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Promoting Health from Outside the State: La Comunidad, Migrants, and Hometown Associations

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Abstract

Migrants and organizational collectives, such as hometown associations (HTAs), have sent remittances to their countries of origin in an attempt to alleviate unmet health care needs. Additionally, migrants will use collective funds to rehabilitating roads; improving sewage systems and water quality; constructing recreational facilities; and refurbishing community buildings. All of these projects contribute to public health. The question explored in this paper is how remittances from abroad potentially contributes to the health of hometown communities. This focus on health and related issues allows for exploring HTA cross-border work as particularly informative in understanding state/society relations. In effect, we bring light to how a migrant transnational social movement can attempt to address health needs in its hometown. The Comparative Immigrant Organization Project (CIOP) is used to answer this question. For this paper, the level of analysis for the CIOP is organizational.

Keywords: *Hometown associations; public health; development; migrants; networks.*

Introduction

Scholars have asserted that the significance of transnational flows of money, resources, and people lies in addressing individual and communal needs. Transnational networks and groups are part of a flow of remittances and social support that can develop into avenues for attempting to meet health care needs. Migrants and organizational collectives, such as hometown associations (HTAs), have sent remittances in an attempt to alleviate unmet health care needs. The explicit purpose of HTAs is to serve migrant communities of origin – specifically by providing a way for migrants in the U.S. to support socio-economic projects to be implemented in their hometowns. These flows of support or collective forms of aid are well-documented in the literature and play a significant part in the lives of communities with outflows of migration (Flores-Yeffal, 2013).

In addressing social problems, HTAs and other organizations like them operate in spaces of state and nongovernmental organization (NGO) failure (Shandra et al. 2010). This is precisely where the literature on HTAs can supplement our understanding of how unique networks operate in these subsystems to create social change. By exploring the role of HTAs in Latin American countries, we can better understand the significance of their attempts to meet health care needs of

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their sending communities and speak to the growing literature on globalization and international public health and health policy (Homedes and Ugalde, 2003). To this end, we ask: Are health care needs in the country of origin a *principal activity* in HTA efforts? Flores-Yeffal (2013: 136) and others (Lamba-Nieves, 2018; Bada, 2016; Strunk, 2014) have written about the trust involved in transnational collectives. It is a shared connection that allows reinforced social cohesion and relationships of trust resulting in individual and collective remittances (Flores-Yeffal, 2013).

This focus on public health issues makes the examination of HTA cross-border work particularly informative in our understanding of state/society relations. In effect, we bring light to how a transnational social movement can attempt to address health needs in its hometown. The CIOP (Comparative Immigrant Organization Project) provides a glimpse into the activities of migrant organizations, particularly those composed of migrants from Mexico, Colombia, and the Dominican Republic, in attempting to meet unmet health needs in their communities of origin in Latin America. Specifically, we examine whether the migrant organizations' principal activities are health related. The outline of this paper is as follows: First, we briefly discuss health reform and then HTA work in Latin America. The remaining sections include a theoretical discussion of HTA work and descriptions of our data, methods, and results.

Latin American Health Reform

Scholars have described the significance of transnational flows of money, resources, and people play a role in meeting health and health-related needs of migrants. These transnational networks and groups are part of a flow of remittances and social support that can develop into avenues for healthcare (Wassink, 2016; Rivera-Hernandez and Galarraga, 2015; Portes, Fernández-Kelly, and Light 2012; González-Block and Sierra-de la Verga, 2011; Frank et al. 2009). For example, Mexican immigrants can travel back to their home country and can access the Mexico's healthcare system; and there are relationships between U.S.-Mexican institutions to encourage this type of care (Portes, Fernández-Kelly, and Light 2012). Programs such as the *Vete Sano, Regresa Sano* (Go Healthy, Return Healthy) program is among a number of initiatives that have worked to respond to migrant health (García Zamora et al. 2015).

These processes above should be thought of in the context of the health reforms and policies implemented broadly in Latin America. Scholarship has explored the transformative steps Latin American countries has implemented in the progression towards universal health care but are not without its challenges (Telesur, 2019; Frenk and Gómez-Dantés, 2018; Prada and Chaves. 2018; Serván-Mori and Wirtz, 2018). A long line of previous debates over the successes and inadequacies found in the Mexican health care system are well understood (Castro, 2005; Frenk et al., 2006; Homedes and Ugalde, 2009; Vance, 2012).

Mexican economic reforms were accompanied by reductions in social expenditures beginning with the negotiation and implementation of the North American Free Trade Agreement (or NAFTA) of 1994 and changes in the Mexican health system more generally. The NAFTA plan included discussion of how health services would be traded, which was debated in the U.S. and Mexico (Castro, 2005). In Mexico, health services coverage provides for 50% of the Mexican population; however, this coverage is limited to the mainly private Institute of Mexican Social Security (IMSS) workers and the public Institute for Social Security and Services for State Workers (ISSSTE). Castro (2005) writes that neither the SS (Secretaría de Salud) nor private medicine is able to meet the needs of the entire Mexican population, which leaves 10 million people without care. The SS is charged with basic care for the rural and poorest population in Mexico. Also at issue is the decrease in social expenditure in urban and rural areas, leaving some populations either without basic services or with

poorly administered services (Shefner, 2012). It is argued that these reductions are motivated by a neoliberal approach, which views social welfare needs, such as health care, as the responsibility of families (Castro, 2005; Laurell, 2001). Reforms in the health care system, as well as wage and institutional upkeep reductions, have led to degraded and poorly performing health services institutions (Laurell, 2001).

The changes to health services programs are important, given that this overburdened system provides what has been described as poor and insufficient coverage to marginalized populations, which include the poor and rural populations (Castro, 2005). More recent writing points to the continued inequalities in Mexico's Seguro Popular (or People's Health Insurance), which was a reform measure put in place after the 2000 elections (Homedes and Ugalde, 2009). This 2003 reform sought to improve access and service options for the poor. Seguro Popular is a "universal health insurance program intended to insure tens of millions of informally employed Mexicans without access to Mexico's employment-based social security program" (Wassink, 2016: 848). One result was, as Wassink (2016) states, that for non-migrants, the proportion of uninsured decreased from 56% to 35% between 2000 and 2010 (Wassink, 2016: 849). Among Seguro Popular's aims was reducing out-of-pocket expenses by providing a "a free at-point-of service, defined package of health benefits to individuals who voluntarily affiliated through a means tested prepayment plan" (Gonzalez, 2011: 2).

Homedes and Ugalde (2009) argue that the inequity can be characterized by fewer subsidies for people in poorer states for the purpose of enrollment in the program. The Mexican government has aimed to remediate this problem, specifically in rural communities, by improving children's health and education with programs such as OPORTUNIDADES. To receive benefits (i.e., money) from the program, parents—specifically mothers—must commit to taking their children regularly for doctor checkups and vaccinations. Additionally, they are mandated to attend family planning, family nutrition, and health education classes for several years (Mason and Beard, 2008). Overall, OPORTUNIDADES has not solved poverty or other issues. From PROGRESA's[1] establishment until 2006, only 20,000—0.4% of the beneficiaries— graduated from the program (Monero-Brid et al., 2009). This finding means that only 0.4% of 5 million ceased living in poverty. However, there was reduction of poverty by 20% within the poverty categories (Behrman and Skoufias, 2006), and with poverty reduction there were improvements in children's health. The neoliberal policies and failure of state programs to alleviate the dire situation of the Mexican populace have pushed people to migrate within and outside of Mexico to address their needs and difficulties. Migrants, nongovernment groups, and other social institutions are attempting to fill this void.

Apart from Mexico, countries such as the Dominican Republic and Colombia have gone through important transformations as well (Homedes and Ugalde, 2005; Glassman, Reich, Laserson, and Rojas 1999) The Dominican Republic has experienced a series of crises in its health care institutions since the 1990s. Institutional bodies, such as the State Secretariat for Public Health (SESPAS) and the Social Security Institute (IDSS), have faced several challenges in running their programs (Glassman, Reich, Laserson, and Rojas, 1999). Glassman et al. (1999) state that 60% of the Dominican Republic population lives below the poverty line, and government subsidies only cover 35% of this group. It is also noted that the IDSS health care network covers only 6% of the population. The rest of the population is able to afford private health insurance. Rathe (2010:8) states that "poor households have a greater propensity to experience catastrophic health expenditures, which can impoverish families or put at risk their most essential needs."

[1] Anti-poverty program established in 1997. The name was then changed to OPPORTUNIDADES.

In the case of Colombia, the first health reform law was enacted in 1990. Colombia has followed the 1993 World Bank prescriptions for privatization of health care management. This country has been one of the models for health care reform in the Americas, as it has provided universal access to several mandated services. However, most of the public costs have benefited the wealthy (Homedes and Ugalde, 2005). Although social security has expanded, researchers have found that healthcare coverage has not increased and that significant co-payments are barring households from participating (Homedes and Ugalde, 2005).

The literature on human rights and migration networks can provide useful insights for this paper. Keck and Sikkink's model allows us to reflect on the process whereby external international groups come to participate in and encourage human rights efforts in other countries. One notable part of this process, as the authors of the "boomerang model" describe, is the way in which the aims of domestic human rights organizations and their calls for change are blocked by the target state. The model describes how domestic grievance groups utilize external outlets that allow for circumventing their original target, which involves participating in what the scholars define as a transnational advocacy network. It is through network ties between the aggrieved groups that domestic and international organizations can influence the target state or government (Keck and Sikkink, 1998:13). The authors' boomerang effect' argument could be used to understand HTAs as part of a network process where international connections, such as migrants who now reside in the U.S., operate in supporting actions to challenge the problems facing the communities they left behind. In this study, HTAs identify problems in their home country and *initiate* a process that circumvents domestic roadblocks, in some cases working with governments to do so, in order to help their community members. This leverage played a role in the creation of the 3 X 1 Program for Migrants, which is an investment initiative that involves a matching grant in which the local, state, and federal governments contribute to and participate in infrastructure and development projects.

Scholars have reported on the health objectives of the many projects of HTA work back home (Somerville, Durana, and Terrazas 2008) and the contributions that these projects can make to public health and healthcare (Simpser, 2016). For example, the 3X1 program involves a 25% contribution from each level of government toward the total project costs (Duquette-Rury, 2014: 116; Aparicio and Meseguer, 2012). Duquette-Rury (2014) states that with the "3 × 1 Program, migrant HTAs and Mexican government officials are financing, selecting, and implementing a wide array of projects including water and drainage systems, roads, electricity, public spaces, and sidewalks in a transnational context." The author goes on to state that "the core objective of the 3 × 1 Program for Migrants is the development of social infrastructure and productive projects in high migration and poor Mexican localities" (Duquette-Rury, 2014: 19). Through this program, it has been argued, costs of infrastructure projects have been reduced, and the leverage allowed the Program for Migrants to transform governance practices at the local level (Bada, 2016).

The article focuses on the migration literature that emphasizes the value of transnational networks and social remittances (Flores-Yeffal, 2013; Muñoz and Collazo, 2013; Levitt and Lamba-Nieves, 2011; Hernandez and Coutin, 2006). Levitt and Lamba-Nieves (2011) argue that the transfer of remittances back and forth between two countries contributes to different forms of capacity building. Flores-Yeffal (2013: 136) writes that "social relationships of support, trust, and sustenance and function simultaneously between the place of origin and those at the destination." There are several elements included in the explanation of the rise and sustenance of these networks, such as preexisting clique-like networks, transnational networks, and collective remittances. The preexisting network matches the experience of many rural origin-based HTAs and is consistent with the scholarship noting the relationship between collective remittances and high-migration states

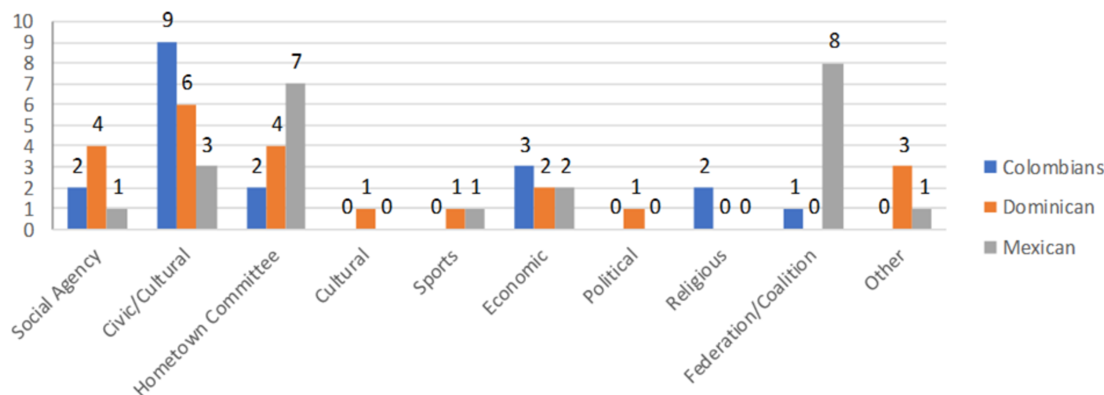
(Duquette-Rury, 2014; Aparicio and Meseguer, 2011). Prior relationships of trust make it possible for MTNs to emerge (Flores-Yeffal, 2013). The transnational ties between migrants and their hometown communities allow for communication, information, and social capital to be exchanged. The communities left behind are able to access collective remittances, and these funds are used toward improving infrastructure and reinforcing cultural practices (Flores-Yeffal, 2013).

Organizations and Health Projects

We examined the likelihood that a Latin American migrant organization's principal activity abroad was health-related. Not all migrant organizations in these data were HTAs; however, all were transnational migrant organizations. In this section, we describe the source of our data and our measures, methodology, and results.

This study used data from the CIOP.[2] The CIOP collected data on Mexican, Dominican, and Colombian domestic and transnational organizations in the U.S. The type of migrant organization varied from social agency to federal coalition (see appendix figure 1 for type of organization). The CIOP provided data from leaders of immigrant organizations to understand their organizations' activities in civic life and politics, in both the U.S. and the country of origin. The CIOP collected the data through three interrelated methods. Two phases, Phase I and Phase II, were involved in the data collection; however, we only used data from Phase II. Phase I consisted of 89 organizational leaders being interviewed from 32 Colombian, 31 Dominican, and 26 Mexican organizations. Due to missing data, we only used Phase II data, specifically the face-to-face interviews.[3] Phase II involved face-to-face interviews with organizational leaders of the most established organizations and other mid-size and smaller organizations (N=68). Of these 68 organizations, 20 were Colombian, 22 were Dominican, and 26 were Mexican. However, due to missing data on organizational incomes, four organizations were dropped from the analysis (N=64).

Figure 1. Type of organization



The Mexican, Dominican, and Colombian organizations' principal activities abroad varied from political to health-related activities. As noted at the outset, the purpose of this paper is to focus on organizational activities related to health activities.

[2] For a description of the CIOP's method and background history, see https://cmd.princeton.edu/publications/data-archives/ciop.

[3] In Phase I, the dependent variable "organizational leader's ranking of importance of health projects as the main act of the organization" was missing 82% (73 of 82) of the responses from the organizations.

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Table 1. Factors Used to Predict the Odds of Principle Activity Abroad is Health by Organizations

Variables	Description	Responses
Dependent Variables		
Principal activity abroad is health	Principal activity abroad is health	1=yes;0=no
Independent Variables		
Nationality of organization	Nationality of members in organization	
Mexican (reference)		1=yes;0=no
Colombian		1=yes;0=no
Dominican		1=yes;0=no
Age of organization (in years)	Organization's age	Continuous
Age of organization squared	Organization's age squared	Continuous
Legal Status of Organization	Legal Status of Organization	
Legally registered as a non-profit & has 501 C-3		1=yes;0=no
Organizational Decision Making	The organizational decision-making	1=yes;0=no
The total membership decides		
Organization's income (ln)	Approximate annual income (ln)	Continuous
Organizational focus is abroad	Organizational focus is abroad	1=yes;0=no
Organizational focus abroad is local	Organizational focus abroad is local	1=yes;0=no
Organizational links abroad	Organizational links abroad "with members of Municipal council, state senate, and national legislature	1=yes;0=no
N= 64		

Table 2. Descriptive Statistics of Factors Used to Predict the Odds of Principle Activity Abroad is Health by Organizations

Variables	Mean	Standard Deviation
Principle activity abroad is health	0.296	0.460
Nationality of organization		
Mexican (reference)	0.359	0.484
Colombian	0.296	0.460
Dominican	0.344	0.478
Age of organization (in years)	13.656	13.156
Age of organization (squared)	356.656	849.480
Legal status of organization		
Legally registered as non-profit & has 501 C-3	0.516	0.503
Organizational decision making		
The total membership decides	0.172	0.380
Organization's income (ln)	9.916	2.061
Organizational focus is abroad	0.516	0.503
Organizational focus abroad is local	0.203	0.405
Organizational links abroad	0.609	0.491
Observations	64	

Dependent Variable: Principal Activity Abroad Relates to Health

We investigated the likelihood that an immigrant organization's principal activity abroad was health related while controlling for other variables. The dichotomous outcome was y, with y=1 if the principal activity abroad was health related and y=0 if the principal activity abroad was not health related using the logit model. Thirty percent of the organizations' principal activities abroad were health related. Only 8%, 11%, and 11% of Colombian, Dominican, and Mexican organizations, respectively, had as their principal concern the issue of health.

Control Variables

Other indicators related to the organizations' principal activities abroad being health related were included as control variables, such as the "nationality of organization," "age of organization," "age of organization squared," "legal status of organization," "organizational decision making," "organization's income," "organizational focus is abroad," "organizational focus abroad is local," and "organizational links abroad". The nationalities of the organizations were Mexican (reference), Colombian, and Dominican. For each nationality, the organization was assigned a value of "1" if the organization corresponded to that nationality and "0" if not. The organizations were mostly Mexican (36%), followed by Dominican (34%) and Colombian (30%). It was expected that the older an organization was, the more established it would be. This is significant as established organizations are more equipped to address infrastructure issues. The average age of an organization was 14 years. The organizations' legal status varied from informal to legally registered with the consulate or as a non-profit organization. The more formalized an organization is, the more issues it can address. For this study, an organization was assigned a value of "1" if it was legally registered as a non-profit organization and had 501(c)(3) status and "0" if not. Fifty-one percent of the organizations were legally registered as a non-profit organization and had 501(c)(3) status. Additionally, each organization's decision-making process varied, with the leader making all the decisions in some and the total membership deciding in others. The more autonomy an organization has, the more likely it is to address dire social issues. For organizational decision making, an organization was assigned a value of "1" if the total membership made decisions and "0" if not. Only in 17% of the organizations were decisions made by the members. The average income of an organization was $294,378. The natural logarithm of income was taken to meet regression assumptions.

Because we were investigating the likelihood of an organization's principal activity abroad being health related, involvement and connections abroad were significant. An organization that had the "organizational focus is abroad" designation was assigned a value of "1" if it had activities abroad and "0" if not. Fifty-one percent of the organizations' focus was in some form abroad. The level of organizational focus in a foreign country varied; as a result, a dichotomous variable focusing on the local level was created. An organization was assigned a value of "1" if the level of organizational focus abroad was local and "0" if not. Finally, the organization was assigned a value of "1" if it had organizational links abroad with members of a municipal council, state senate, and national legislature and "0" if it did not. Sixty-one percent of the organizations had links abroad.

Logistic Regression

Using these data, we performed a binary regression model analysis to discern the importance of health in the range of activities carried out by the immigrant organizations. The logit coefficients were transformed to odds ratio, a nonlinear transformation using Long's and Freese's (2006) "*listcoef*" STATA command. For the interpretation of the results, the factor change (odds ratio) was

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converted to percentages in the text with the "*listcoef, percent*" STATA command (100*{exp(βκ*δ)-1}).

Table 3. The Odds of Principle Activity Abroad is Health by Organizations

Variables	Odds Ratio	Standard Error
Nationality of organization		
Mexican (reference)	-	-
Colombian	0.225	0.283
Dominican	0.519	0.651
Age of organization (in years)	1.079	0.089
Age of organization squared	1.000	0.002
Legal status of organization		
Legally registered as non-profit & has 501 C-3	16.870*	21.090
Organizational decision making		
The total membership decides	12.390*	13.935
Organization's income (ln)	0.831	0.178
Organizational focus is abroad	7.471*	7.306
Organizational focus abroad is local	30.324**	35.817
Organizational links abroad	0.312	0.315
Constant	0.055	0.150
Likelihood ratio chi-squared	29.79***	
Pseudo R-squared	.38	
Observations	64	

The estimated models clearly show that immigrant organizations are more likely to be principally involved in health projects if their organizational focus is abroad versus not abroad. The odds of organizations with an organizational focus abroad having their principal activities abroad to be health related are 647% greater than for organizations whose organizational focus is not abroad, holding all the other variables constant (p=0.040). The odds of organizations whose organizational focus abroad is local for their principal activity abroad is health related are 2932% greater than for organizations whose organizational focus abroad is not local, holding all other the variables constant (p=0.004). Organizations in which the total membership make decisions are more likely (1139%) to be principally involved in health projects in their country of origin than those in which decisions are not made by the total membership (p=0.025). Non-profit organizations are more likely to be principally involved in health projects abroad than otherwise. This can coincide with the idea that most nonprofit organizations focus on providing one type of service, including health services.

Latin American migrant organizations become more active in health projects if the members' community is being affected specifically, as opposed to the issue occurring the regional or national level. This coincides with the idea that immigrant organizations first aim to address their own communities' issues before expanding their efforts to the regional and national levels.

Conclusions

The paper points to the constellation of care that can be found within transnational networks, groups, and individuals, which are created by the flow of remittances and social support dedicated

to health care. Our paper adds to the research that explores the relationships between transnational networks and health care needs in communities of migrant origin. Migrants will attempt to meet the needs of network members and HTAs. The CIOP data can provide a clue as to the extent of the action taken toward meeting health needs, but falls short in providing information on the success of the organizations' health projects. Future transnational research could include ethnographic and survey work exploring how aid geared toward hometowns has addressed health needs specifically. Our statistical analysis suggests that there is no reason to suspect that migrants' organizations, such as HTAs, do not regularly address the health needs of their communities of origin. This is more likely when the needs are local to the individual sending communities, as well as when the organizational culture operates democratically. We also found that as a population, migrant connections with family and friends leads to a higher likelihood that the migrants will come to the aid of these individuals.

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