Caring for the Border Communities

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Few would argue that the behavioral regimen required for diabetes management is for many a drastic and challenging change in lifestyle. As we have seen in this book, the demands upon diet, physical activity, medication regimen, and clinical attendance require that patients obtain and practice multiple skills. Individual self-management is the focus for controlling diabetes complications, however, the larger environmental context will either support or hinder the ability of people with diabetes to adopt and maintain self-management behaviors (Jack et al., 1999). This chapter will describe the specific challenges to those living with diabetes in border communities and will recommend some core elements of diabetes outreach and education programs that have proven successful in this environment. In addition, the chapter will explore strategies for addressing broader environmental influences on diabetes prevention and self-management.

U.S.–MEXICO BORDER ENVIRONMENT

The U.S.–Mexico border environment is shaped by five overlying factors, which in turn serve to complicate a person’s ability to follow diabetes self-management recommendations.

1) Poverty. Approximately 30% of the population on the U.S. side of the border live in poverty. Of the 25 U.S. counties on the border, 3 are among the 10 poorest in the nation and 21 are designated by the Federal Government as economically distressed (HRSA, 2000).

2) Growth. At the same time, the border is experiencing rapid population growth compared to other parts of the country. According to the U.S. Census, 2000, 2 of the 10 fastest growing cities, Yuma, AZ and McAllen-Edinburgh-Mission, TX, are located on the U.S. side of the border, and border communities will double in size over the next 30 years (U.S. Census, 2000).

3) Young population. The age distribution on the border is contributing to the rapid population growth. Approximately 25% of the border population is under 15 years of age (PAHO, 2000).

4) Shared infrastructure. The U.S.–Mexico border is a line drawn on the sand; however, communities on both sides of the line share the same water, the same air, and many of the same services. U.S. and Mexican citizens alike cross the line to visit relatives, shop, access health care, and purchase medication.

5) Militarization. In spite of a bicultural and binational community, U.S.–Mexico border
residents are living in an increasingly militarized environment. In 2002, there were 9,500 border patrol agents working in the region (Cañizo, 2004), nine times as many as were allocated to the U.S.–Canadian border, which is twice as long. In addition to ground patrol, efforts to control illegal immigration include electronic sensors, night vision scopes, aircraft, and most visibly, the construction of a steel wall. The environment of low-intensity conflict increases the psychological stress of people living within the community.

Clearly, people with diabetes on the U.S.–Mexico border are living in unique surroundings. The rapidly growing population coupled with extreme levels of poverty exacerbate the inadequate infrastructure, and ensuing environmental concerns. While the border environment offers the unique experience of shared culture flowing both north and south, the growing presence of uniformed and armed patrol leads to escalating levels of intimidation and fear, which impacts one’s ability to access medical and other services. Although the population is relatively young, the morbidity and mortality related to diabetes is inordinately high. A person with diabetes must overcome numerous challenges in order to access, interpret, and apply information regarding how to control the disease.

This chapter focuses on the U.S.–Mexico border because of the enormous impact of diabetes in border communities. The U.S.–Canada border has a different scenario. Residents on both sides of this border share comparable language and culture, socioeconomic status, population growth rate and age distribution, as well as infrastructure. A stark difference between the two borders is that Canada is considerably less militarized. Because of these characteristics, the U.S.–Canada border seems physically and psychologically invisible. One interesting similarity is the increasing trend of U.S. residents crossing both borders to obtain more affordable prescription drugs.

**DIABETES ON THE U.S.–MEXICO BORDER**

The impact of diabetes on the U.S.–Mexico border is devastating. Diabetes was the fourth leading cause of death among Mexican communities on the border between 1995 and 1997 (Anonymous, PAHO, 2000), and the diabetes mortality rate in the border region is nearly 50% higher than in the rest of the country (ADA, 1996). Everyone that you speak to in a border community will have a family member who has or who has died from diabetes. While the population is young, the occurrence of type 2 diabetes among Mexican American children is being diagnosed at an increasingly younger age (ADA, 2000).

The epidemic proportion of diabetes is related to the border characteristics outlined above because these contribute to and aggravate an environment in which it is difficult to prevent or control diabetes. The most glaring issue is that the region is highly medically underserved. If the U.S.–Mexico border region were a state it would rank last in access to health care. More than 30% of the Hispanic population is uninsured (HRSA, 1999), a rate twice as high in the rest of the country. Lack of insurance, the seasonal nature of employment for farmworkers, and fear and discrimination related to immigration make it difficult for Mexicans living in border areas to establish a regular source of care (Ruiz-Beltran and Kamau, 2001). The fact that residents frequently cross over to Mexico to access medical services makes it difficult for physicians to provide consistent diabetes treatment. Studies document that up to 40% of residents in border communities in the United States go to Mexico to utilize physician health care services (Landeck and Garza, 2000; Marcias and Morales, 2001).

A second issue is that the border environment creates specific challenges to diabetes self-management. Border residents who are not eligible for Medicaid programs can rarely