of infectious disease the highest priority, calling for early warning surveillance and prompt sharing of findings of concern along the U.S.–Mexico border (USMBHC, 2004). However well-intentioned this program might have started out, it is easy to point out that U.S. proponents were the ones who first mobilized for making changes within the institution, raising questions about the incentives for Mexican proponents. At the Commission's Binational Infectious Disease Conference (USMBHC, 2011), Ali S. Khan[21] discussed challenges to cross-border surveillance and preparedness work. His pre-

sentation included identifying difficulties in aligning priorities between countries, different public health systems, legal issues, travel restrictions, language, and bureaucracies, and the fact that unfortunately due to the current fiscal situation of the United States, the EWIDS program funding has been reduced by 50%. Homedes (2012) argues that the United States is interested in continuing programs like EWIDS, as they can lower the cost of disease treatment and control, although the constant budget cuts only reinforce how underfunded the Commission continues to be. Moreover, the USMBHC provides forums and summits that attempt to achieve collaboration by including public health officials from the U.S. and Mexico to facilitate communication on the constant problems they face and how to solve them.[22]

Texas Office of Border Health

Another institution of interest that is related to discussions of cross-border health governance is the Texas Office of Border Health within the Texas Department of State Health Services. The Texas Office of Border Health (OBH) was created in 1993, and its work is concentrated on enhancing the agency's efforts to promote and protect the health of border residents, in collaboration with communities and U.S. and Mexican local, state, and federal entities (Texas Department of State Health Services, 2013). However, it is unclear exactly with which Mexican entities the office was collaborating. An email exchange with the OBH's program manager for the city of El Paso (4 March 2013) clarified that the collaboration with Mexican entities is done mainly through work with binational health councils and through projects funded by the USBMHC. Additionally, the OBH collaborates with other federal agencies such as the CDC, which is an operating division of the U.S. Department of Health and Human Services. To address the security and health aspect of the border, the U.S. Department of Health and Human Services and the Mexican Secretaría de Salud (Ministry of Health) developed the U.S.–Mexico *Guidelines for Cooperation on Public Health Events of Mutual Interest* (Guidelines, 2013), which were formally adopted on 22 May 2012 (CDC, 2013b). This document aims to achieve a level of identification and coordination for mutual epidemiologic events, facilitating entities' knowledge on how and when to share information. Among issues of mutual interest are national security and terrorist events.

Unlike other attempts at coordination, these guidelines were agreed upon by public health officials from both countries. Dr. Ricardo Cortés Alcalá, the General Director of Epidemiology for the Mexican Ministry of Health, commented that there were many drafts of this document, and

sometimes the two countries disagreed on terminology, but in the end, both countries wanted to use epidemiological surveillance to increase national security (USMBHC, 2011). Examining this achievement through a historical institutionalism perspective, it is clear that establishing mutual interest and defining procedures for notification and action on binational issues will likely affect the development of the Guidelines, their implementation, and their function in improving collaboration in and response to events of mutual interest. Moreover, this document provides incentives for a well-functioning, improved process of sharing information in situations that demand reliable and accurate data for collective action. The Guidelines not only take into account the legal compositions of both U.S. federal, state, and local governments and Mexican laws regarding health and epidemiologic events, but also the agreements between public health authorities in Mexico and the United States.

Payan's (2010) collaborative typology would indicate that the Guidelines have clear objectives and vision, and acknowledge the interdependence between epidemiological situations, purpose, and trust. The downside to this document, however, is that the Guidelines are not legally binding to either of the two countries, rather "it is planned they will lead to the development of shared protocols to facilitate their full implementation" (Guidelines, 2013). Therefore, the mechanisms of interaction are not necessarily permanent or binding; public health officials from both countries created the Guidelines to review current laws that affect data sharing and are aware of how to proceed with binational problems. Similarly, physical location is not well specified, but rather implies communicating through "the appropriate channels" (binational, federal, state or local). Since the document went into effect in 2012, it is yet to be seen whether the Guidelines will be followed accordingly.

Conclusions

Health and security interlinkages through emerging infectious diseases and bioterrorism threats are serious issues that countries such as the United States and Mexico are beginning to take note of while developing cross-border public policies, programs, and institutions. A variety of scholars continue to study cross-border health governance and their research contributions in the areas of epidemiological surveillance, institutions, and civil society are valuable because they continue to identify the gaps that exist between security, health, and quality of life for borderland populations. However, barriers continue to divide true collaborative efforts through improper funding, communication problems, intra-agency

overlaps, mistrust, and different interests. Through documenting and sharing practical and creative experiences, lessons learned, and other practices addressing health, it is possible to create an evidence base in order to transform policy practices into best practices (Moya et al., 2012). Institutions should communicate regularly to avoid duplication of programs, allow for information sharing to improve gaps in the system, and be able to convey their opinions, interests, and address policy barriers. Moreover, institutions should continue improving surveillance and tracking of diseases by working with health professionals, organizations, and programs that address the same mission. All these should help to produce further effective results. Also there should be a higher transparency in the allocation of resources and in the roles that actors undertake. Cross-border health governance does not just happen because reports and publications say so; collaboration should be reflected in programs and the security and health of borderland populations.

The study of health issues lies mostly in certain disciplines; therefore there is a need for future research that generates a multidisciplinary approach, drawing political scientists to study cross-border health governance. In order to continue future research, I propose following Payan's (2010) border typology and expanding it to operationalize low, medium, and high levels of interaction in cross-border health institutions. More specifically, a qualitative methodology through interviews with government officials and individuals who hold key positions (for example, Commission members and representatives) may also be useful; providing a way to evaluate true collaboration between the United States and Mexican officials. Studying national, state, and local efforts would bring a better understanding to identifying gaps, making improvements, and continuing the development of institutions that promote the development of cross-border health governance along the U.S.–Mexico border.

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NOTES

1. IDRC (n.d.). The International Development Research Centre is one of the world's leading institutions in international development.
2. The Bracero program was initiated in 1942, during World War II; it enticed Mexican labor to the U.S. for agricultural purposes and tested the workers for tuberculosis. The workers who tested positive for tuberculosis were not admitted into the program, and many settled in Ciudad Juarez, therefore increasing the tuberculosis rate (See Collins-Dogrul, 2006). Moreover, in 1942, the Pan American Health Organization (PAHO), a regional office of the World Health Organization (WHO), established an office in El Paso, Texas to help start a border health campaign. In 1943, the U.S.–Mexico Border Health Association was established.
3. Communicable diseases are not analyzed in this article; however they do present serious issues in the border region. Communicable diseases include metabolic and nutritional diseases (diabetes and obesity), and cardiovascular diseases. See PAHO (2007).
4. In Chapter 9 of *Social Justice in the U.S.–Mexico Border Region* (2012), Eva Moya, Oralia Loza, and Mark Lusk address the social determinants of health, and argue for addressing inequalities both in the social and the physical environment, stating it is possible to increase health equity, decrease disparities, and ensure social justice.
5. Some other infectious diseases in border populations mentioned by Homedes (2012) are diarrheal illnesses such as *campylobacter* and *shigella,* and sexually transmitted infections such as gonorrhea, syphilis, and hepatitis B.
6. See CDC (2013a) for a full list of bioterrorism agents/diseases.
7. For a more comprehensive review of the various terms of governance and theoretical approaches see Dodgson, Lee, and Drager (2002).
8. See "Foreign Policy and Health Security" (WHO 2013b) for a deeper understanding of how taking care of health is usually a domestic concern, but is increasingly being recognized as a mechanism of foreign policy and public health to cooperate in preventing emerging infectious disease and bioterrorism.
9. In 1917, the U.S.–Mexico border (El Paso–Juarez) witnessed humiliating procedures in the name of health security, as U.S. health officials were concerned about a typhus (spread by lice, fleas, mites and ticks) outbreak coming in from Mexico. At the ports of entry, Mexicans were subjected to disinfection "camps," which were gasoline baths of kerosene and vinegar. The practice continued for years until health officials realized that some of the chemicals used were dangerous.
10. An example of an alienated borderland due to disease can be seen in the case of Zimbabwe and Botswana with the recent epidemics of foot-and-mouth

Disease (FMD) on local cattle, which are a source of income for many communities. While there are claims that the border fence was also installed to stop unauthorized immigration and the HIV/AIDS epidemic, the outbreaks of FMD nonetheless were primary to the erection of the fence, in an attempt to protect the lucrative cattle industry of Botswana. Thousands of cows were slaughtered as a result of the outbreak.

11. One would expect the impact of globalization to help create improvements in health collaboration given the increased interdependence. However, a study conducted to address the economic interdependence created by the North American Free Trade Agreement (NAFTA)—to see if it had a positive effect on international policymaking and improvements in binational health collaboration along the border—found the opposite result (Homedes & Ugalde, 2003). Noting that NAFTA did not include public health issues as part of the agreement, the study found that globalization has not helped improve health collaboration between the U.S. and Mexico; few truly binational cooperative programs exist, and U.S. health officers, practitioners, and their Mexican counterparts face multiple constraints that impede the design and implementation of these types of programs.

12. See "Barriers to Binational Cooperation in Public Health between Texas and Mexico" by the Texas Department of Health (2001).

13. "Othering" is understood as an exclusion from some group; it is considered a social (linguistic and psychological) mechanism that distinguishes or separates those we consider "us" from "them." We can see types of othering in medical terms (such as the stigma of HIV/AIDS patients) or the othering process that was created after the terrorist attacks of 11 September 2001. Thus, securitization in health issues may lead to stigma as in the influenza A (H1N1) virus outbreak, where many people created an othering of Mexican citizens, as the outbreak originated in Mexico. For a more detailed approach to social exclusion and othering, refer to Take et al. (2009).

14. I am also taking note that historical events, such as the terrorist attacks of 11 September 2001, may have the capability to dramatically change policy outcomes and the creation of institutions.

15. According to Payan's border typology, both coordination and cooperation contain barriers that impede true cross-border governance. For example, out of the seven fields, coordination and cooperation do not have shared understandings (or partial), minimal trust, no acknowledgement of interdependence, etc. Factors such as those mentioned are crucial for institutions to be trusted, and make it difficult for effective public policy and programs to emerge from such fragmented typologies.

16. Using the term "good" does imply a normative approach to health issues, because health should be viewed as equitable for and inclusive of all border/nonborder populations.

17. Also referred to as "the Commission."

18. This clause reads: "Formulate recommendations for a fair method by which the government of one country would reimburse a public or private person

in the other country for the cost of a health care service furnished to a citizen or resident alien of the first country who is unable to pay for the service." See Library of Congress (1994).

19. In 2004, the Commission was designated the authority of an International Organization. See Homedes (2012).

20. I am by no means implying that the U.S.–Mexico Border Health Commission does not collaborate. Indeed, they have contributed to a better understanding of health issues along the border, and help coordinate projects such as the Binational Health Week, research forums, and summits. Yet it is important to be able to detect the mechanisms that block true collaboration. I acknowledge and support the great work that institutions and individuals produce despite the barriers they face.

21. Ali S. Khan is the U.S. Assistant Surgeon General (retired) and Director of the Office of Public Health Preparedness and Response.

22. According to the U.S.–Mexico Border Health Committee, a brief report states that due to disparities, the U.S. and Mexico are not coordinated and cannot serve the objectives of early warning responses to outbreaks. See USMBHC (2009).

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Gobernanza transfronteriza en la frontera EE.UU. - México: desafíos institucionales y desarrollos en la colaboración binacional en el sector Salud

Pamela Lizette Cruz

Resumen: Este artículo examina las políticas públicas y el desarrollo de las instituciones en la frontera México-Estados Unidos en relación con la progresión de la gobernanza sanitaria transfronteriza. Estableciendo vín-

culos entre el sector salud y los aspectos de seguridad de la colaboración transfronteriza, la autora presenta sistemáticamente un panorama descriptivo de los problemas inherentes a la gobernanza sanitaria transfronteriza y analiza las perspectivas institucionales y la tipología de frontera. Como las fronteras continúan cambiando con el tiempo, la colaboración transfronteriza continúa redefiniéndose y tomando forma. En el análisis de los desafíos que enfrenta la frontera hoy, ¿qué implicaría una gobernanza transfronteriza eficaz? ¿Quiénes son los actores y procesos que facilitarían la gobernanza sanitaria transfronteriza?

Palabras clave: EE.UU. (Estados Unidos de América), frontera, gobernanza, México, salud

Gouvernance transfrontalière à la frontière Etats-Unis - Mexique: défis institutionnels et développements de la collaboration en matière de santé

Pamela Lizette Cruz

Résumé: Cet article examine les politiques publiques et les développements institutionnels survenus à la frontière américano-mexicaine dans le domaine de la gouvernance sanitaire transfrontalière. En établissant des liens entre la santé et les aspects sécuritaires de la collaboration transfrontalière, j'entends ainsi dresser un panorama descriptif des problèmes inhérents à la gouvernance sanitaire transfrontalière, tout en analysant les perspectives institutionnelles et la typologie des frontières. Alors que les frontières continuent d'évoluer avec le temps, la collaboration transfrontalière ne cesse continuellement de se façonner et se redéfinir. Au regard des défis actuels de la frontière, quels enjeux impliquent une gouvernance transfrontalière efficace? Qui sont les acteurs et lesquels sont susceptibles de faciliter la gouvernance de la santé transfrontalière?

Mots clés : Etats-Unis, frontière, gouvernance, Mexique, santé