

HEALTH IN BORDER AREAS

Wadie Wanies Kamel

Tempe, Arizona, 85283, USA

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Summary

This article presents the health-related issues and challenges in border areas from a global perspective. It is divided into five sections: (1) general definitions, (2) current and continuing concerns of health in border areas, (3) recent international recognition of border health concerns, (4) current and potential border health promotion, and (5) conclusions. We must admit from the outset that available knowledge about this universally neglected area is limited and in discussing each aspect we can be neither extensive nor conclusive. Border research and studies, although starting to grow, have been scanty in health as well as in other disciplines concerned with borders, such as geography, political science, sociology, anthropology, law, ethics, and history.

1. Definitions

In his book *Political Frontiers and Boundaries* Prescott (1) defines a "Boundary" as a

line of physical contact between states, which affords opportunities for co-operation and discord between states. “Border” has usually been understood as denoting the adjacent areas which line the boundaries, while frontier is a zone category that refers either to a political division between states or to a division between the settled and uninhabited parts of a country. A borderland is a transition zone within which a boundary lies (Prescott, 1987).

“Border communities” are the population settlements, rural or urban, in close proximity to the borders. “Refugees” are defined as persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters, and cross their home country borders to take refuge and seek asylum in other countries. In contrast, “internally displaced persons” (IDP) are defined as persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters; and who are within the territory of their own country.

The social construction of borders has evolved from the regime of military security towards a political construction which builds upon the regulation of economy, the formation of polity, and the internationalization of civil society practices (2). States remain “sovereign”, because they police the boundaries of their territories and, to the degree to which they are credibly democratic, represent the citizens living within those borders. In Western Europe in the 1990s, the processes of unification and integration tended to decrease the security role of borders within the continent, giving more importance to other functions of “border”. In globalization, cross-border exchanges may no longer be an issue solely between blocs and pairs of countries; their scales change and become of universal impact. However, in spite of the accelerating tendencies towards “globalization”, many authors think that the state will remain the major “sovereign” context in which people organize their daily lives in the future (2).

2. Current and Continuing Concerns of Health and Development in Border Areas

2.1. The universal neglect and marginalization of border areas, border communities and border crossers impact communities beyond the borders.

Border communities, regardless of their size, are often regarded by policy makers as peripheral in terms of social programs but paradoxically have high priority in terms of national security, a perception that leads to the marginalization of border residents’ concerns. National policy makers are preoccupied with the population in their central areas, resulting in the neglect of their border communities. In many situations national policy is at odds with border needs and priorities.

It makes greater sense strategically to have sparsely-populated border regions with poor infra-structure functioning as a barrier against external threats from the states across the borders.

As a result of this neglect, inequitable access to resources prevails at the borders. In addition, apathy and antipathy are often evident when borders are discussed in many

responsible circles. Worldwide, there is a deficiency of basic information and statistics about health, environmental safety, and development at border communities, and health policies and public concern are often lacking or non-existent.

2.2. Borders are crucial entry points for communicable diseases which, if not properly managed, would affect the country's population significantly.

Communicable diseases, such as T.B., AIDS, poliomyelitis, and malaria, are among the most prevalent diseases at the borders. In many countries, depending on their border entrances, there are few or no restrictions upon entry in relation to health and immunizations.

U.S. experts agree that the disease that currently poses the greatest risk, both to the border crossers themselves and the public at large, is tuberculosis (TB). More than 75 percent of patients diagnosed with tuberculosis in El Paso, Texas, identify contacts in Ciudad Juarez, Mexico. An estimated 50 percent of Juarez residents have shoppers' passes allowing them to remain in El Paso for 72 hours. Many U.S. citizens live in Ciudad Juarez, Mexico, and work in El Paso, Texas, with the reverse also being true. Families may be geographically split, with some members residing in El Paso while others reside in Juarez. An estimated 25 to 30 percent of El Paso tuberculosis patients have dual residence in El Paso and Juarez (3).

Although TB may be the most significant border-related public health threat, a range of illnesses, including malaria, cysticercosis, typhoid and other enteric diseases, leprosy, schistosomiasis, viral hepatitis, and Chagas disease also appear in U.S.- Mexico border populations (4). The border is far more permeable to disease, air and groundwater contamination, mosquitoes, and rabid animals than it is to people. Problems brought on by overcrowding, poor sanitation, and the explosive growth of the past twenty years include diseases virtually unknown in the rest of the United States, often carried by border crossers from the interior of Mexico and Central America through the border and to points beyond. Texas' sixteen border counties have twice the national rate of TB. Shigella dysentery occurs at three to four times the national average, hepatitis at five times. The rates of syphilis, other venereal diseases, and teen pregnancies are also high (5).

It is also important to stress that the communities on the Mexican side of the borders similarly experience many health problems brought over to them from the United States, demonstrating that the flow of people at the borders is in two directions. Hundreds of thousands of young people, tourists, and retirees regularly cross the border to Mexico bringing their own social, physical, and behavioral ills.

In Southeast Asia, in a symposium on containment of melloquine-resistant falciparum malaria, with special reference to border malaria, the participants highlighted several important questions related to the factors responsible for and contributing to the spread of multi-drug resistant falciparum malaria at the Thai-Cambodian and Thai-Myanmar borders (6). Border malaria control requires specific approaches and control strategies for each paradigm. In this context, intersectoral collaboration, community participation, training, operational research and health education have been discussed as the vital

components for effective malaria control (7).

Also in Southeast Asia, several reports indicate that HIV has spread rapidly among injecting drug users in the north-eastern states of India. Manipur, a north-eastern state of India bordering Myanmar, has experienced very rapid transmission of HIV among its vast drug-injecting population. Myanmar produces opium and its derivatives and forms part of the area of south-east Asia known as the Golden Triangle. Populations with a common language and culture move freely across the long international border that Myanmar shares with four states of the region. Two other north-eastern states of India bordering Myanmar have faced a similar epidemic within a short period of time (8).

2.3 Border communities frequently suffer from lack of health care, minimal or non-existent access to preventive health services, emergency medical services, and health promotion.

The health care delivery problems of the U.S.-Mexico border region are longstanding and profound; public health programs remain fragmented and in need of coordination. According to figures cited by the National Association of Community Health Centers, 10 of the 24 counties along the U.S.-Mexico border are in "double-jeopardy", being both medically underserved and poor. The residents of these counties face a dismal overall health status. The border's lack of access to health care is a significant problem, due in part to a dearth of insurance, especially among the Mexican -American population. It is also based on non-financial barriers to access. Some of these are an uneven distribution of physicians/health professionals and hospitals, a shortage of primary care providers, inadequate transportation, a lack of bilingual health information and health providers, and culturally insensitive systems of care. Standard health indicators demonstrate the consequences of these problems along the border (9).

According to Rodriguez (2.2), Emergency Medical Services (EMS) demand greater attention on the U.S.-Mexico border. On the Arizona-Sonora border, binational EMS activities have been dramatically affected by a population increase in Arizona border counties and Sonoran border cities, a post-NAFTA increase in manufacturing activity, and an increase in tourism and other social and cultural border-crossing activities. In response to this there has been an increase in various medical/health exchanges along the border. These exchanges involve emergency medical services, occupational and environmental health, border health coalitions, and governmental and private /public initiatives pertaining to immigration, drug prevention, and enforcement. Currently, Mexican EMS are in a crisis due to an increase in border crossings and emergency medical transports of American citizens into Mexico, and Mexican citizens from the Sonoran border into Arizona. This crisis is worsening due to high mortality rates from motor vehicle collisions on the Arizona-Sonora border; unsafe transport of EMS and first responder vehicles and equipment (from both Arizona and Sonora) to and from emergency sites on the Arizona-Sonora border; and limited binational EMS data on resources, sites, staff, training, and equipment on the Arizona-Sonora border.

The challenge on the Arizona-Sonora border is to understand better and respond to the effects which increased economic activity has on emergency services. The current emergency medical system forms a core public health component (similar to community

sewage systems, municipal wastewater treatment facilities, and clean drinking water systems) on which other types of infrastructure, i.e. tourism, industry, and housing, etc, must depend (10).

From the provider's perspective, issues of health policy and health care delivery will have to be addressed with regard to utilization of health services along the Arizona-Sonora border. People at the U.S.-Mexican border have been using health care providers on either side of the border for many years. Studying how the movement of patients has been taking place, and how it has affected health care providers' practices, is the first step towards the understanding and organization of health care services for the border region. Improved communication between the health care providers on both sides of the border, the establishment of health care protocols with quality assurance programs, and suitable health care financing mechanisms are some of the issues that require immediate attention if the health care delivery system at the border is to function more efficiently and to the satisfaction of health care providers and consumers (11).

Border crossing for hospital care has implications for the use of statewide data. A major concern of researchers using state data sets for population-based analyses and market share studies in the health care sector is the potential bias caused by border crossing patients -- patients receiving care out of state. At the county and zip code level, border crossing is more frequent but tends to be concentrated in areas adjacent to other states (12). Biased statistics misrepresent the needs of a population and can impact the adequacy of health care planning and delivery.

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Biographical Sketch

Born in Egypt, **Professor Wadie Kamel** studied medicine in Cairo (M.B.,Ch.B.) and carried out his postgraduate work at Harvard School of Public Health (M.P.H.).

He had extensive working experience with the World Health Organization in various countries and pursued a full academic career in the U.S.A., first in the University of Illinois, then at the University of Arizona, in Tucson and Phoenix.

He held numerous honorary appointments, wrote and published extensively and was widely known in the International Health community.

Professor Wadie Kamel passed away in October 1999.