

ROUTLEDGE FOCUS

# IMMIGRATION AND STRATEGIC PUBLIC HEALTH COMMUNICATION

Lessons from the Transnational Seguro  
Popular Project

Robert Courtney Smith,  
Don J. Waisanen, and Guillermo  
Yrizar Barbosa

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# Immigration and Strategic Public Health Communication

This book engages a key question facing governments and similar institutions in countries of immigration or emigration: how should these governments and institutions communicate with immigrants so that they will listen to and act on their messages?

Drawing on original research with Mexican emigrants in New York and the Mexican government's Seguro Popular health care program, the authors examine the ways in which governments integrate migrants into diasporic political, medical, educational, and other systems, and how migrant-sending countries communicate with their emigrants abroad. In analyzing how these efforts fail or succeed, this book presents strategies and policy recommendations that many governments and institutions can use to engage their citizens or clients ethically and effectively.

Offering a valuable approach to the study of race, migration, and public policy, this book will be of key importance to researchers and graduate students in public health, sociology, marketing and business, political science, Latinx studies, and international communication.

**Robert Courtney Smith** is a Professor in the Marxe School of Public and International Affairs at Baruch College, and the Sociology Department of The Graduate Center, City University of New York (CUNY). He wrote *Mexican New York: Transnational Worlds of New Immigrants* (2006), which won the 2008 Distinguished Book Award from the American Sociological Association and five other prizes. He was a Guggenheim Fellow and has been funded by the National Science Foundation, W.T. Grant foundation, Russell Sage Foundation, Social Science Research Council, and others. He serves as Board Chair of Masa ([masany.org](http://masany.org)).

**Don J. Waisanen** is an Associate Professor in the Marxe School of Public and International Affairs at Baruch College, CUNY, where he teaches courses and workshops in public communication—including executive speech training, communication strategy, and seminars on leadership, storytelling, and improvisation. All his research projects seek to understand how communication works to promote or hinder the force of citizens' voices, including his recent book, *Political Conversion: Personal Transformation as Strategic Public Communication*. He is the founder of Communication Upward (commupward.com), an adjunct lecturer at Columbia University and New York University, and received a PhD in Communication from the University of Southern California's Annenberg School.

**Guillermo Yrizar Barbosa** is a PhD candidate in sociology at The Graduate Center, and data manager at Baruch College, CUNY. He has been (2018–2019) a research associate and coordinator for the Legislation and Migration Policy Observatory at El Colegio de la Frontera Norte in Tijuana, and a Visiting Research Fellow (2017–2018) at the Center for US-Mexico Studies, University of California, San Diego, School of Global Policy and Strategy. He was a fellow at the CUNY Institute for Demographic Research (2014–2017).



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Lessons from the Transnational Seguro Popular Project

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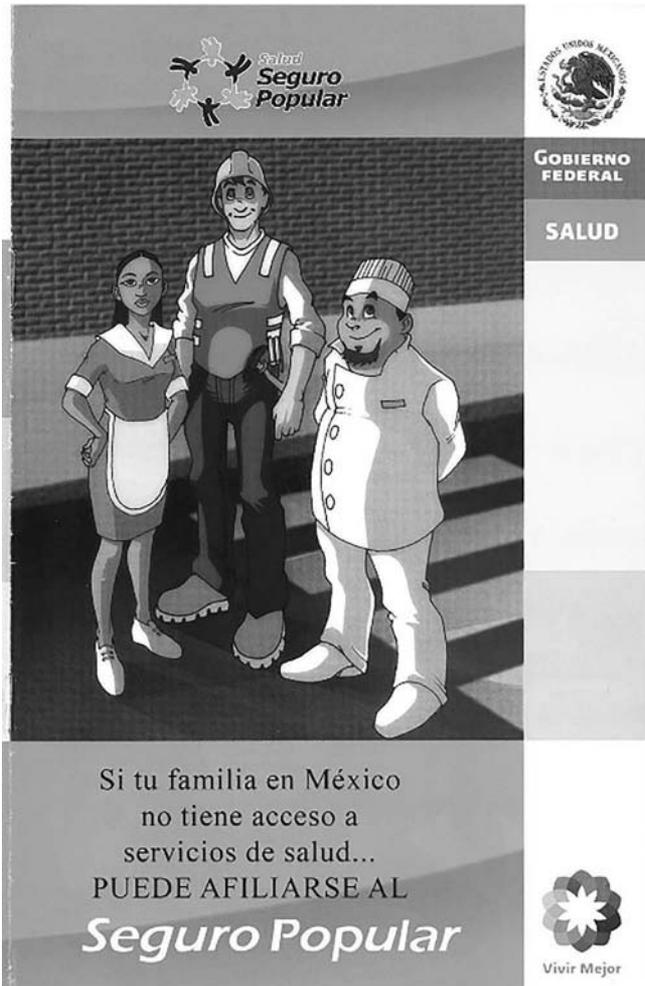
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# 1 Seguro Popular, Diasporic Bureaucracies, and Social Marketing

This book started with curious, counterintuitive questions. Officials from the Seguro Popular (SP) government health care office visited Robert Smith (Principal Investigator on this project) at the City University of New York and asked if Mexican immigrants in NY would use this public health policy in Mexico. Do migrants even know about the program? Do New York–residing migrants’ families in Mexico use SP now? And could we approach Mexican immigrants in NY to promote use of this program by their families in Mexico? These officials suspected that migrant families weren’t using SP as much as they could and that returning migrants weren’t using it at all.

At first glance, these questions make little sense. Why market a health policy or program based in Mexico to migrants in the US? Why not just market directly to their families in Mexico? Yet the questions make perfect sense in the context of decades of Mexican migration to the US and New York. Some evidence indicates that migrants returning to Mexico have worse health and greater health care needs (Arenas et al., 2015). Moreover, these questions align with the Mexican government’s increasing efforts to develop what Smith (2008) calls *diasporic bureaucracies* to cultivate links with its migrants abroad and promote the positive integration of Mexicans into the US, especially in the last 25 years. That Mexican government officials working in a program offering health services only in Mexico would promote its use by New York–residing migrants and their Mexico-residing families reflects how transnationalized some dimensions of Mexican migrant life have become and how the Mexican government has sought to engage its diaspora on key issues in migrant life, including health. Indeed, SP officials approached us with a pamphlet designed for outreach to immigrants in NY, the cover page which is reproduced below (Figure 1.1). The initial research on how much Mexican immigrants in NY knew about SP and how much they or their families used it,

2 *SP, Diasporic Bureaucracies, Social Marketing*



*Figure 1.1* Cover of a Pamphlet or Comic Book in Spanish, Designed by the Mexican Government to Promote SP among Mexicans in the United States, Stating, “If Your Family in Mexico Does Not Have Access to Health Services ... It Can Enroll in Seguro Popular.”

presented in Chapter 2, led to the second project, constituting the main analytical work of this book. We seek to understand how Mexico’s efforts to reach out to its diaspora were understood or misunderstood by immigrants, and how it might do better.

While the empirical grounding for this book is Mexico's attempts to promote the use of SP among migrants and their families, this opens a larger theoretical and policy conversation about how governments and institutions should communicate with immigrants so that they will actually listen, including in their own messaging and via different platforms such as social media. Given the growth in the immigrant population in the US and other traditional receiving countries in recent decades, it's imperative for governments and institutions to know how to communicate with immigrants and their children to promote positive integration into their new societies.

The SP project underlines a fundamental contradiction between the transnational lives of many migrants and their families, and the local, state, and national governmental entities that deliver public services. The nation-state and its subdivisions are organized for service delivery by territory but also by formal membership category. Those in the territory with full membership are entitled to services such as access to the labor market or health care, while those lacking such membership are not. We discuss this issue more at length in Chapter 4, but we highlight a crisis that can also be seen as an opportunity for the Mexican state: returned and vulnerable migrants in general and, more specifically, *Los Otros Dreamers* ("The Other Dreamers"), Mexicans who get deported back to Mexico from the US, after living there for years (Anderson & Solis, 2014; see also Landa, 2014). Many left Mexico as babies and were raised in the US, speak English fluently, don't know Mexico, and may have their own US-born, US-citizen children. They're essentially being deported to a foreign country. Moreover, most parents who are deported have "mixed status" families. The result is that about a half-million Mexicans who grew up in the US but were deported now live in Mexico, and another half-million US-citizen children are enrolled in Mexican schools, after coming back with their families (Anderson, 2015; Anderson & Solis, 2014; Escobar Latapí, Lowell, & Martin, 2013; Zuñiga, 2015; Zuñiga & Hamann, 2008). These *retornados* ("returnees") are low-hanging fruit for enrollment in health policies such as SP, which has already been working to enroll them. These steps are to be applauded, and they should be expanded: they offer a welcoming hand by the Mexican government to its *retornado* population. We return to this issue in Chapter 4.

This book develops insights from the SP research project in New York. It does three kinds of analytical work. First, it describes the SP project in NY, presenting new research on what immigrants knew about this health policy and what factors affected immigrants' or their families' knowledge or use of it. It offers a demographic and social

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profile of Mexicans in NY as critical for Mexico to use in approaching its diaspora. It also adds to the growing literature on Mexican immigrants in new destination cities, including NY, America's archetypal city of immigrants (Foner, 2013), which epitomizes a demographic transition to diversity (Alba & Yrizar Barbosa, 2016).

Second, the book analyzes the SP project as a public service promotion by a diasporic bureaucracy—an institution created by a home country to work with its immigrants abroad—specifically, to learn how to engage with immigrants and promote programs improving the well-being of immigrant families in Mexico and the US. We recognize that most of our recommendations haven't been carried out, but we emphasize the fact that Mexico and other sending states have created and developed diasporic bureaucracies to attend to relations with immigrants abroad, with a long-term interest in health. Commissioning the SP project demonstrates Mexico's interest in learning how to develop such links. In this vein, the book proposes a set of actions that could further deepen links between Mexico and its citizens abroad via diasporic bureaucracies, including through social media and other methods. Because the central object of analysis isn't SP as a health policy or program in itself, but rather Mexico's interest in promoting its use among immigrants in NY, we only briefly assess that program's political and public health meaning. We spend more time on how Mexico's current and previous approaches to its diaspora have been understood, and how Mexico and similar countries might do this communicative work better.<sup>1</sup>

Third, our research offers insights into how governments and institutions should communicate with immigrants and their families, including what language and methods to use in their approaches. A key finding is that the words and framing will be understood by immigrants within the context of the larger immigrant-institutional relationship. Two examples are illustrative.

Immigrants in our research rejected the form of address that the Mexican government has been using for two decades in its Programa Paisano (a program designed, among other things, to thwart the extortion of returning migrants by Mexican customs officials), Programa 3 × 1 (a community development matching-fund program with collective remittances), Grupos Beta (the humanitarian corps/agency to assist and protect migrants in Mexico), and other federal programs. The term *migrante* ("migrant") was resented by immigrants in our study because, for them, it emphasized the difference in power between immigrants who were forced to come to the US and consular personnel, who came voluntarily.

At the same time, our informants rejected SP when it was discussed as a “social right”—the framing that SP uses, based on the Mexican Constitution—but embraced it when it was reframed as “a paid insurance policy,” based on exchange (getting a service because you pay for it). Defining this policy as a social right highlighted what many immigrants thought was the Mexican government’s broken social contract that had forced them to leave their country to begin with, whereas the payment-for-service framing made them contractually equal parties. This implies that to assess the communication and social marketing strategies that governments, institutions, and organizations should take to persuade immigrants to take action (e.g., enrolling in health care programs), they should do specific research to understand how their audience will interpret language choices.

This book contributes to our understanding of how Mexican and US (and other) institutions and governments can and should promote such engagement and action. The book thus makes theoretical contributions to our understanding of how people’s identities, relationships, and preferences can best be mobilized in programmatic outreach, including practical, how-to insights for designing such outreach. It should be of special interest in the US, where all levels of government (federal, state, and local) and many institutions (foundations, multi-lateral agencies, etc.) are seeking to engage immigrants and their children in myriad activities, from promoting pre-K enrollment or school achievement, to developing closer relationships with the police or law enforcement agents, to working more closely with social-services or community-based organizations.

This book presents original findings from the SP project,<sup>2</sup> the result of two research contracts during 2011–2012 between the Centro de Investigación y Docencia Económica (CIDE) in Mexico City, and Baruch College, of the City University of New York (CUNY), completed in consultation with staff at SP and other Mexican government functionaries. While the initial focus of the study was on immigrants’ knowledge of and disposition to use this policy, the broader opportunities for this project that we outlined above quickly surfaced. Our conversations with immigrants about their own or their families’ use of SP opened questions about how diasporic and other bureaucracies and organizations should talk to immigrants and how they might get them to act in their own interest. This is a significant issue facing governments and private institutions seeking to mobilize immigrants and others toward some goal. The key is that these institutions must talk to immigrants in ways that will get them to listen and to hear *intended* rather than *unintended* messages. This issue plays out in many

public-policy issues, from how to get people to wear seat belts, to increasing sign-ups for the Affordable Care Act (Blanding, 2014). We engage these academic and policy conversations throughout this book.

### **History of SP, Diasporic Bureaucracies, and This Project**

Mexico's modern health bureaucracy dates to the 1943 creation of the Secretary of Health and the Instituto Mexicano de Seguro Social (IMSS; Mexican Social Security Institute) and the later creation of the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE; Institute for Social Security and Services for State Workers) in 1959 (Barba Solano, 2010; Córdova Villalobos, 2010; Frenk et al., 2003). The late 1970s saw expansion of a primary-care approach to health care. A key milestone was the 1983 constitutional reform declaring health care a constitutionally guaranteed "social right." This right was enacted more fully in the 2003 Reform of the General Health Law that created the Sistema Nacional de Protección Social en Salud (SNPSS, or simply SPSS).<sup>3</sup> These reforms were broadened by a systematic reorganization of the health care system in the 2001–2006 National Health Plan to create SP in 2004. Seeking the "democratization of health," these reforms sought to enable the national health system to better cover the entire population, particularly those not covered by IMSS or ISSSTE.

SP has taken several measures to attempt to make health care a real social right in Mexico, embodying this constitutional right in institutional practice. First, from its founding during the administration of President Vicente Fox (2000–2006), SP delinked access to health care from employment. If health care access is via one's employment (as in IMSS or ISSSTE), unemployed citizens or those working in the informal economy—over 50% of Mexico's workforce—are effectively denied health care. SP granted program access to anyone who couldn't otherwise access health care, including the unemployed. Second, SP significantly expanded free health services via multiple programs: Seguro Médico para una Nueva Generación (SMNG; Healthcare for a New Generation), to all children born after 2005; the Embarazo Saludable program (Healthy Pregnancy), which offered universal prenatal care; and greater coverage for chronic conditions, e.g., diabetes and catastrophic events, such as recovery from emergency surgery.

These expansions were designed not only to provide a social right to health care but also to fight poverty (they were implemented alongside complementary antipoverty programs like Oportunidades, which gave families cash payments—e.g., for keeping their children in

school (Garza, 2015; Knaul et al., 2012; 2015; Laurell, 2014). If mothers had prenatal care and children had regular medical care, they would be healthier and less likely to be poor. If the government could prevent catastrophic health care costs from bankrupting families, fewer children would grow up in poverty. Prior to SP, most poor families without insurance faced an impossible choice: pay for health care or pay for food and necessities. Any special procedure or surgery had to be paid for privately. Many chose not to have medical care. For those who did pay, it crippled family finances for years and diminished educational and other life chances for their children. SP, thus, sought to disrupt this cycle of impoverishment by removing or diminishing the cumulative financial impacts of catastrophic illness. In so doing, it sought to create a social right with legal, financial, and health care benefits that all citizens would enjoy *as citizens*, regardless of ability to pay (Laurell, 2014), and to transform Mexico's public health service into a health-insurance service that would also fight poverty (Lakin, 2010).

SP represents an important attempt by the state to deepen and broaden the health care coverage offered to all Mexicans. The concept of "social rights" is explicit in the Mexican Constitution, which theoretically guarantees a host of rights that the US Constitution does not, including the right to an education, equality for women, and health care. SP represents an attempt by the Mexican state to decrease the sometimes large gap between a key constitutionally guaranteed right and the inability of most Mexicans to exercise it. While not always discussed this way in public debate, SP officials framed it this way to us and saw it as justification for their work.

Research on SP has been both critical and supportive. Some research shows that SP has had positive effects on the health and well-being of Mexicans. King et al. (2007, 2009) analyzed the impacts of SP in Mexico, concluding that it had slashed catastrophic and in-patient and out-patient out-of-pocket expenditures and that citizen satisfaction has generally been high (King, n.d.). Paradoxically, they found that only 66% of those automatically eligible for a parallel complementary program, the Programa de Desarrollo Humano Oportunidades<sup>4</sup> (Human Development Opportunities Program), knew about their automatic eligibility or affiliation (King et al., 2009, p. 1451). Hernández-Torres et al. (2008) also found that catastrophic health spending decreased because of SP. They found less evidence that the program was being used for preventive services, or to reduce larger health-risk factors. SP has improved health access and outcomes for diabetic patients, compared with similar patients not enrolled in the program (Sosa-Rubí,

Galárraga, & López-Ridaura, 2009), and improved health outcomes among patients with hypertension in Mexico (Bleich et al., 2007). By 2013, according to an annual report by the Mexican federal government, 55.6 million people were enrolled in SP, showing real growth, compared with 2004 (5.3 million) and 2010 (43.5 million) (Secretaría de Salud & Seguro Popular, 2014). Knaul et al. (2012) argue that SP has steadily improved its performance by ongoing, evidence-driven evaluations of how its programs have worked, improved overall health, and prevented catastrophic health care expenses from bankrupting families.

Other scholars have been more critical of SP. Laurell (2014) called SP neoliberal health care because it isn't universal, combines public and private institutions, and often requires patients to pay for services, especially for tests or specialists. She also describes it as "segmented and fragmented," compared with plans of other Latin American countries, because labor health care is "mandatory and public," while SP "is voluntary and only the population without labor health care" are eligible (pp. 13–14). SP further required huge financial and bureaucratic investments to become operational. According to Lakin (2010), despite increasing health spending, "expected contributions from states and families have not materialized, leaving the program severely underfinanced and its long-term sustainability threatened" (p. 316). Laurell (2014) argues that large expansions in enrollment in SP are not evidence of significant impact but, rather, of efforts by Mexican states that want the federal funding that follows new enrollees (pp. 117–118). Indeed, some people have been enrolled in the program without their knowledge. SP has left 30 million people uncovered, including, in 2010, some 10.5 million living in "extreme poverty, corresponding to 35.7%" of Mexico's poorest people. Nigenda et al. (2015), using information collected from external evaluations, argue that the implementation of SP confronts major challenges due to "limited institutional capacity" at the federal and state levels, among other political and financial factors, such as "a continuous power struggle between the federal government and states over the implementation of Mexico's health reform" (pp. 224–225). Other researchers have argued that SP has exaggerated its successes and not reformed an unresponsive bureaucracy whose lethargy endangers the public health and negates its intended effects, such as reducing infant mortality or poverty (Díaz, Castañeda Pérez, & Meneses Navarro, 2010, p. 11). Daniela Díaz, of the nonpartisan advocacy group Fundar, argues that the administration of federal funds for SP lacks transparency and that its underperformance at the federal and state levels should be investigated (Alatorre, 2016; see also

Lavielle, 2012). A special journal issue on the Mexican Health System and Reforms focused on these issues, including Garza's (2015) policy recommendations to increase the responsiveness of services provided by SP.

Our goal is to recognize but not resolve these debates about SP and the prevailing health inequalities that Mexico is still facing, despite this policy (Flamand & Moreno Jaimes, 2014), potentially leading to significant changes under the Andrés Manuel López Obrador administration. Research shows that SP *has* improved access to health care and health outcomes for many Mexicans, especially those who weren't covered under previous systems, for routine (e.g., birth of a child) as well as catastrophic events (some types of cancer), but that it has fallen far short of its goal of universal health care and has become a target of criticism over funding. Setting this debate aside for now, we turn to the questions leading to this study of immigrants and SP in New York.

SP raises interesting questions for Mexico regarding the goal of reaching universal health care, its nationals living abroad (11.7 million in 2014), and the development of dissemination campaigns in the US (where 98% of Mexicans abroad reside): how much would immigrants know or not know about SP? How much would they use its services? And how would Mexico promote the program's use among those in the "migration belt" of Mexico or across the different migration sending regions? Research on the relationship between migration and health comes to varying conclusions, but findings that returning migrants tend to be in worse health would support the logic of marketing SP to migrants abroad (Arenas et al., 2015; see also Wilson, Stimpson, & Pagan, 2014; Escobar Latapí et al., 2013; Oristian et al., 2009; Salgado et al., 2012).

Several studies link health status with different types of return migrants from Mexico. Using the Mexican Family Life Survey, Arenas et al. (2015) found higher probabilities of return migration for Mexican migrants in poor health and lower probabilities of return for those with improving health. Wilson et al. (2014) state that legal immigrants "did not have a significantly higher risk of having a self-reported diagnosis of hypertension, diabetes, heart or lung problems, or poor mental health compared to nonmigrants," but nevertheless, "the hazard ratio for unauthorized deported immigrants" was higher for diabetes and poor mental health, compared with nonmigrants (p. 1). A case study in a community of high emigration in central western Mexico showed that "returned migrants reported higher rates of asthma, high blood pressure, heart problems, and muscle problems than do migrants who stay in the US, and they are only slightly less likely to report obesity

or high cholesterol.” However, returning migrants “are less likely than US-based migrants to report an infirmity, indicating that they are relatively healthy” (Oristian et al., 2009, pp. 221–225). A binational policy-oriented research team found that migrants have bad health conditions in both countries—especially, returned migrants, who are less healthy than older individuals who didn’t migrate out of Mexico and less healthy than those who stayed in the US (Border Health Commission, 2011; Salgado et al., 2012). This evidence shows that officials of programs and policies like SP have been right to try to build connections with and improve the health outcomes of Mexicans with international migration experience.

The SP officials’ hunch that migrants and their families weren’t using this health policy as much as they might is at least partly supported by our analysis of the overlap between migration and per-capita spending on SP, presented in Figure 1.2 below. This map shows that six states (Aguascalientes, Colima, Durango, Hidalgo, Nayarit, and Zacatecas) with high or very high rates of migratory intensity have lower levels of per-capita spending on SP (\$467–\$720; Mexican pesos), while four (Guerrero, Oaxaca, Morelos, and San Luis Potosí) with high levels



Figure 1.2 SP Spending and Migratory Intensity by States in Mexico, 2010.

of migratory intensity have medium levels of spending (\$721–\$958). Only three (Guanajuato, Jalisco, and Michoacán) with very high or high levels of migratory intensity have high levels of per-capita spending (above \$958; only five states out of the 32). While not conclusive, this quick analysis suggests an inverse relationship between migratory intensity and per-capita spending on SP—states with more migrants tend to spend less on SP.

### **Diasporic Bureaucracies and the SP Project**

Mexico's interest in addressing the needs of its nationals abroad isn't unique in the history of state–diaspora relationships. During the last great wave of migration to the US, sending states and their diasporas were in close contact and sought to cultivate and maintain relations with their emigrants abroad and protect them in their adopted lands. Such efforts continue today, even among countries that are mainly immigrant receiving but that also have significant numbers of migrants abroad. Such state–diasporic relationships are driven by a host of issues central to any national community, including remittances (which help the sending state financially), influence on home-country policies toward the sending country (a foreign-policy issue for the sending state), and voting from abroad (enabling immigrants or expatriates living outside their country of birth or citizenship to vote in that country's elections, recognizing them as members of the national community; Bauböck, 2007; Bauböck & Faist, 2010; Collyer, 2013; Faist, 1995; Fitzgerald, 2009; Gonzáles Gutiérrez, 2006; Green & Waldinger, 2016; Lafleur, 2011; Schmitter, 1985; Waldinger, 2015; Yrizar Barbosa, 2008, 2009. Countries of destination have, of course, crafted policies to decide which immigrants to let in, for how long, and under what conditions (Fitzgerald & Cook-Martin, 2014; Zolberg, 2006).

Diasporic policies linked to Italian migration in the late 1880s–early/mid-1900s migration and Mexican migration today can usefully be compared. In the late 1880s–early 1990s, Italy's General Commission on Emigration (later replaced by the General Bureau of Italians Abroad) was in charge of protecting Italians' rights but also of creating institutions to maintain and strengthen their links with their homeland (Cordasco, 1980; Foerster, 1919; Smith, 2003a, 2003b, 2006, 2008). Moreover, after World War II, Italy worked with receiving states that didn't want Italian workers to permanently settle (e.g., in France or Germany) to create what Schmitter Heisler (1984) called “exclaves,” or institutionalized communities oriented more toward their country of origin than their country of settlement. Other Italian institutions, such

as the Scalabrinian missionaries, were dedicated to ministering to Italian immigrants abroad, in Europe and the Americas, and to cultivating Italian nationalism and identity among them. Some scholars have noted that many Italian immigrants identified more with their villages or regions than with Italy as a whole when they left their homeland, but came to identify as Italian when treated as such in their new homes and by Italian emissaries like the Scalabrinians or staff from diasporic bureaucracies (Choate, 2009; Gabaccia, 2000; Smith, 2003a, 2003b, 2008). Following the steps of Italians in the US, other sending states have created state–diaspora programs to maintain these relationships, including Spain, Portugal, India, Morocco, Philippines, Mexico, and Ecuador (Asis & Baggio, 2008; Brand, 2006; Délano, 2011; Herrera, Moncayo, & Escobar, 2012; Iskander, 2010; Sharma, 2006; Solé, 1995).

Further comparing the Mexican and Italian cases highlights a key difference between many contemporary and previous migrant-sending state–diaspora relations. Whereas most Italian immigrants in the late 1800s–early 1900s came with, or quickly achieved, legal resident status, or easily became US citizens and hence could reunify their families if they wished, contemporary Mexican and other immigrants often remain in long-term undocumented status, making family reunification more difficult and creating even more disadvantaged circumstances for Mexican immigrants and their children. These circumstances have tilted the work that the Mexican state (and others with large undocumented populations) conducts with its diaspora to help with these issues. For example, a key problem for long-term undocumented immigrants is lack of necessary secure identification to interact with institutions in the US or other destination countries. In NY, the New York Immigration Coalition (NYIC) successfully lobbied NY’s government to recognize, and encouraged the Mexican Consulate to develop, the *Matrícula Consular*, a secure ID issued by the consulate to identify the immigrant. This resolved vital everyday issues, such as undocumented immigrant parents who couldn’t enter their US-citizen children’s schools to visit teachers because the parents lacked the requisite ID to enter NYC public schools and other public buildings, which became increasingly necessary after 9/11. The Mexican government developed a set of binational policies to help these immigrant and binational families—e.g., creating *Plazas Comunitarias*, enabling immigrants to continue their precollege educations online, in the US or in Mexico, or through health and labor initiatives in collaboration with local or state-level US authorities and organizational partners (Bada & Gleeson, 2015; Carrasco-Garrido et al., 2009; Marietta, 2006; Martínez-Wenzl, 2013; Sánchez-Siller & Gabarrot-Arenas, 2015; Schmid, 2017; Shtarkshall, Baynesan, & Feldman, 2009; Vázquez et al., 2011;

Weissman et al., 2018). Mexico isn't alone in promoting cross-border health care, as studies on Turks in Denmark, Ethiopians in Israel, and West Africans in the US show (Asamani-Asante, 2014; Nielsen et al., 2012; Shtarkshall et al., 2009).

The range of intents and actions in such diasporic bureaucracies has been broad. Sending states usually create diasporic bureaucracies when their position in the geostrategic system changes, their immigrants begin making autonomous demands, and the place of immigrants in the national community becomes a political issue. Creating a diasporic program usually helps political elites resolve some domestic political issue (Délano, 2011, 2018; Gambetta, 2012; Lafleur, 2011, 2012; Shibata, 2015; Smith, 2003a, 2003b, 2008; Yrizar Barbosa, 2008, 2009; Yrizar Barbosa & Alarcón, 2010).<sup>5</sup> The type of diasporic bureaucracy created varies by each regime, its hold on power, and the country's place in the global system. During the 1960s–1970s, Turkey's programs for its diaspora in Germany were believed by many to function as surveillance for dissidents, as a means of keeping an eye on their organizing efforts abroad (Miller, 1981). Many contemporary immigrants similarly don't work closely with their consulates in the US, feeling they're extensions of governments seeking to control dissent more than offer concrete help (Graham, 2001; Guarnizo, 1998).

Mexico has become a poster child over the last 20 years among immigrant-sending states seeking to develop programs to cultivate ties with their own diasporas. At a conference in Mexico City in the early 2000s, representatives of most major sending states presented summaries of their own programs but also expressed avid interest in how Mexico had developed relationships with its diaspora, especially the concrete steps it was taking and who/what was funding its work. The first author recalls a high-ranking representative of Haiti's diasporic bureaucracy, who presided over its older but less well-developed program, as eager to talk with his Mexican counterparts and impressed at the range of activities they had been able to organize. Other Latin American sending countries similarly looked to Mexico for guidance. These meetings resulted in a book published by Mexico's Secretary of Foreign Affairs in 2006, *State–Diaspora Relations: Approaches from Four Continents*, edited by Carlos González Gutiérrez, a principal architect of Mexico's diasporic strategy, and now Mexico's consul general in Sacramento, California (González Gutiérrez, 1999, 2006; see also Besserer, 2004; Délano, 2011, 2018; Fox & Bada, 2008; Fox & Rivera-Salgado, 2004; Glick-Schiller, Basch, & Szanton-Blanc, 1995; Goldring, 1998; Irazuzta & Yrizar, 2006; Levitt, 2001; Moctezuma, 2015; Pries, 2017; Smith, 1998, 2003a, 2003b, 2006, 2008).

Mexico's stated goals in this work have been to promote immigrant integration into the US and deepen Mexico's relationships with these immigrants (Délano, 2018; González Gutiérrez, 1999; Smith, 2006, 2008). The work engages three distinct kinds of relationships. First, it means promoting contact between Mexicans in the US and the US-based institutions serving those communities—hospitals, schools, universities, etc.—to foster better integration into the US. Second, it implies deepening collaborative relationships between migrants and their communities of origin. This includes programs supporting the work of hometown associations (HTAs) (Escala Rabadán, 2016). The third kind of program recognizes the complexity of transnational life and seeks to address needs stemming from being “between” the two countries. For example, in the Programa 3 × 1, immigrants in the US and their Mexico-residing relatives could choose (in consultation with local authorities) public projects to support. Each dollar the immigrants sent would be matched by a dollar from the local or state government and the federal government. Such projects sometimes exposed the interests of immigrants and nonimmigrants. Nonimmigrants would ask: why build a sports field (that immigrants could play on when they returned) when we need a new school or clinic more? (Goldring, 1998; Moctezuma, 2015; Smith, 2003). The larger point is that the 3 × 1 structure adopted by the federal government recognized that immigrants were settled in the US but still had interests and legitimate claims on Mexico's public resources because they were contributing, ongoing members of their communities of origin.

These federal programs followed a path forged by state-level governments. Recognizing the contributions of HTAs, immigrants in Los Angeles, Chicago, Texas, and other areas formed state-level federations in the 1980s–1990s to advocate for themselves vis-à-vis their state governments and governors, who were often quicker to respond than the federal government. The most famous federation is the Zacatecanos, formed in the mid-1980s, whose close collaboration with the governor and state government of Zacatecas has been well documented (Goldring, 1998; Moctezuma, 2015; Smith, 2003). These collaborations have included sponsoring the construction of public works in Mexico, scholarships, and related support for students in the US and Mexico, and even the opening of the state-level political system to enable Zacatecanos in the US to vote for governor and run for office in Zacatecas (Moctezuma, 2015). Yrizar Barbosa (2008) argues that a key issue was the repatriation of the bodies of Mexicans who died in the US (Lestage, 2012). These state-level differences have emerged from and enhanced political competition, as political parties seek to engage

migrants abroad and their families at home. It has created a kind of mirror image to “immigration federalism” (Rodriguez, 2017; Varsanyi, 2010) in the US. Where inaction by the US Congress on immigration reform has spurred a variety of state and local policies seeking to integrate or exclude immigrants, including the undocumented, in Mexico, state and local governments initially took the lead in creating programs for their migrants abroad. While the federal government has created several substantial diasporic bureaucracies, an *emigration federalism* remains in Mexico, created by the variation in state and local policies and capacities to engage with their migrants abroad.

The seriousness of Mexico’s intent can be measured in the progressive institutionalization of this work. From a small program started in the mid-1990s, Mexico’s federal diasporic bureaucracies have grown and spanned four presidential terms, indicating that they aren’t special projects but part of the government’s central mission. Moreover, the training among consular staff has substantially changed, from a previous era’s focus on international institutions like the UN to one including substantial training in migration-related work and scholarship covering transnational communities, migration, and remittances. The Mexican Consulate network in the US has grown to some 50 consulates in 25 states today (González Gutiérrez, 1999). This increased capacity has enabled the Mexican government to do more work with its diaspora than many other countries. Mexico has created or expanded several institutions through its Secretary of Foreign Affairs, including the Program for Mexican Communities Abroad in the mid-1990s and the creation of the Institute for Mexicans Abroad, or IME, in 2003, whose job it was to cultivate these ties. The Consultative Council of the Institute for Mexicans Abroad, or CCIME, was formed at the same time, with the goal of creating a space for immigrant leaders to be chosen by their peers to represent their interests to the IME and the Mexican government. Scholarship on IME and CCIME discusses motivations for and results of these programs (Alarcón, 2006; Délano, 2010, 2011; Délano & Yrizar Barbosa, 2017), but for this project’s purposes, they clearly constitute diasporic bureaucracies.

Promoting knowledge of and access to health care among immigrants has been one of the most successful and least controversial areas of work for these Mexican diasporic bureaucracies. Mexico has had a National Health Week for 15 years, the Health Initiative of the Americas (HIA), set up in 2001 with the University of California–Berkeley School of Public Health to provide “action-oriented research” and “scientific-based activities to inform and influence policy changes,” addressing the conditions of Latino populations and US–Mexico

migration flows (Health, 2017). Mexico has set up Health Windows (HW, or *Ventanillas de Salud*) at all its US consulates, and implemented other work wherein local consulates partner with hospitals or other health-oriented institutions to promote better health in immigrant communities. These projects include campaigns against diabetes or Alzheimer's, as well as blood-pressure and blood-sugar screenings and referrals (Gambetta, 2012).<sup>6</sup>

Recent studies trace the history and increasing institutionalization of health policies toward Mexicans in the US. This institutionalization has run parallel to the consolidation of the Mexican consular network (*red consular*). As early as 1943, the creation of institutions like the US–Mexico Border Health Association and the Field Office of Panamerican Health Organization (*Organización Panamericana de Salud*, OPS) in El Paso, Texas (see also Border Health Commission, 2011), promoted such efforts (Salgado et al., 2012). Salgado and colleagues report that in 1990, the Mexican government offered health insurance for families under the name “IMSS Migrantes.” In 2001, the Secretary of Health and Human Services of the US and the Mexican Secretary (Ministry) of Health created the United States–Mexico Border Health Commission (BHS). Furthermore, in 2004, BHS was designated a Public International Organization by Executive Order, with the mission of providing “international leadership to optimize health and quality of life along the US–México border” (U.S.–Mexico, n.d.). By 2009, Déllano (2011) had identified 40 consulates in the US with HW; in 2016, there were 53 such HW, one in each consulate plus three “mobile” HW (Déllano, 2018).<sup>7</sup>

State-level programs promoting the health of Mexicans in the US also emerged. Yrizar Barbosa (2008, p. 139) reports that in 2000, about a dozen Mexican state governments pledged (in the *Declaratoria de Puebla*) to “implement health campaigns” toward their populations in the US (pp. 75–76). Since 2001–2002, state officials from Michoacán have further participated in a Binational Health Week (BHW, *Semana Binacional de Salud*) in Los Angeles, California. However, some of these efforts are “paper programs” doing symbolic work but possessing little capacity to get work done. In 2007, the budget for Michoacán's State Program on Health for Migrants was about 12,350 MX pesos (less than US\$1,200 at the time).

The government of Puebla has had a state-level office for Migrants Abroad for over a decade, and sometimes sought to do health programs, but the budget has varied. Its most important work has been to establish two *Mi Casa Es Puebla* locations, its official state offices, in NYC and Passaic, NJ. These offices serve as community centers

promoting access to many services, including local, US-based health care, and also offer concrete help, such as issuing Mexican birth certificates for youth applying for Deferred Action for Childhood Arrivals (DACA).

Given this history, the SP research project we conducted in NY can be seen as an outgrowth of Mexico's work over the previous two decades as an innovator in state–diaspora relations. SP staff working with us on this study wanted to know how much Mexican immigrants in NY knew about SP, and if they could be urged to use it when they returned to Mexico—or at least encourage their families in Mexico to use it.

Toward this end, we posited three theories of action in our project. The first was to mobilize recent immigrants who were likely to return to Mexico because their families were there, and who were in NY only for a short stint to make money and return to Mexico. The second was to get long-term immigrants whose families had remained in Mexico to encourage those staying in their home country to use SP. The third was to encourage immigrants, those who migrated regularly between NY and Mexico as well as the long-term-settled in NY, to use SP when in Mexico to visit their relatives.

A larger issue involves the evaluation of these programs. Mexico usually evaluates its programs by presenting data on how many people attended or used them—e.g., how many people asked a question at the Health Windows? This offers a useful measure of activity but not of effect (Délano, 2018). How much do these programs promote the larger goals they seek to promote—to foster fuller integration and closer links with Mexico and serve the in-between needs of migrants who live in the US but have family in Mexico and who need support? We will return in Chapter 4 to this perennial question in evaluation research.

## **Social Marketing and Communication**

Our project examines how immigrants and community leaders understood SP to develop approaches and language about the program that could ensure better comprehension and use. Our research from the first part of this book showed that public service promotions can change how immigrants think about the program. As will be detailed, our public service promotions increased knowledge of SP by 23%, and many migrants reported positive experiences with the program in Mexico, especially for relatives living in the country. While the first part of our project was primarily survey-based and sought to

document the level of knowledge about SP among immigrants in NYC – and the factors that affect that level of knowledge – the latter part of this book focuses on *how* immigrants and their leaders understood or misunderstood SP and proposes strategies that SP and similar programs could use to promote more positive, accurate narratives about such health care initiatives in immigrant communities.

Our project applies an overarching “social marketing” strategy with immigrant populations. Social marketing is one of the most established approaches to developing or redeveloping public initiatives and is currently used by nonprofits, cities, and other public agencies across the planet, such as the World Health Organization, the US’s National Institute for Child Health and Human Development, and the Centers for Disease Control and Prevention (Andreasen, 2005; Weinreich, 2010). Lee and Kotler (2016) clarify that “social marketing principles and techniques are most often used to improve public health, prevent injuries, protect the environment, increase involvement in the community and enhance financial well-being” (p. 33). Social marketing has been used to conceive, implement, and evaluate public campaigns, especially in domestic and transnational public health initiatives (Cheng, Kotler, & Lee, 2009; French et al., 2010; Harvey, 1999; Hastings, 2007; Lefebvre, 2009; Llanos-Zavalaga et al., 2004; Lovett, 2011; Rice & Robinson, 2013; Siegel & Donor, 1998; Smith, 2003). More on social marketing in general can be found in Kotler and Lee (2009), McKenzie-Mohr and Smith (2011), and Smith (2002).

For years, the social marketing literature has been replete with efforts to improve public health. Examples include Peru’s campaign to reduce tuberculosis, Tokyo’s movement to increase breast-cancer-screening rates, the organization NetMark’s sustainable malaria-prevention efforts in Africa, Pakistan’s family-planning initiatives, and India’s initiatives to reduce diarrheal disease (Lee & Kotler, 2011; other research includes Asgedom, 2015; Lee & Kwak, 2012; Lovejoy & Saxton, 2012; Magro, 2012; Sabogal & Cordingley-Klein, 1999; Sugarman et al., 2011; Williams & Kumanyika, 2003). It is thus an appropriate framework for examining *how* immigrants and their leaders understand or misunderstand SP and for constructing new strategies that SP and similar programs can use to fashion more effective communication with their priority audiences.<sup>8</sup>

The social marketing and communication approaches applied in this book both critique and move us beyond many common ideas about how communication and outreach best work. Communication shouldn’t be made into a “caricature of quick formulae and predetermined action, dissemination materials and media, and clever messages” that have

remained the largely unreflective, staple approaches of many governments and agencies (Waisbord, 2015, pp. 155–156). The colossal waste of public funds spent by initiatives like the US government’s over \$1 billion National Youth Antidrug Media Campaign underscore the importance of this point. Evaluations of that campaign either showed no effects on youth beliefs and behavior around drug use, or potential “boomerang effects,” where the campaign increased the very problems it sought to decrease (Hornik, 2013, p. 44). Social marketing and evidence-based work in communication hence take a multifaceted approach to change, drawing from and working with fields such as health communication, which use applied research and established theories that consider “the multicausality of social problems and recommend multilevel interventions” at individual, organizational, and policy levels (Waisbord, 2015, pp. 148–149).

We sought to promote health outcomes at the level of populations, which means aligning broader community action with communication strategies, not just throwing paid advertising at problems (Dorfman & Wallack, 2013, p. 337). Rather than appealing to intuition or tradition (Manheim, 2011), effective campaigns should incorporate long-standing theories of communication into their frameworks. Why reinvent the wheel when so much is already known about how communication works? Particularly in health communication, the value of basing government or organizational goals on a number of established communication concepts and frameworks continues to be supported in practice (Buller et al., 2013, p. 198). All the strategies we recommend in this book follow from our original survey, interview, and focus-group research, discussed at length in the following chapters. This book hence addresses a need highlighted by scholars and practitioners of strategic communication: to work across disciplines, using grounded empirical research, and to make “nonrelativistic conjectures” about how international communication could and should work (Nothhaft, 2016, p. 69). In the second part of this book, our research with immigrant communities will be integrated with this work to draw lessons for similar campaigns and initiatives seeking to improve their public marketing and outreach strategies.

## Notes

- 1 This book doesn’t fully examine the larger political forces affecting the creation of SP, as Smith (2008) did with Mexican migrants’ right to vote from abroad.
- 2 The official, rather unwieldy, title of this first funded study was “Estudio del Nivel de Información Sobre el Seguro Popular con Que Cuenta la Población Migrante Mexicana de la Ciudad de Nueva York, EE.UU”

- (“Study about the Amount of Information about Seguro Popular among the Mexican Migrant Population in New York City”). Please note that we present the most important findings and themes from our previous research in this book. The original research report can be referred to for further details (Smith & Seguro Popular Team, 2012).
- 3 This change was preceded by a 2001 pilot program, Health for All (Salud para Todos), implemented in Aguascalientes, Campeche, Colima, Jalisco, and Tabasco (Uribe, Rodríguez, & Agudelo, 2013).
  - 4 The Oportunidades program represented a major social-policy expansion and shift, changing the focus from treating poverty to longer-term changes enhancing incentives for families to invest in human capital, such as the education of their children.
  - 5 We’re aware of the analytical differences between migrants, immigrants, and emigrants, or what Waldinger (2015) identifies as a “paradox” in how societies of origin (sending country) and destination identify these populations differently. In this book, we decided to stick with the term “immigrants” because our perspective is from the society of destination (reception country).
  - 6 At least since 1990, the Mexican government has developed health policies and programs targeting its nationals abroad (e.g., a binational program targeting United Farm Workers) (García-Acevedo, 1996, p. 140). By 2009, 40 consulates in the US had Health Windows, a program “designed to provide information on preventive health to persons who visit the Mexican consulates” (Délano, 2011, p. 212). More recently, the Program for Migrant Health (Programa para Salud Migrante)—a component of the National Program on Health 2007–2012—listed four objectives: (i) strengthen multilateral and bilateral ties; (ii) consolidate the Binational Health Weeks; (iii) promote SP among migrants, tapping on the HW; and (iv) improve the repatriation of sick Mexican immigrants (Salgado et al., 2012). In a visit to NYC (June 7–8, 2016), officials from the Mexican Secretary of Health and the Secretary of Foreign Affairs declared in a public statement that they were on a working visit with the intention to “promote the health services offered by the Government of the Republic to promote the integration of the Hispanic and Mexican-American communities in the United States” (IME, 2016: Boletín Especial Lazos #1672, June 8).
  - 7 Salgado et al. (2012) situate the origin of the Binational Health Weeks in 2001 with the Health Initiative of the Americas and—in addition to the Health Windows or SP programs for migrant families (since 2010 and migrant children since 2011, in collaboration with DIF, or the National System for Integral Family Development)—they mention the following health programs for migrants: Programa de Repatriación de Conacionales Enfermos (by the ministries of Foreign Affairs and Health); and Programa Vete Sano, Regresa Sano (started in 2001 by the Health Ministry). These researchers also identified the Program for Migrant Health (Programa para Salud Migrante) as part of the National Program on Health in 2007–2012. In 2015, the Mexican Health Secretary/Ministry, via two offices (Dirección General de Relaciones Internacionales and Dirección General Adjunta Para la Salud del Migrante), listed seven health programs for the Mexican migrant population: HW, the Program for the Repatriation of Sick Conationals, BHWs, Programa de

Investigación en Migración y Salud (PIMSA), Programa de Trabajadores Agrícolas Temporales (PTAT), Modulos de Atención Integral de Salud para Connacionales Repatriados, and BHS/CSF. For additional studies stating the challenges of binational health in North America, such as the initiatives Salud Migrante and Medicare in Mexico, or the most recent efforts to address the link between undocumented migration in the US or specifically in NYC, see Vargas Bustamante et al. (2012), Rodríguez, Young, and Wallace (2015), and Barrios-Paoli (2015). At least since the late 1990s, those born outside the US are least likely to possess health-insurance coverage (Reed, 1998).

- 8 At the same time, we will apply interdisciplinary research on communication strategy to SP. Public campaigns that don't use such approaches (incorporating applied research and social-scientific knowledge on communication strategy) put themselves at a serious disadvantage in a cluttered and competitive information environment (Lanham, 2006; Manheim, 2011; Smith, 2012).