

# Health Services Provision for Migrants Repatriated through Tijuana, Baja California: Inter-agency Cooperation and Response Capacity\*

## Oferta de servicios de salud a migrantes repatriados por Tijuana, Baja California: Cooperación y capacidad de respuesta interinstitucional

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### ABSTRACT

This article explores the institutional capacity to respond to the health needs of Mexican migrants repatriated through Tijuana, Baja California, Mexico. Twenty-one semi-structured interviews with governmental and civil society organizations were conducted. The information was analyzed using the concept of “cooperation.” Results show an informal inter-institutional network based on common goals and interdependence of resources. Health service provision is not completely functional, due in part to lack of trust between some actors and to demand overload in the most important public provider of secondary and tertiary care services in Tijuana.

*Keywords:* 1. health services, 2. repatriated migrants, 3. cooperation, 4. Tijuana, 5. Mexico.

### RESUMEN

Este artículo explora la capacidad de respuesta institucional a las necesidades de salud de migrantes repatriados por Tijuana, Baja California, México. Se realizaron 21 entrevistas semiestructuradas a actores gubernamentales y de la sociedad civil. La información fue analizada usando el concepto *cooperación*. Se encontró la presencia de una red interinstitucional informal basada en objetivos comunes y una interdependencia de recursos. La oferta de servicios de salud no es del todo funcional debido, en parte, a la ausencia de confianza entre algunos actores y a la saturación del más importante proveedor público de segundo y tercer nivel de atención en salud en Tijuana.

*Palabras clave:* 1. servicios de salud, 2. migrantes repatriados, 3. cooperación, 4. Tijuana, 5. México.

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## *INTRODUCTION*

This article addresses the relationship between return migration and the health of migrants from a human rights and inter-agency management perspective. The intense population mobility seen today between Mexico and the United States of America requires states to carry out actions and strategies to guarantee the rights of the mobile groups. In Mexico, “the democratization of health” began to become part of the national discourse during the first decade of the 2000s, making explicit the necessity of involving more social actors in the processes linked to health service provision to the population without health insurance, among them return migrants (Arredondo et al., 2013). In the area of public policy for migration and health, adjustments to mechanisms of coordination and cooperation between local, national, and international bodies have become imperative in order to respond to the health needs of the mobile population (Zimmerman, Kiss, and Hossain, 2011). In particular, return migration entails upheavals of greater complexity in physical and mental health due to the accumulation of risks migrants have been exposed to since leaving their places of origin, during their journey, possible detentions, and their forced or voluntary return. Despite that, this problem has not received enough attention from academia and decision-makers (Davies et al., 2011).

Since 2007, a federal program for the orderly reception of Mexican migrants called Programa de Repatriación Humanitaria (Humanitarian Repatriation Program, known by its Spanish initials PRH), and including a health care component, has been in operation in Mexico through the Instituto Nacional de Migración (National Migration Institute). It is a relatively pioneering model where action is taken by different levels and dependencies of the government, by the binational initiative known as Comisión de Salud Fronteriza México-Estados Unidos (United States-México Border Health Commission), and by local and international civil society organizations. The provision of health services by this joint initiative has enjoyed a series of successes; there also are areas of opportunity that need to be studied to improve the services' functioning and overall health care for this vulnerable population.

The objective of this article is to explore the response capacity to address the health needs of the population repatriated to Mexico from the United States, by governmental and organized civil society actors in Tijuana, Baja California. The following sections will describe the services provided, the actors involved, and the path to access health services for those repatriated, beginning at the National

Migration Institute's El Chaparral receiving point. The description of the interactions and the inter-agency coordination established among these actors is done utilizing the concept of cooperation. Finally, strengths and weaknesses are identified, and specific recommendations suggested.

### *COOPERATION AS RESOURCE AND STRATEGY*

Cooperation plays a role in this study as a conceptual guide for interpreting the information collected in the field. The literature relative to this construct generally makes reference to the cooperation between governmental actors at their different levels, or between companies. In this work the defining elements of cooperation are adapted to understanding the interaction between governmental actors and civil society organizations.

The act of cooperating is justified by the scope of common objectives among organizations (Smith, Carroll, and Ashford, 1995). As modern societies pose challenges that are difficult for just one organization to resolve, an integration of activities involving a number of actors becomes an advisable strategy (Lundin, 2007). For Gulati (1999), resource needs lead to the emergence of networks or strategic partnerships defined as voluntary links of inter-organizational cooperation. According to this author, when one organization faces exogenous restrictions or situations out of its control, there is a tendency to establish links with other organizations that have the necessary resources and capabilities to overcome these restrictions.

According to Lundin (2007), cooperation between government actors occurs as a function of interdependence of resources, shared objectives, and trust. When the achievement of certain objectives depends on the exchange of resources, the organizations tend to cooperate among themselves until establishing a mutual dependence; nevertheless, if one actor does not trust the other, the objectives will not be met even though both pursue the same ones. A central issue is the possibility of developing trust when the individual actors frequently have face-to-face contact and personal preferences and interests come to be familiar between them (Meijboom, 2004).

From a perspective of dynamics and process, cooperation changes in terms of the disposition of each group or organization, as they evaluate the desirability of interacting with others (Smith, Carroll, and Ashford, 1995). Despite the mutual recognition of the advantages of cooperating, it is not easy to carry this out in practice (Meijboom, De Haan, and Verheyen, 2004; Mur-Veeman, van

Raak, and Paulus, 1999). These partnerships carry risks resulting from the uncertainty of partnering, above all when there is little to no information about the competences of the other party, bringing forward doubts about the other party's trustworthiness (Gulati, 1999). Furthermore, Lundin (2007) mentions that the organizations avoid cooperation when costs exceed benefits. The interdependence of resources involves the participating organizations' seeking to obtain advantages such as information, human resources, financing, etc., that bring about a decline in its autonomy.

In the study of public administration, cooperation is tied to what is called the "new governance." This term emerges from a context of a redrawing of national and international relations that outlines public needs and problems of greater scale and complexity. In the face of the decline of the welfare state, governments show an insufficient response capacity that results in new public management challenges. In this context, other "governmentally independent" actors enter the scene, optimizing resources through strategic partnerships and contributing to fulfill social functions (Aguilar, 2010). This idea is called "associated management" by Moreno (2010). It is expected that the state will promote a horizontal cooperation without political interests interfering, propitiate confidence between the parties, and strengthen the management capacity of the civil society organizations.

Some indicators that have been used to assess the joint work among organizations are: frequency of communication, the regularity with which persons are transferred between organizations, and the amount of help that a central organization receives from other organizations, as well as the use of various coordination methods such as inter-agency committees and work groups (Lundin, 2007). This conceptual framework is useful for understanding our study case. The provision of health services to repatriated migrants brings with it a series of negotiations, conflicts, and means of arriving at a consensus established in an implicit or explicit way among the various actors. In Tijuana, a complex context involving public health services overload and the eventual return of more compatriots with health care needs frames the experience of the cooperation between governmental actors and civil society organizations studied in this work.

### *CONTEXT OF THE STUDY*

Between 2012 and September 2015, there were a little more than a million events of repatriation from the United States to Mexico through the National Migration

Institute. Sixty-five percent of these events took place at local receiving points in Mexicali, Tijuana, Ciudad Acuña, Nuevo Laredo, and Matamoros. In particular, the receiving point El Chaparral in Tijuana recorded 33 621 repatriations in 2014. Of the total number of people repatriated during this period, 95 percent were older than 17, and 90 percent were men. In the first semester of 2015, Tijuana received 49.8 percent of the total of those repatriated through Baja California, and 14.7 percent of the total who entered through the nine receiving points distributed throughout Mexico's northern border (Segob, 2015).

Although some of those repatriated arrive in Mexico needing medical attention, the exact number of those who are ill is not known. The Secretaría de Salud (Health Ministry) does not record information about the number of repatriated migrants that it provides care for (González-Block and De la Sierra, 2011). For its part, the National Migration Institute has a register of the demand for medical care for those repatriated who voluntarily accept health services. According to available data, from January to September 2015 the PRH provided medical assistance to 3 388 people at the receiving point in Tijuana, 15.4 percent of those repatriated through that point during the same period (Segob, 2015).

The scarce literature in Mexico about this issue reports a diversity of illnesses in the population that voluntarily returns or is forced to return. The repatriated migrants who were detained by the Border Patrol shortly after crossing the border often have traumatismos and musculoskeletal problems, while those deported from the interior of the United States more often have chronic health problems (González-Block et al., 2011). The health damages that the migrants suffer are linked not only to their stay in the United States but also with the overall migration process (Salgado de Snyder et al., 2007; Ruiz et al., 2014; Nigenda et al., 2009). This overview generates the urgency for a governmental response in keeping with the migrants' needs, focused on guaranteeing them accessible and quality services in their place of origin, in transit, at their destination, and upon their return (Zimmerman, Kiss, and Hossain, 2011).

In normative terms, the right of migrants in transit and those repatriated to receive health services in national territory is stated in Article 4 of the Constitution (H. Congreso de la Unión, 2016) and in official documents such as *Programa Sectorial de Salud 2013-2018* (Sectoral Health Program 2013–2018) (Segob, 2013) and *Programa Especial de Migración 2014-2018* (Special Program for Migration 2014–2018) (Segob, 2014). To date, the implementation of the governmental health strategies directed at migrants has been effected through the Humanitarian

Repatriation Program and the Sistema de Protección Social en Salud (Social Health Protection System) through Seguro Popular (Popular Insurance).

When it comes to repatriated migrants, the universe of public health services is limited to the Health Ministry,<sup>1</sup> which provides medical care through the 2<sup>nd</sup> Health District of Baja California. The installed capacity is insufficient to care for all those without health insurance, which between 2010 and 2014 increased by 35 714, to 659 000 in 2014.<sup>2</sup> The health district has 0.29 hospital beds and 0.75 doctors<sup>3</sup> per 1 000 inhabitants without health insurance, while at the national level this indicator is 0.59 beds and 1.5 doctors per 1 000 (DGIS, 2014).

These public services constitute the governmental health provision that those repatriated find upon arrival in Tijuana. The important presence of organized civil society that provides ambulatory health services to migrants also merits mentioning. In this city, there are around a dozen legally constituted civil organizations linked to serving migrants. Most operate as non-profit shelters with assistentialist ends and depend on public resources and donations (Moreno and Niño, 2013).

### *METHODOLOGY*

Tijuana was selected as a case of study for being the place where health service provision to repatriated Mexicans by the PRH has gained the most experience compared with other border cities. An instrumental case study was undertaken<sup>4</sup> to understand the nature and functioning of a particular phenomenon (Stake, 2013). This exploration required the collection of information about its background, social context, and groups of actors. This research method allows the examination

<sup>1</sup> The Mexican health sector operates under a segmented model of providers based on the population's employment status. The population without health insurance, inserted in the informal economy or unemployed, constitutes the target population of the Health Ministry.

<sup>2</sup> This refers to the population that is not covered by Instituto Mexicano del Seguro Social (the Mexican Social Security Institute, also known by its Spanish acronym IMSS), Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (the Institute for Social Security and Services for State Workers, or ISSSTE), Petróleos Mexicanos (the state oil company also known as Pemex), the Ministry of Defense (Sedena), or the Ministry of the Navy (Semar).

<sup>3</sup> Includes doctors in contact with patient in outpatient and inpatient services.

<sup>4</sup> There are three types of case studies: intrinsic, instrumental, and collective. The first is to understand the particulars of a case; the second focuses on a conceptual or empirical problem illustrated as a "case"; and the third includes various "case studies" to analyze more general phenomena.

of the complexity of a unique case defined by the limits of time and space and shaped by a sequence of interrelated events (Gundermann, 2001).

The information was collected firsthand during May and June 2015. Semi-structured interview was employed as a data collection technique with the purpose of exploring the perceptions and experiences of the informants about health service provision for migrants. An interview guide was designed that included the following sections: 1) perception about possible changes in the demand for health services on the part of the repatriated population, 2) information systems about the sociodemographic profile of this population, 3) the offerings and characteristics of health services provided by the actors interviewed, 4) barriers to access to health services, 5) financing, and 6) inter-agency coordination.

A purposive sample of 21 actors was put together (Table 1). The informants worked in governmental initiatives at the federal, state, and local levels, as well as in civil society organizations whose functions focused on the migrant population.<sup>5</sup> The criteria of selection of the participants was to have accurate, in-depth, and trustworthy information about health care for the population repatriated through Tijuana through their activities as health service providers, institutional links, or as managers of research projects directed at the migrant population.

TABLE 1. Number of Interviewees, by Type of Actor\*

<i>Type of actor</i>	<i>Geopolitical reach</i>	<i>Number</i>
Governmental	Federal	4
	State	3
	Local	4
Mixed	Binational (Mexico-United States)	1
Civil society organizations	International	1
	Local	8
<i>Total</i>		<i>21</i>

\* Leaders of the organizations were interviewed in all cases.

Source: Authors' calculation based on fieldwork.

<sup>5</sup> The study did not seek to interview the repatriated population, because the purpose of this work was to explore the health services from the standpoint of the supply and not from the demand of those repatriated.

The identification of the informants took place through an online search and consultations with experts on migration and health. A directory of actors was built; contact was established with them through an institutional letter. In a second stage, they were invited by phone to participate in the study. Once the first interviews were done, more informants were identified through the snowball technique.

The research project was approved by the Ethics, Research, and Biosecurity Committees of the National Public Health Institute of Mexico. Verbal consent of the participants was obtained and the contact information of those responsible for the research project was provided. The interviews lasted an average of 40 minutes, were audio recorded and transcribed verbatim.

The information was systematized through previously designed codes based on the instrument of collection, and open coding was used with the goal of reducing, examining, and comparing the data, and seeking similarities or differences in people's statements. Furthermore, a selective axial coding was done to regroup categories and subcategories<sup>6</sup> (Strauss and Corbin, 2002). This analytical exercise allowed the reduction of a large number of statements to a compact set of data for the elaboration of a flowchart and to establish relationships (Saldaña, 2013). After the first systematization of the information, a technical meeting with some of those interviewed was held with the goal of presenting preliminary results and getting feedback.

### *ACTORS AND THE PROCESS OF HEALTH SERVICE PROVISION TO REPATRIATED MIGRANTS*

In Tijuana, the institutional response to the health needs of repatriated migrants begins at the receiving point El Chaparral. Governmental actors and civil society organizations work together there under the framework of the PRH. This program operated by the National Migration Institute has the purpose of carrying out an ordered and assisted repatriation through the offering of various services of legal advice, health coverage, food, and access to phone calls and the internet, among other things. The agencies and programs of the government that participate in the health component of the PRH are the Popular Insurance, the federal Health Ministry, the United States-México Border Health Commission (whose initials in

<sup>6</sup> This work did not seek to arrive at the level of conceptualization, but rather to take the concept of "cooperation" as its research guide.



Spanish are CSF),<sup>7</sup> and Grupo Beta, a National Migration Institute unit that aids migrants (Herrera, 2010).

The Popular Insurance works through a membership office. The Régimenes Estatales de Protección Social en Salud (State Regimes for Social Protection in Health, known by the Spanish initials REPSS) can provide 90-day health insurance policies to the population repatriated from the United States. The beneficiaries obtain this policy by showing their repatriation document issued by the National Migration Institute and have the option of renewing it once while they seek other documentation that certifies they are Mexicans. This Popular Insurance policy exempts the migrants from having to cover the costs for illnesses treated at the Health Ministry's facilities in any federal entity, provided that these illnesses are included in a limited catalog of treatments (Secretaría de Salud, 2014).<sup>8</sup> Up to October 2015, the Popular Insurance had 12 315 repatriated migrants as members through 90-day policies,<sup>9</sup> a number that represents half of those repatriated through the El Chaparral port of entry until then.

For its part, the Health Ministry and the CSF operate a health module offering quick tests for detection of HIV, general health care, a protocol for psychological crisis intervention, and management of referrals to secondary and tertiary levels of care. The medical personnel who serve the module are social service interns of the Universidad Autónoma de Baja California (Autonomous University of Baja California) commissioned by the local office of the Health Ministry, and psychologists and health promoters contracted using the resources of the CSF. The Border Health Commission is a management initiative focused on training and research as inputs for decision-making in terms of migration and border health.

Grupo Beta also has a paramedic team that provides help to migrants inside and outside El Chaparral. An ambulance donated in 2014 by the state government for the exclusive care of migrants is used for taking them from the border to the hospital. Finally, the Programa de Repatriación de Connacionales Enfermos Graves (Repatriation of Gravely Ill Compatriots) of the Secretaría de Relaciones

<sup>7</sup> Binational organization with independent legal status created by presidential decree in 2000.

<sup>8</sup> Known as the *Catálogo universal de servicios de salud* (Universal Catalogue of Health Services). In 2014, this catalogue included 285 treatments.

<sup>9</sup> Information provided by the Popular Health Insurance membership coordinator in Baja California.

Exteriores (Foreign Ministry) defrays the cost of air transport of those who are routed from U.S. hospitals to Mexican ones.

Furthermore, organized civil society has an important presence inside the PRH through a module of attention for repatriated migrants operated by the *Coalición Pro Defensa del Migrante* (Coalition for the Defense of Migrants). This organization created in 1996 brings together six other organizations and provides legal advice in terms of human rights to those repatriated, guarantees the provision of quality medical services, and helps transport those repatriated from El Chaparral to the shelters, among other activities.

In this study, health service provision for those repatriated through Tijuana was systematized based on their health situation. With this criterion, one group of repatriated people is those having such grave ailments that they cannot travel by themselves, for which reason they are transported by land or air from a U.S. hospital to a Mexican hospital with the assistance of Mexican consulates, the Health Ministry, and the Foreign Ministry. The receiving hospitals can be located in Tijuana or in other Mexican cities that have resources available to care for the illnesses of those repatriated. Once sent to the hospitals in Mexico, there is no institutional follow-up; this means that it is not known what kind of care or treatment those repatriated subsequently receive. A second group of repatriated people includes those who are healthy, or apparently healthy, who are transferred by land from the United States to the receiving station at El Chaparral. They have the option of going voluntarily to the health module located at the port of entry. According to a medical intern, of every 40 repatriated people, on average 25 agree to go to the medical check-up. From this health module, there are three possible destinations for repatriated people who received medical care: 1) referral to the Hospital General de Tijuana (Tijuana General Hospital) when a grave health problem is diagnosed; 2) referral to a shelter when the repatriated person is healthy; or, 3) going into Tijuana on their own if that is their preference. On the other hand, not all of those repatriated who did not agree to go to the health module are necessarily healthy; they can present possible symptoms of ailments that were not diagnosed in the United States or in Mexico and that wind up being treated at the shelters they are channeled to.

Of the three destinations mentioned, the transfer to shelters is the most common. The health service provision by these civil society organizations basically consists of preventive and ambulatory treatment in basic medical dispensaries. This care is complemented by visits to the shelters of the Red Cross and Grupo

Beta, who use their ambulances as mobile clinics on designated days depending on the demand for care. When those who are repatriated and living in the shelters need specialized care, they are channeled to the Tijuana General Hospital or to specialized rehabilitation centers. As a representative of one civil organization said, referrals to secondary care by the shelters is done in an informal manner: "... we send a brief letter to the General Hospital, where we say, 'Please take care of this migrant for us,' but there is no written partnership agreement, only a verbal one. It has functioned well this way" (Luján, interview, 2015).

On the other hand, some government agencies at the state and local level away from El Chaparral also are involved in the provision of medical services to migrants. The local Health Ministry has a network of outpatient facilities that offer free services to repatriated people who are affiliated with the Popular Insurance. Furthermore, the Centro Ambulatorio para la Prevención y Atención en SIDA e Infecciones de Transmisión Sexual (Ambulatory Center for Prevention and Care of AIDS and Sexually Transmitted Diseases, known by its Spanish acronym CAPASITS) receives repatriated people who have HIV or sexually transmitted diseases referred from Health Ministry facilities or the shelters. Also, the Sistema de Desarrollo Integral de la Familia (System for Comprehensive Family Development, known by its Spanish acronym DIF) at the state level receives unaccompanied repatriated children and adolescents, and at the local level repatriated adults; in both cases they are given ambulatory medical care. Special or exclusive initiatives to provide care for migrants and their health problems do not exist and they are cared for using the installed capacity of these services.

There are 40 Health Ministry outpatient facilities distributed throughout the city (DGIS, 2014). Nevertheless, the majority of those repatriated are referred to one health center in the central zone of Tijuana because of its geographical closeness to El Chaparral. This facility is three kilometers from the port of entry and has 12 consulting stations, X-rays, and a laboratory, among other services. In terms of its functioning, one state official said: "The Tijuana Health Center already has 55 000 people assigned to it; this means that we are charging just one center with all the care [of migrants]" (Pérez, interview, 2015). It is worth mentioning that the Popular Insurance also offers a "collective policy" directed at shelters that satisfy a series of administrative requirements.<sup>10</sup> This type of policy covers medical

<sup>10</sup> Constitutive act, the Federal Taxpayer Registry, a legal representative, and proof of residency.

services for repatriated people who in their passage through the port of entry did not accept the temporary policy. Subsequently, upon being placed in shelters that have the collective policy, they have the right to receive treatment in the health center closest to their shelter.

Tijuana General Hospital, and to a lesser extent the Red Cross, are the only options for medical care for repatriated people with complex ailments. According to a municipal official, the hospital receives repatriated patients referred by U.S. hospitals, from the health module at the port of entry, and from the shelters.<sup>11</sup> “All we have is the General Hospital or, on some occasions the Red Cross helps us, but that is it ... many hospitals are private” (López, interview, 2015). The General Hospital users are treated without taking account of their migrant status; therefore, those repatriated and the general population are subject to the same wait times. The only variant in medical treatment for those repatriated occurs when there is an institutional accompaniment on the part of Grupo Beta paramedics. In this case, the service for those repatriated is expeditious and of greater quality, because the Grupo Beta paramedics are authorized to do medical procedures inside the hospital with the goal of not overburdening the personnel contracted by the hospital. Figure 1 shows, from left to right, the described health care process.

Other actors are involved in second level services in a tangential way. The private religious hospital is an atypical case that only interacts under a verbal agreement with one of the shelters interviewed. The shelter refers only cases of extreme urgency to the private hospital when the wait time to be seen in the Tijuana General Hospital is so long that it could have fatal consequences.<sup>12</sup> On the other hand, the Mental Health Hospital of Tijuana is not considered to be very accessible for the migrant population because of the high cost for its care.

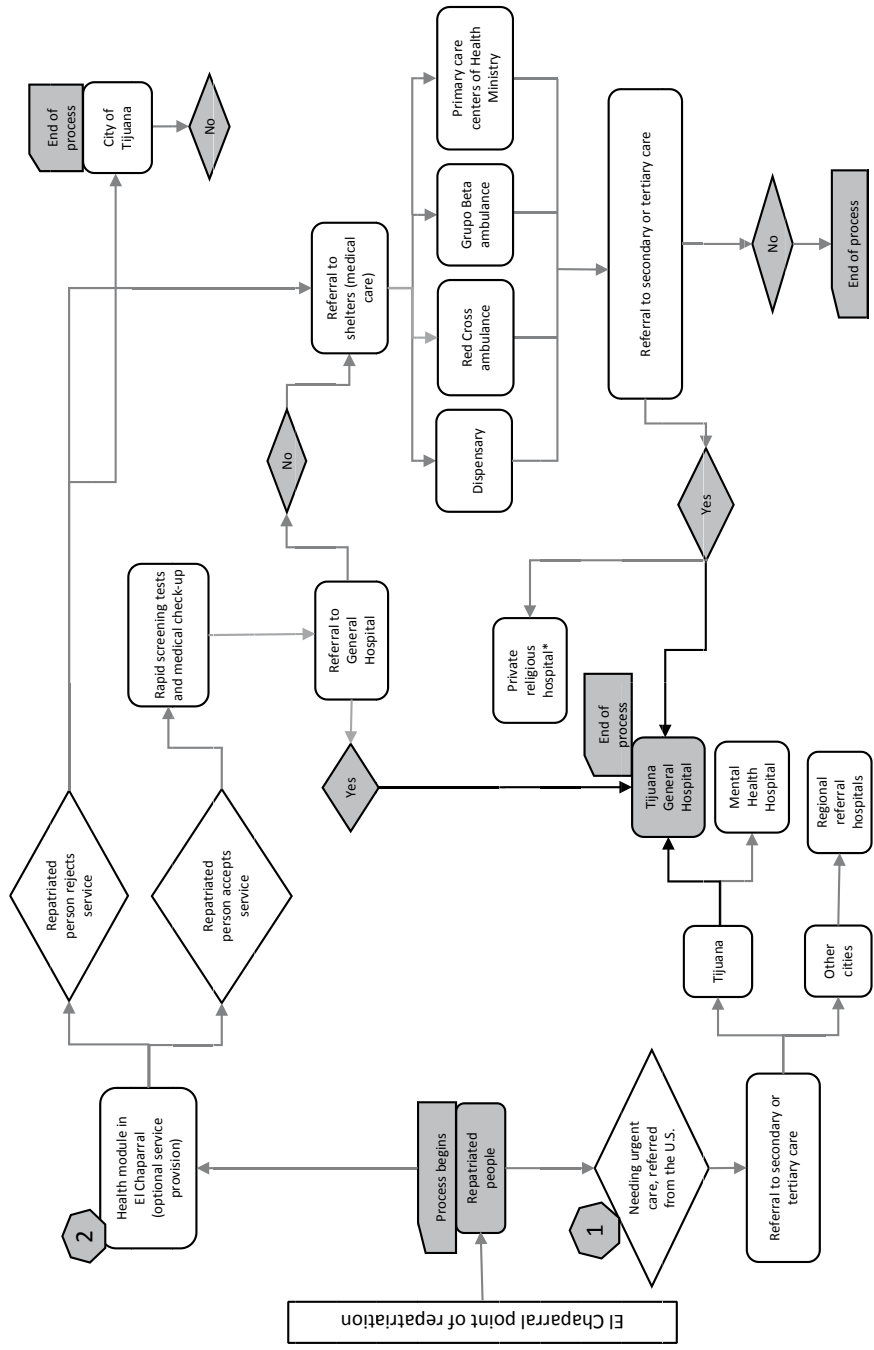
### *The Logics of a Cooperation “under Construction”*

In Tijuana, the provision of health services to the repatriated population involves the participation of governmental actors and organized civil society. The government has an impact through migration policy and the Health Ministry at the federal and local level; simultaneously, organized civil society offers ambulatory

<sup>11</sup> A process of formal counter-reference between the shelters and the Tijuana General Hospital does not exist; on occasions those repatriated return to the shelters on their own to ask for medicines they were not supplied with at the hospital.

<sup>12</sup> The private hospital assumes the cost of the service.

FIGURE 1. Process of Ambulatory and Inpatient Medical Care Provision to Migrants Repatriated through Tijuana, 2015



\* This private hospital only has an agreement with one shelter.  
Source: Authors' calculation based on 21 interviews with key informants during May and June of 2015.

health care. The shared objective of attending to the health needs of the repatriated migrants has led the actors interviewed to mutually depend on terms of exchange of material and human resources to increase their response capacity to the health problems of those repatriated. However, the incipient development of trust identified between government and organized civil society, as well as the demand overload on health infrastructure, above all in tertiary care, eventually limits the potential for the inter-agency cooperation that is underway. To organize the information, three elements of cooperation were used as a guide: common objectives, resource interdependence, and trust (Lundin, 2007).

According to Flamand and Moreno (2014), governmental entities, more than collaborating, compete among themselves to obtain resources. Moreover, in the scheme of a decentralized federal government that operates under a multilevel infrastructure, conflicts are more frequent due to the double challenge of coordinating “horizontally” between different government agencies and “vertically” among the federal, state, and local orders. In the case concerned, the conflicts in the relationships between government actors are infrequent and are linked to an inadequate communication that precisely derives from a complex structure of multilevel government. One of the main findings was inefficient spending due to a duplication of efforts. To combat this problem, some government agencies have been able to combine activities directed at migrants under the framework of the PRH. An initiative proposed by personnel attached to the Secretaría de Desarrollo Social (Social Development Ministry, known by its Spanish acronym Sedesol) promoted the coming together of institutional efforts between agencies to make migrant care more efficient through a module: “In view of the needs, you have to knock on doors, and I thought, why don't we all get together? Participating now in the module to care for migrants are the National Migration Institute, Grupo Beta, the DIF and us” (Cortés, interview, 2015). This initiative illustrates inter-agency cooperation based on similar objectives that strengthen the health service offerings for those repatriated through the coordination of efforts around common ground.

However, not all the governmental actors focused on serving migrants work in a collaborative way. The Consejo Estatal de Atención al Migrante (State Council for Migrant Support), created in 2014, undertook strategic coordination activities based on the *Ley para la protección de los derechos y apoyo a los migrantes del estado de Baja California* [Law for the Protection of the Rights and Support of Migrants of the State of Baja California (Congreso del Estado de Baja California, 2014)]. Up to the time of the interviews, the work of the state council consisted of convening

some governmental actors and civil society organizations to participate in monthly sessions; however, there were governmental actors who said they were never invited.

On the other hand, with respect to the dynamics of the sessions organized by the State Council, some representatives of shelters said they did not see fruitful results in terms of service to migrants. “The State Council needs direction. Something like 100 of us arrive for the meeting ... and all it's worth is a cup of coffee. There is no structured project ...” (Ojeda, interview, 2015). Despite not having a clear objective, this initiative has had a strong convening power that could be exploited to overhaul the functions of the participating actors and strengthen institutional cooperation.

### *Interdependence of Resources*

The relationship between government and civil society reflects an interdependence of resources founded on the shared goal of providing health services to migrants. According to one informant, the inter-agency coordination between shelters and the National Migration Institute responds to the limited infrastructure of the institute to cover the demand for public services for those repatriated.

Another element that illustrates the interdependence of resources is financing. The management capacity of the civil society organizations is strengthened through budget allocations earmarked and put out for bid by the government. To be able to benefit from this resource, civil society organizations must be registered in a catalog of civil organizations in the entity and must comply with requirements established in the *Ley de fomento a las actividades de bienestar y desarrollo social para el estado de Baja California* [Promotion of Welfare and Social Development Law for the State of Baja California (Congreso del Estado de Baja California, 2001)]. Additionally, some shelters mentioned receiving a governmental subsidy that complements other sources of funding: “the state government basically covers 50 percent of the shelter's costs, it is a subsidy we have had for seven or eight years. Persons or institutions of goodwill provide 25 percent, and the rest comes from training workshops that we give” (Jiménez, interview, 2015).

This interdependence of resources is also complemented in terms of health personnel, infrastructure, and medicines. The shelters that participated in this study have medical personnel available through a number of modalities. The shelters that receive the most repatriated migrants<sup>13</sup> had three sources for this care: 1) formal

<sup>13</sup> Casa del Migrante, Salvation Army, Casa YMCA, and Instituto Madre Asunta.

agreements with Health District No. 1 that guarantee a weekly visit of interns doing their social service through the program “Health Caravans,” 2) contracting or having agreements with general practitioners and/or psychologists, and 3) the participation of volunteer doctors.<sup>14</sup> The convergence of public and private medical care constitutes one more indicator of resource interdependence. In this regard, an official in the health district said: “Mobile Unit 8 is designated for attending to the migrant population in the mornings. It's only one for everyone, and sometimes it attends to them on a Monday, other times on a Tuesday, and other times two or three days a week. It provides consultation, it takes them medications, it does glucose testing, deals with diabetes and hypertension, provides vaccinations, and distributes pamphlets” (Ortega, interview, 2015). In terms of medications, the exchange between shelters and the governments goes in both directions. In the shelters, dispensaries are supplied by public sources (the health district) and private ones (donations by pharmacies or the general public). In turn, these civil organizations sometimes supply prescriptions to repatriated people who did not receive their medications in the Tijuana General Hospital because its stocks were depleted (Table 2).

There is also a communications network between the civil society organizations (shelters) for exchange of support in medical care for migrants. The cooperation between these organizations is closer and more solid: “it's more informal, more involving trust. They help us and we help them ... it's sharing services and resources” (Guzmán, interview, 2015). When a shelter is overflowing, it communicates with another to take in migrants. The lack of public provision of mental health services in Tijuana is a problem pending resolution in light of the high prevalence of psychiatric disorders among those repatriated.

### *Trust*

As for the subject of trust, no statements gathered showed total reciprocity between governmental actors and shelters. The representatives of the civil society organizations admitted maintaining a certain reserve with some government actors, above all during their political participation in election campaigns: “The same thing happens to us and other shelters, people making statements to the media

<sup>14</sup> There are private doctors who donate their services for free in the shelters at times of the doctors' choosing, and also doctors who receive migrants in their private practices, charging the shelter a symbolic fee, such as in the case of the Casa del Migrante.



TABLE 2. Interdependence of Resources Identified in Interviewed Shelters

<i>Shelters (civil organizations)</i>	<i>Ambulatory medical service offerings inside the shelter*</i>	<i>General practitioners</i>			<i>Origin of medicines</i>		
		<i>Interns referred by Health District No. 2 (Sesa)**</i>	<i>Private doctors (volunteers or hired by the shelters)</i>	<i>Stock of medicines in the shelter</i>	<i>Public (Health District No. 2)</i>	<i>Private (private donations or from Mexican and U.S. pharmacies)</i>	<i>Referral to secondary and tertiary care</i>
Casa del Migrante	✓	✓		✓	✓	✓	Tijuana General Hospital, Red Cross
Instituto Madre Asunta							Tijuana General Hospital, Red Cross, Private hospital
Casa YMCA	✓	✓		✓	✓	✓	Tijuana General Hospital
Salvation Army		✓			✓		Tijuana General Hospital, Red Cross
Desayunador Padre Chava (soup kitchen)	✓	✓			✓		Tijuana General Hospital, Red Cross
Casa de los Pobres (House for the Poor)	✓		✓	✓		✓	Tijuana General Hospital, Red Cross
CIRAD (Rehabilitation center)	✓		✓	NA	NA	NA	Tijuana General Hospital
Las Memorias	✓	Does not have doctors		✓	✓	✓	Tijuana General Hospital

Note: Some shelters also have ambulance support from Grupo Beta and the Red Cross.

\* Restricted hours.

\*\* Servicios Estatales de Salud (State health agencies).

Source: Authors' calculation based on 21 interviews with key actors in May and June 2015.

in our buildings. They are just a distraction to us. They always announce millions and millions of pesos for the care of migrants in the state but nobody has ever seen it” (Ojeda, interview, 2015; Román, interview, 2015). In contrast, the perception of public officials about the joint work with civil organizations was expressed as a solid and unconditional support that would be difficult to take away. “We have communication with the Casa del Migrante, the Salvation Army, and with [Instituto] Madre Asunta [which helps repatriated women and children] ... If a migrant comes here and doesn't know where to go, we talk with the Casa del Migrante so that it will give him shelter” (Calleja, interview, 2015).

On the other hand, some civil society organizations mention that the support they receive from the government generally is based on interpersonal trust that does not manage to permeate the institutional environment. The direct contact they have established with the employees of the General Hospital has facilitated access to the hospital for migrants to be treated without going through an institutional protocol; thus, the referral process flows thanks to verbal agreements at times sustained through old friendships, as one member of Grupo Beta said: “we have a number of years in the field and we know people from the General Hospital; this in one way or another facilitates the flow of treatment” (Pérez, interview, 2015).

One of the factors that hinder the development of trust between the government and civil society organizations is the rotation of personnel that occurs with changes in government. This historic lack of continuity in programs and those responsible for them in Mexico brings about a lethargy in the processes and makes the provision of services to migrants less efficient since civil society organizations must establish contact with new officials in each *sexenio* (six-year term).

On the other hand, some representatives of the civil society organizations spoke of the existence of an inter-agency network that is being consolidated. The principal characteristic of this network is that it does not originate with consensual planning in the medium or long term, but rather in the resolution of daily emerging needs. A representative of a shelter said this network “... is intuitive and hidden; it moves from below, it is not institutional, and exists because experience allows it” (Jiménez, interview, 2015). The formalization of this network does not appear to be a pressing issue for its members upon seeing that the informal relationships at the interpersonal level traditionally established between them have been successful for the provision of health services to migrants; moreover, some considered that formalizing the inter-agency relationship would decrease the fluidity of care. Civil society organizations did not have unanimity when it came to

how they viewed the participation of the government in building a network of health services for migrants. While some rejected cooperating with governmental actors because this involved implicit political interests, other found working with the government to be indispensable in making the inter-agency work of providing health care to migrants more efficient.

### *DISCUSSION AND CONCLUSIONS*

In Tijuana, inter-agency cooperation between the government and civil society organizations in terms of health care for those repatriated occurs in an informal manner and without established protocols for the referral and counter-referral of migrants from the shelters to governmental health services. The activities of the identified actors are synchronized on the basis of a common objective and an interdependence of resources that has brought them to work together to resolve the immediate health needs of the migrant population; nevertheless, the relationships between governmental actors and civil society do not reflect mutual confidence in the institutional arena.

The relationships of trust that were identified were of the interpersonal type. The accumulated interaction of years of work between actors attached to the institutions and organizations has generated a close communication, permeated by a familiarity that facilitates cooperation. A limit in these relationships of trust is that they depend on the time that the persons stay with their organizations.

The governmental health service provision to repatriated migrants who are ill in the United States begin with the Mexican consulates. This study found the need to improve the work of the consulates in terms of visits to detention centers in the United States to identify migrants with health conditions and get them proper treatment before they are repatriated. Once those repatriated are in Mexican territory, the Humanitarian Repatriation Program includes urgent medical care, but it does not offer a comprehensive health plan. Those repatriated have a right to receive health services in whatever level, involving a system of referral and counter-referral. Nevertheless, despite the existence of inter-agency cooperation, the government commitment to provide them comprehensive care is complicated because of the limited capacity to provide secondary and tertiary care. While the burden of the health services the repatriated migrants may be low (González-Block and De la Sierra-Vega, 2011), this is inserted into a historical and structural problem of the Mexican health system; that is, a structural and organizational

service capacity that has problems of access despite the broadening of coverage through the Popular Insurance.

Furthermore, this study concludes that the strategic partnerships established between the actors interviewed do not totally guarantee the right to health care of those repatriated. With the majority of medical services' being of an ambulatory nature, the support capacity focuses principally on the resolution of urgent ailments and/or conditions that are not serious. On the other hand, migrants with chronic degenerative diseases such as diabetes, hypertension, and kidney failure are managed using the limited infrastructure available in Tijuana to later be transferred to other federal entities, but in the process of referral medical follow-up is lost. The most evident lack of care is seen among the group of those repatriated with mental illnesses such as depression, anxiety, schizophrenia, and bipolar disorder, often associated with the use of drugs. This means that inter-agency cooperation based on an interdependence of resources and interpersonal trust is not enough to meet the shared objective. These elements of cooperation need a broader health infrastructure as a base.

In the framework of this associated management model (Moreno, 2010) coordinated by the Humanitarian Repatriation Program, it is suggested that the creation of a coordinating agency at the local level be put forward and that it be charged with designing a comprehensive program to support migrants and lead the various initiatives and sectors involved to guarantee the repatriated population's right to health care.

For future research, it is recommended that the size of the repatriated population that needs medical care be estimated. This information void means that there is a disadvantage when it comes to managing resources to operate a health program specifically for those repatriated, for which reason it is important to carry out a study to quantify their health needs, principally in Mexico's northern cities. The health service provision model for those repatriated that was explored here constitutes an experience with successes and areas of opportunity that serves as a reference for similar programs to be implemented in the future in other border cities that have a demand for public services from this vulnerable population.

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