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The Role Of Soft Infrastructure In Developing Sustainable Volunteer-Based Healthcare For Transient Migrants In The El Paso-Ciudad Juárez Border Region

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THE ROLE OF SOFT INFRASTRUCTURE IN DEVELOPING SUSTAINABLE VOLUNTEER-BASED HEALTHCARE FOR TRANSIENT MIGRANTS IN THE EL PASO-CIUDAD JUÁREZ BORDER REGION

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DEDICATION

More than just a thesis, it is my life that I dedicate to all captured lifeforms, as Tâm Liêu Âm articulates. To liberate all captured lifeforms, embrace opacity, prevent the act of killing, become an endless illuminating source, attract anonymously, and end violence now. The echoes of these words continue resonating throughout my journey.

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by

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1.1.1. The Trigger Event & Initial Reaction

Each year since 2018, unprecedented numbers of people have been arriving at the border cities of Ciudad Juárez, Chihuahua, Mexico and El Paso, Texas, United States, creating a local and national quandary due to concerns related to insecurity and lack of resources (Martínez, 2021, p. 182; Campbell, 2021, p. 9). Most of these people were—and continue to be—asylum seekers, not having the border as their final destination (Delgado et al., 2022). They are considered transient migrants in this research because "[t]ransit migration occurs as people stop in places between origin and intended destination, sometimes for short periods of time and sometimes for many years" (Castañeda, 2023, p. 35). Although this migratory situation intensified wary and ambivalent sentiments about migration vis-à-vis local and national security, it has also been a trigger event for remarkable local philanthropic mobilizations for migrant care (Martínez, 2021, p. 184).

More specifically, in October 2018, personnel from the U.S. Immigration and Customs Enforcement (ICE) agency released approximately 100 asylum seekers on the streets of downtown El Paso (Price, 2019). Most of these transient migrants were from Central America, consisting of many families with young children and unaccompanied minors. Consequently, on the spur of the moment, medical professionals in El Paso mobilized as volunteers to meet with these migrants and assess their health, addressing their most pressing medical concerns. Henceforth, these volunteer medical providers foreshadowed the current volunteer-based healthcare system available for transient migrants in the El Paso-Ciudad Juárez border region (hereafter as border region).

Given the scale of healthcare needs for transient migrants in the border region and the limited resources available to respond to this demand, Delgado and colleagues argue that relying mostly on volunteers is very costly and thus unsustainable, calculating its running cost in the millions of US dollars (2022). Additionally, 2024 began with a direct attempt to criminalize humanitarian organizations that provide care to transient migrants in the borderland, particularly in El Paso. Therefore, volunteer-based humanitarian assistance for transient migrants in the border region appears to be facing sustainability challenges related to its economic and political implications. This research focuses on the social challenges that impedes sustainability specifically for the medical volunteerism that helps transient migrants in this region.

1.1.2. Purpose

The existing scholarship on migratory phenomena predominantly centers around the experiences of migrants themselves, often investigating the multifaceted impacts of policies, discrimination, borders, organized crime, and broad structural economic and political configurations. While there is an extensive body of literature exploring migrants' narratives of violence and resilience, a significant gap exists in understanding the perspectives of the healthcare professionals and volunteers who provide healthcare to migrants in transit. To contribute to identifying challenges and the factors that determine the sustainability of a volunteer-based healthcare for transient migrants at the border region, I explore how volunteering infrastructures operate for the volunteers themselves in their experience, relation with each other, and the spaces where they provide their service. In particular, I focus on intangible factors that facilitate social interactions within a social space, what Kavanaugh and colleagues call "soft infrastructure" (2022).

The purpose of this research is therefore to explore the experiential and interpersonal processes of developing sustainable volunteer-based healthcare for transient migrants in the border region. The objective was to collect and analyze qualitative data on how the development of sustainable volunteer-based healthcare for transient migrants in the border region intertwines with border dynamics related to securitization practices and discourse. This is important because "[t]oday, securitization practices and discourse dominate migration management," particularly at the intersection of migration, health, and borders (Castañeda, 2023, p. 39). Moreover, notions of *immobility* have determined to some extent today's (post-COVID-19) migration management (p. 2). Therefore, this research also considers how migratory mobility and immobility in the border region influence the portability and directionality of pro bono healthcare for transient migrants. As it was aforementioned, to target qualitative interpersonal processes of developing a sustainable volunteer-based healthcare for transient migrants, this research utilized the frameworks of volunteering and soft infrastructure.

1.1.3. Volunteering Infrastructure

Volunteering infrastructure is understood by the United Nations Volunteers (UNV) program as the underlying and supporting structure that is necessary to have a sustainable type of volunteering (Grandi et al., 2018, p. 4). Volunteering is defined as a "wide range of activities undertaken of free will, for the general public good, for which monetary reward is not the principal motivating factor" (p. 29). The concept of volunteering infrastructure encapsulates three dimensions: 1) the enabling environment, 2) operational structures, and 3) implementation capacities (p. 6). Each of these three dimensions have their particular elements, all of which, when interconnected, intend to serve the purpose of promoting, mobilizing, engaging, managing,

and supporting volunteers. Furthermore, there is a distinction between formal and informal volunteering where the former is undertaken through an organization while the latter is not (p. 29). More specifically, informal volunteering tends to be more direct and unmediated by any formal organization that would otherwise coordinate volunteering activities.

The conceptual distinction between formal and informal volunteering helps shed light into how volunteer-based healthcare for transient migrants at the border region develops, especially because at least in El Paso most is outpatient healthcare (Delgado et al., 2022, p. 2) When it comes to providing pro bono healthcare for transient migrants, Heide Castañeda points out that organized initiatives stemming from nongovernment organizations, nonprofits, and charity clinics continue to be "short-term, improvisational solutions and can sometimes translate into absolving the state of its responsibilities" (Castañeda, 2023, p. 57). Therefore, paying attention to volunteering infrastructure can help examine the type of volunteer-based healthcare needed in the border region to be long-lasting, systematized, and ultimately sustainable.

1.1.4. Soft Infrastructure

Soft infrastructure refers to intangible factors that facilitate social interactions within a social space (Kavanagh et al., 2022). It includes—but is not limited to—phenomena like trust, hope, self-efficacy, personality, social norms, worldview, among others that inform the nature of social relationships (p. 7). Relationships lead to action, allow coordination, foster resources, and found communities. Moreover, in agreement with Wallerstein and colleagues, I understand communities as "(1) *functional spatial units* meeting basic needs for sustenance, (2) *units of patterned social interaction*, [and] (3) *symbolic units of collective identity* and/or social units where people come together politically to make change" (2015, original italics). Hence, in the

context of exploring soft infrastructure within volunteer-based healthcare for transient migrants at the border region, volunteer medical providers will be considered to be part of a broad community that has emerged involving intangible elements that are indispensable for determining its sustainability.

It is important to pay attention and not underestimate soft infrastructure because "even in the presence of vast amounts of projects funds…the people-processes, rather than the funds themselves, are the key to community betterment" (Kavanaugh et al., 2022, p. 7). Additionally, the funding and developing of health promotion for specific types of populations have traditionally neglected the foundational intangible soft factors of social relationships that improves well-being and behavior-change. Heide Castañeda points out that this involves "the capacity of individuals and groups to flexibly utilize resources such as knowledge, money, power, prestige, and beneficial social connections" (2023, p. 30). Therefore, this research will focus on the development of soft infrastructure with the intent of contributing to the understanding of key processes for sustainable volunteer-based healthcare for transient migrants in the border region.

1.1.5. Medical Infrastructure & Healthcare for Transient Migrants

It is worth noting that volunteering and, especially, soft infrastructure are important dimensions of the broader notion of medical infrastructure. Medical infrastructure is understood in this research as the physical and social network topology that underlines the multiple spaces and services that have been employed specifically to provide healthcare to transient migrants in the Paso del Norte region. Moreover, a conceptual distinction worth making is that between medical care and healthcare, which according to the Rogue Community Health, is that the former

"focuses on treating illness and injury, while health care focuses on preventing illness and promoting health" (2023). In this sense, medical care is a branch or subset of healthcare. Making this specification is important for the context of this research because I am focusing on volunteer medical providers assisting transient migrants at the border region who arrive with a deteriorated health due to their strenuous migratory journey and thus have a need for treatment of illness or injury (Castañeda, 2023, p. 34). More specifically, during their period of being in-transit, "migrants may experience significant health risks, physical danger, exposure to violence, trauma, hunger and thirst, and poor access to medical care even in emergency situations" (p. 35). Therefore, it is important to highlight how healthcare for transient migrants looks like in the context of the border, especially knowing that, according to the International Organization for Migration, the U.S.-Mexico border is now considered the deadliest migration *land* route in the world (2023).

Healthcare at the border involves primarily addressing physical injuries recently caused by failed attempts to cross or navigate the natural terrain and material-security infrastructure (e.g., walls) along the border itself (Jusionyte, 2018; Del Bosque, 2023). However, these physical medical concerns often have direct mental effects. For example, neurological surgery resident, Dr. Alexander Tenorio, and colleagues, have quantitatively identified correlations between the extension of the San Diego-Mexico border wall and the increase of more frequent, severe, and costly spinal injuries (2022), traumatic brain injuries (2023, February), and rare blunt cerebrovascular injuries (2023, July). More generally, mental illness stemming from trauma exposure and post-traumatic stress is an increasingly relevant medical concern for many transient migrants along the border (Morales et al, 2022). Mental trauma here stems from a variety of experiences like threats, sexual assaults, and witnessing, a lot of which occurs during migratory

journeys. Due to the prevalence of mental concerns among transient migrants, especially for sub-groups (e.g., unaccompanied Central American and LGBTQ+ children), Morales and colleagues advocate for the need for trauma-informed, culturally sensitive, and improved access to healthcare at the border.

Moreover, scholars have found that the healthcare available to transient migrants at the border tends to be reactive as opposed to preventive (Reynolds et al, 2022; Castañeda, 2023, p. 29). This reactive approach to healthcare is in itself a global trend for assisting transient migrants. However, this research will focus on the way in which the geography-specific context of the border region influences the development of sustainable volunteer-based healthcare for transient migrants.

1.1.6. Volunteer-Based Healthcare Emerging Globally for Transient Migrants

The impacts and challenges related to transient populations has a global-local nexus, which some scholars have called "glocalization" (Steger, 2017, p. 2). Glocalization refers to the complex but productive interconnectedness between the forces that are considered global, and the practices or arrangements found in a local context. In this sense, glocalization is a defining aspect of volunteer-based healthcare that has emerged as a response to a global exodus and diaspora reaching the local context of the border region. This can be considered an instance of a global mushrooming phenomenon consisting of volunteer-based healthcare programs established in multiple local contexts as a result of what Achille Mbembe have called a repopulation of the earth (2019, pp. 9-10). These volunteer-based healthcare programs for transient migrants are often inchoate, which this research studies in the context of the border region. Although I do not

use the term glocalization as such, it is important to keep in mind that border dynamics are not merely local, but a global issue localized in border-space.

1.1.7. Geography

El Paso and Ciudad Juárez belong to a broader international and inter-state region known as Paso del Norte. The Paso del Norte region is home to around 2.4 million people across the "El Paso and Hudspeth Counties in far west Texas, Doña Ana, Luna, and Otero Counties in southern New Mexico, and the municipality of Ciudad Juárez, Chihuahua, Mexico" (See Figure 1, Paso del Norte Health Foundation, 2023)[1]. This region also includes the *colonias*, unincorporated peri-urban areas, which are not part of this research, albeit they are very important and subject of study by many scholars.

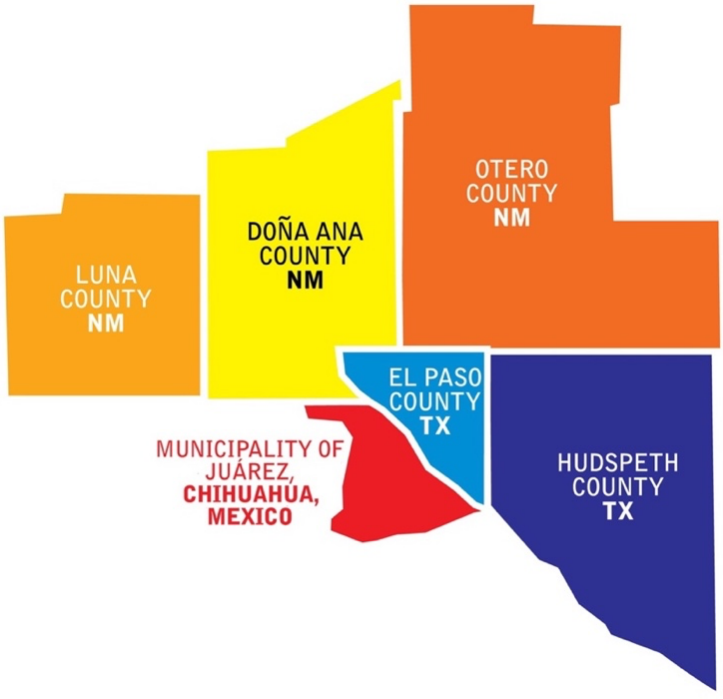

Figure 1 The Paso del Norte Region

[1] The graphic of "Figure 1" was provided by the Paso del Norte Health Foundation

1.2. Scope of the Study

This research seeks to better understand the emergence and development of a volunteer-based healthcare program for transient migrants in the border region between October 2022 and April 2024. To shed light onto the deep complexities pertaining to socioecological processes in developing sustainable volunteer-based healthcare for transient migrants, the research takes as a case study a program referred to here as the Clinic. This is a single, yet significant, initiative that was launched in October 2022 by Border Solidarity Network (a pseudonym), an El Paso non-government, non-profit, faith-based organization. Four essential goals driving this program are to 1) provide free high-quality healthcare to vulnerable migrants; 2) serve as a platform for binational collaboration and education among healthcare providers; 3) create a culture of respect for human rights; and 4) raise awareness regarding the complexities of border health among the medical community.

The Clinic is a program that has emerged in collaboration with volunteer medical providers in El Paso and a Mexican government migrant shelter in Ciudad Juárez (hereafter as the Shelter). Although the Clinic's main site was inside the Shelter, it also operated outside the Shelter itself, occasionally establishing "pop-up" or "street" clinics in targeted spaces throughout Ciudad Juárez where clusters of unsheltered transient migrants concentrate. There are at times few paid facilitators engaged in this program. However, operations are always volunteer-run, consisting typically of a leading clinician, other attending physicians, medical students, and Spanish-English interpreters.

The Clinic is not the first health-related project that BSN has been involved with in Ciudad Juárez. Through formal and informal relationships (i.e., interpersonal and inter-organizational) established in Ciudad Juárez during 2019 and 2020, BSN was able to contribute

to the development of three health related projects for transient migrants there: 1) a health fund that provided support to those unable to access public health services; 2) a program that connected migrants, especially pregnant women and mothers, with legal and medical services as they remained in a state of immobility at the border; and 3) amidst the COVID-19 pandemic, establishing an ad hoc shelter where newly arrived migrants could be quarantined before joining established shelters, thus preventing the virus from spreading across the shelters themselves. BSN's role in these projects included providing economic support and provision of food, medical supplies, and medical professionals. This resulted in BSN continuing its partnerships in Ciudad Juárez, identifying healthcare to be an important long-term need, which was a vision that would later be consolidated with the Clinic.

The Clinic will be considered a microcosm for the broader medical infrastructure for transient migrants in the border region. This program exercises cross-border mobility, which then exposes volunteers to people and situations on both sides of the border. Data and models regarding medical conditions and treatment are thus exchanged between staff at the Shelter and U.S. medical volunteers. This is important because shared data are essential components in the transition to shared governance, particularly within the unique contexts of borders (Heyman, 2022, pp. 2 & 6). Regarding volunteer and soft infrastructures, the Clinic is a program that can shed light into the processes involved in developing a sustainable type of volunteer-based healthcare for transient migrants within the specific context of the border region.

The following chapter focuses on reviewing more extensively the literature concerning humanitarian volunteering, specifically healthcare for transient migrants, and the role of soft infrastructure and border dynamics.

CHAPTER 2: LITERATURE REVIEW

This chapter reviews academic literature related to humanitarian workers, particularly volunteers who provide healthcare to migrants, by organizing the first half of the discussion into key thematic sections: motivating factors, the role of the community, benefits and challenges, medical models, medical liability, compensation in volunteerism, and the role of immobility and borders. The second half discusses key concepts that shape my theoretical framework: pragmatic solidarity, structural violence, vulnerability, transnationalism, crisis, soft infrastructure, sustainability, and debates on humanitarianism (i.e., neutrality, criminalization, and negotiating space).

2.1 Motivating Factors in Medical Volunteerism for Migrant Healthcare

According to the United Nations Volunteers (UNV) program, formal and informal volunteering involve different motivations (2018, p. 11). It is a practice that typically requires providing personal time, knowledge, skills, energy, and resources (Seah et al., 2021, p. 1; Gomez et al., 2020, p. 3). Furthermore, Seah and colleagues show that the demand for volunteerism has increased in recent years, particularly within the field of medicine at the intersection of crisis (p. 1). They also stress that one of the global consequences of the COVID-19 pandemic was the shortage of healthcare workers in general, which increased the demand for not only professional physicians but also medical students who could volunteer supporting healthcare systems (p.1) In their qualitative study consisting of focus-group discussions and semi-structure interviews with 33 medical students (volunteers and non-volunteers) and volunteer supervisors in 2020, it was found that the key motivations identified

> can be applied to other volunteering contexts in various crisis situations: (1) increasing expression of values such as altruism, (2) seeking learning opportunities and experiences

> to understand world-views during health crises, (3) enhancing personal growth and psychological development, such as through the fulfillment of their calling and passion pursuit, (4) gaining career-related clinical skills and experiences, (5) fortifying social relationships with peers and beneficiaries (e.g., migrant workers), and (6) protecting oneself from feeling bored, purposeless and guilty for not helping (p. 12).

Additionally, part of the findings involved distinguishing that these motivating factors can be intrinsic (e.g., personal) and extrinsic (e.g., social) (p. 15).

However, a different study consisting of a cross-sectional approach among 121 preclinical medical students in 2016 and 2017 in Southeastern United States found that volunteerism in a student-run clinic for underserved and vulnerable populations was not correlated with service interest (Rogers, 2020, pp. 3-4). This study also showed that intent to work with vulnerable populations was not related to age, sex, race/ethnicity, being from a rural hometown, academic qualifications prior to medical school, or anticipated debt at medical school graduation (p. 3). What the study did found is those premedical students "with definite interest in caring for the underserved" had prior experiences doing so as volunteers in different settings prior to medical school (p. 5). Therefore, motivation to help vulnerable populations does not necessarily stem from institutional or socio-demographic variables. Furthermore, in a 12-week participatory study with volunteers providing humanitarian care to transient migrants at the US-Mexico border, Leif Johnson proposes "seduction" as a motivating factor in these endeavors arguing that sensational representations of the border can entice people to help (2015). Put differently, because the border is politicized and a contested site, it can attract people and influence their individual notions of political agency and thus motivations (Johnson, 2015).

Moreover, Gomez and colleagues explore in a more thorough manner the motivations that humanitarian volunteers have when they help vulnerable migrants at the U.S.-Mexico border (2020). Focusing on the role of empathy and compassion, a typology is proposed, meticulously

distinguishing between secular and faith-based motivations and deontological and moral-virtue motivations (Gomez et al., 2020). The taxonomical results involved the "Missionary," "Good Samaritan," "Do Gooder," and "Activist." The "Missionary," although rare in the study, is motivated by faith-based and religious principles committed to service, love, and solidarity. The "Good Samaritan," although it originates from faith-based organizations and is inspired by faith, does not consider faith a requirement for humanitarian practice. Instead, these volunteers include average people motivated by a secular notion of humanity. The "Do Gooder" is secular and driven by a strong desire to do good, dissipate suffering, and make of the world a better place. The "Activist" is strongly driven by social justice, human rights, often via a progressive political ideology and secular deontology, considering all life to have intrinsic value that ought to be protected.

The aforementioned typology that Gomez and colleagues propose helps better articulate humanitarian motivations vis-à-vis migration care, border enforcement, and security (2020). In their study they also show that the movement of migrants along the border—often deterred movement—corresponds with the movement of their humanitarian care (p. 2). They display and categorize diverse reasons that motivate humanitarian care for vulnerable populations in transit, specifically within the complex context of the border. Therefore, the evidence-based typology for humanitarian motivations at the border has the potential for providing local community organizations with a better understanding of what type of volunteers they have and how to channel their motivations more effectively (p. 1).

2.2 The Role of Community in Medical Volunteerism for Migrant Healthcare at the Intersection of Immobility and Transnationalism

The role of the community, especially in the peculiar context of the border, is an important factor determining the effectiveness of humanitarian care for transient migrants. To understand how this is true, it is first important to emphasize that what makes the border a peculiar setting is that it is a space where human im/mobility fluctuates. Border securitization, especially during the COVID-19 pandemic, "fundamentally shifted the management of human mobility" by imposing upon transient migrants a state of immobility (Castañeda, 2023, p. 2).

Moreover, im/mobility impacts the way medical volunteers provide healthcare to migrants. Polly Pallister-Wilkins highlights that "organized life-saving at borders is a relatively recent practice, intimately tied to changes in the way mobility is controlled and unequal mobility entrenched" (2022, pp. 19-20). A 2019 mixed methods study in Europe revealed that the healthcare provision for migrants differs according to the stage of the patient's migratory journey (e.g., whether they are still in transit or have arrived at their final destination) (Chiarenza et al., 2019). The study also found that factors determining the difference in healthcare for migrants includes legislative, financial, linguistic, and administrative barriers. It is important to emphasize the relationship between im/mobility and the barriers that determine the type of healthcare that migrants receive because this intersection alludes to why the community has played a pivotal role in addressing healthcare gaps for migrants. This is especially the case post-COVID-19 pandemic given that it amplified the importance of having better coordination and management in all levels of government and social mobilization, emphasizing the need to address volunteer scarcity and exhaustion of border health (Castañeda, 2023, p. 75).

Medical volunteers, particularly in El Paso, have been able to provide healthcare to migrants precisely because the community is actively involved, particularly through collaboration and partnership between local religious, nonprofit, and non-government organizations (Delgado et al., 2022, p. 8). Academic institutions can also be involved as part of the community by having medical students be more engaged with volunteering in the form of service-learning or internships (Seah et al., 2021, p. 13). Having strategic partnerships between hospitals, community organizations, and academic institutions has a strong potential to build spaces for volunteers to deliver healthcare services, especially during moments of crisis (Braund & Beck, 2021, p. 175; Seah et al., 2021, p. 15). For example, Caperon and colleagues employed a socio-ecological model to organize and analyze data from nine workshops with community members (mostly volunteers) involved in a large community health program in Europe between October 2020 and March 2021 (2022). They found that the factors needed for community engagement include social support, trust, community identity, physical spaces, political processes, economic status, and access to technology (p. 11).

Moreover, immobility confines people into experiencing uncertainty in multiple areas of their lives, including healthcare and displacement, especially at borders (Bélanger, 2019; Blue et al., 2021; Castañeda, 2023, p. 75). During moments of crisis, like a pandemic, transient populations tend to remain invisible and further marginalized from healthcare, among other services (Infante, et al., 2022; Tena Muñoz & Payán, 2023). This is important to emphasize because volunteers provide significant amounts of humanitarian care to the most vulnerable populations. According to the United States Census Bureau, during the peak of the pandemic, over half of the U.S. population who was over the age of 15 *informally* volunteered in different sectors—while nearly a quarter *formally* volunteered—which amounted to an estimated value of

4.1 billion hours and $122.9 billion (Schneider & Marshall, 2023, my emphasis). Regarding medical volunteers, Abbas and colleagues reveal that "much of the healthcare provided to migrants during the 2015–2017 crisis was by volunteers" (2018). While they conclude that medical volunteers "need to be supported by sufficiently strong healthcare, administrative and financial systems" (p. 8), within the context of the border, the systems that support medical volunteerism for transient migrants stem significantly from the community (Delgado et al., 2022, p. 8).

At borders, volunteer-based approaches in healthcare provision to migrants can be transnational despite its uncommonness (Castañeda, 2023, p. 7). For example, there have been instances of medical volunteers from the U.S. side of the border crossing into Mexican border cities to provide healthcare for transient migrants there (Martinez et al., 2022). Martinez and colleagues discuss the challenges of U.S medical volunteers providing healthcare to transient migrants in Tijuana, Mexico, showing that political and moral dilemmas among the volunteers often intersect (2022). More specifically, the authors explain medical volunteers navigating diminishing resources at border cities, high medical demands, and international travel restrictions, all of which can be considered part of the broader interplay between transnational violence and transnational solidarity (Martinez et al, 2022; Castañeda, 2023, p. 133). While the notion of transnational violence is understood from the point of view of policies that create insecure conditions for migrants, transnational solidarity is referred to the shared understanding of mutual interests and responsibilities among individuals or communities on both sides of the border. To this regard, Donnan & Wilson clarify that, at the border, transnationalism consists of

> border structures and organizations, immersed in the same or similar ways of acting, thinking and perceiving, which transcend the borderline between states, precisely because the people who share these cultural forms have more in common with each other than they do with the majority populations in their states" (1999, p. 80).

2.3 Benefits and Challenges in Medical Volunteerism

Medical volunteerism is typically a rewarding practice that can be both fulfilling and challenging (Keelan, 2015). As a medical volunteer herself, Keelan points out that benefits of volunteering generally include acquiring unique experiences, sharpening social and problem-solving skills, and improving knowledge of overall global health. Moreover, a qualitative study among 16 physicians in emergency care for undocumented migrants in Spain between June 2019 and March 2020, identified three main themes regarding the physicians' experiences: rediscovering humanistic medicine, leaving the personal and professional comfort zone, and improving medical emergency care (Granero-Molina et al., 2021). A more recent study shows that volunteers tend to feel satisfaction from sharing skills, contributing to a collective mission, and perceived impact on personal and professional identity (Badger et al., 2022).

Challenges, on the other hand, can vary especially if medical volunteers are providing healthcare to migrants, particularly those who are considered undocumented or unauthorized. A systematic review conducted in 2019 on qualitative studies researching challenges within the coordination process between healthcare services and volunteers found that, in terms of organizing, it is a challenge for volunteers to have a common understanding with any salaried person in the workspace, which is typically addressed by involving a volunteer coordinator (Fredriksen et al., 2020). Sandblom and Mangrio conducted a qualitative study to explore the experiences and challenges of nurses in Sweden who volunteer providing healthcare to asylum seekers (2016). Their results identify three categories: 1) structural inadequacy deviated from the conventional healthcare system; 2) ethical challenges involving making unforeseen decisions; and 3) personal impact regarding burnout and coping mechanisms (pp. 288-289). Given these three areas, the volunteer nurses embodied responsibly and ethical duty for migrants (p. 290).

Their caring work and related coping mechanisms were considered to be leveraged by the volunteer experience itself, which fostered a sense of purpose and fellowship.

Regarding burnout, a mixed methods study of 192 medical volunteers in Italy working in the reception system for "illegal" immigrants revealed that all participants experienced different levels of burnout because of a "large workload, mental fatigue, and lack of social support; inability to understand the language and cultural differences of the immigrants; having to deal with organizational problems that come up repeatedly" (Nonnis et al., 2020, p. 1). Moreover, a systematic review regarding providers' perspective on challenges in providing healthcare for migrants shows that these providers are highly influenced by differences in culture and language, limited institutional capacity, and conflicts between professional ethics and laws restricting healthcare rights to migrants (Suphanchaimat et al., 2015). Martinez and colleagues also emphasize that volunteers' challenges tend to include shared vulnerabilities, ethical dilemmas, and making difficult decisions (2022). Therefore, the challenges of medical volunteers assisting migrants can be generally viewed as both structural and ethical.

Keelan recommends having realistic expectations being aware of possible challenges that can be experienced while volunteering (e.g., emotional impact) (2015). This is important because, despite volunteers' good intentions, there are often unintended consequences to their humanitarian work (Huschke, 2014). Among the challenges that require careful navigation is the sharing of information that volunteers gather while they provide care to migrants (Clayton et al., 2020). This includes informally obtaining information and sharing it not only with the public but also between organizations or institutions (p. 204). The hesitancy to share information related to migrant care is justified for the purposes of protecting both the migrants and the humanitarian workers themselves. Information can be weaponized or instrumentalized by law enforcement

authorities and anti-immigration activists for the purposes of inflicting violence to migrants and those who help them (Clayton et al., 2020).

Furthermore, regarding language barriers, especially in a binational setting, the usage of medical interpreters is a crucial aspect in providing healthcare to transient migrants. However, despite "undergoing a process of professionalization", the "role of the medical interpreter remains unstandardized and often undefined" (Castañeda, 2023, p. 62). Additionally, the usage of medical interpreters lacks diversity and inclusivity, especially regarding indigenous languages. The consequences of this, for example, have been documented in how U.S. immigration authorities systematically deny healthcare for migrants who speak indigenous languages (Slack et al., 2018).

2.4 Medical Models, Medical Liability, & the Role of Compensation

Regarding the types of approaches that medical volunteers can have, it is worth identifying differences between medical models. Particularly understanding and navigating the role of culture in healthcare provision refers to cultural competency, which is a crucial yet debatable aspect of the *explanatory* model in healthcare (Castañeda, 2023, pp. 62-63). The explanatory model prioritizes patients' perceptions and explanations regarding their own health and illness, which contrasts the broader and positivist conception of health that is used in the *biomedical* model (p. 123). The biomedical model is the conventional practice of medicine in the United States (p. 124). Highlighting this is important because healthcare for transient migrants at the border may require operating outside conventional models and formal settings (Martinez et al, 2022, p. 277).

Regardless of the approach that medical volunteers employ when they provide healthcare, it is important to highlight that their practice can be restricted by broader structures like medical liability. While medical volunteers, particularly physicians, often provide free or low-cost care to vulnerable populations in different settings like clinics and shelters, their practice raises liability concerns related to potential malpractice and the limits of Good Samaritan laws (e.g., the Good Samaritan Health Professionals Act, HR 1733, 133th Congress)[2] (2013). Federal and state laws provide limited protection to physician volunteers with laws like the Volunteer Protection Act and the Federal Tort Claims Act (Benrud et al., 2010, pp. 207-209). However, these laws vary across the country and does not necessarily protect volunteers in all cases. Therefore, Benrud and colleagues suggest that physician volunteers inform themselves about the protections that their state offer and obtain personal insurance coverage, stressing that "[f]ears of liability should not deter physicians from volunteering" (p. 211).

Furthermore, there is a debate on whether volunteerism should be compensated and if doing so can deter the value that stems from the practice itself. For example, George L. Head discusses the potential risks involved in compensating volunteers, stressing that while some organizations may want to express gratitude to their volunteers by giving them something, doing so ambiguates the distinction between paid and volunteer work (2024). Therefore, Head suggests that instead of providing compensation, volunteers can be supported by having their expenses while volunteering covered (e.g., reimbursements), providing them with social events, and publicly acknowledging their contributions (p. 4). Moreover, Rocio López-Cabrera and colleagues discuss the tensions that emerge between paid staff and volunteers working for a non-

[2] The "Good Samaritan Health Professionals Act of 2013" attempts to amend the Public Health Service Act to limit the liability of medical professionals who volunteer providing healthcare during "disasters" if they have good faith belief of an urgent need.

profit organization (2020, p. 1). By emphasizing the role of organizational structure and assigned responsibilities, they identified four areas of conflicts: task, process, status and relationship (p. 3). With these distinctions, the authors make the case that paid staff and volunteers perceive conflicts differently in the clinical setting. Paid staff experience higher levels of conflicts, possibly related to their role and responsibilities (p. 2). Volunteers were reported to be flexible and able to freely disengage from the organization while paid staff tend to face more pressure and dependency on the organization (p. 5). This taxonomy and reasons for differences in experience between paid and volunteer work helps disentangle the processes that influence the soft factors in a volunteer-based clinical setting.

2.5 Pragmatic Solidarity, Structural Violence, & Vulnerability

Medical volunteers who help transient migrants at the border do not exist in a vacuum. What they do and how they do it has implications within broader dynamics of power. Regarding healthcare for vulnerable populations, Paul Farmer proposes the notion of "pragmatic solidarity" as a framework to respond to "structural violence" by employing praxes that address the root causes that perpetuate social inequalities and injustice (2004, pp. 8 & 20). Pragmatic solidarity is meant to be a sustainable and long-term intervention as a way to adequately address structural violence. For Farmer, the notion of structural violence is helpful for exploring and better understanding how human rights, especially health, are violated systematically through different structures (e.g., economic and political). To adequately grasp the role of structural violence, Farmer stresses to avoid reductive understandings and, instead, consider how social structures intersect to perpetuate health disparities (p. 43). For Heide Castañeda, structural violence is typically employed in medical academic fields to "explain the processes by which the

arrangement of social institutions causes harm by depriving people of resources or preventing them from reaching their potential" (2023, p. 23). Keeping all of this in mind helps understand medical volunteer approaches and their effectiveness in the contexts of violence.

Furthermore, by focusing on multiple case studies, Carruth and colleagues employ the notion of structural vulnerability to analyze challenges in clinical care and healthcare advocacy for migrants within the context of the U.S.-Mexico border and Dijibouti, Africa (2021). Structural vulnerability refers to structural violence vis-á-vis vulnerability to grasp not only how broad social, political, and economic structures influence health but also that health itself is not merely driven from an individual or cultural level (Carruth et al., 2021; Martinez et al., 2022, p. 276; Castañeda, 2023, p. 23). This is particularly important as Carruth and colleagues show how even though migrants and their providers face different types of structural vulnerabilities, these are entangled within global migration systems (2021). Precisely because life does not exist in a vacuum, "migrant vulnerability shapes the lives of non-migrants and communities connected to them" (Castañeda, 2023, p. 129). More specifically, the health of local communities is intertwined with the health of transient migrants (Tena Muñoz & Payán, 2023).

Moreover, because medical volunteers who help migrants at the border are situated in a bi-national context, Martinez and colleagues evoke the concept of "transnational solidarity" (2022). They state that transnational solidarity can be understood as an ethics that has guided medical volunteers into identifying and challenging the structural vulnerabilities that migrants experience at the border. More specifically, by challenging stigmatization, providing in-person or telehealth care to those with limited access to services, and channeling critical resources across and along borders (Castañeda, 2023, p. 278).

2.6 Implications of Perceived Crisis at the Border in Medical Volunteerism

To make sense of phenomena pertaining to migration and health, the notion of *crisis* is employed and qualified in multiple ways using words like migrant, humanitarian, asylum, border, national, security, medical, and health. Therefore, it is worth examining the notion of crisis itself, paying attention to its role in how people perceive reality, how volunteers and even nation-states organize around the notion of crisis, and the possible consequences of such perceptions. According to Greg Beckett, the concept of crisis has historically denoted a crucial disruption often perceived as a scientifically objective condition and overlooking its etymology from ancient Greek medical practice where crisis refers to the life-threatening turning point in experiencing a disease, where the patient will either die or live (2019, pp. 12-13). Crises are overwhelming circumstances that always involve individuals. They are situations where people can act in meaningful ways and attempt to critically make sense of their situation. In this sense, this notion of crisis helps recognize that when medical volunteers provide healthcare to transient migrants at the border where notions of crisis prevail, they do so as a necessity to intervene in a situation that is urgent and potentially life-threatening.

In the context of the border, controversial politics over the perception of migration has been physically and symbolically productive, contributing to the establishment of physical border infrastructures and symbolic notions of crisis (Heyman et al., 2018, p. 774). These two are interconnected, specifically as diverse, sophisticated, and expensive forms of border-immigration enforcement that create "ways of seeing", or perceptions of crisis attributed to migrants (Nevins, 2010, pp. 11-12). Additionally, the way a migration crisis is expressed via language influences the notion of deservingness that people assign to newcomers in the community or nation, which "shapes and reflects policies of entitlement and exclusion" (Castañeda, 2023, pp. 24 & 128). The

way crisis is perceived has implications in how the general public feels, which becomes part of the context in which medical volunteers intervene providing healthcare to migrants at the border. Using an interpretive phenomenological approach, Correa-Cabrera and Garret identified that, due to a perceived migrant crisis occurring at the border, the phenomenology of perception related to border security increasingly involves fear, all of which prevents meaningful political dialogue on immigration and border policies (2014). This is something that not only impacts local border communities but also confuses and divides national opinions on realities at the border vis-à-vis migration (Heyman et al., 2018, p. 776). However, although the physical and symbolic power of the border can create divisions, they can be contested by relationships and community (López, 2024), which medical volunteers can do as it was aforementioned in the sections on pragmatic solidarity and transnationalism.

2.7 Soft Infrastructure, Crisis, & Sustainability

Before further inquiring into volunteerism and humanitarianism, it is worth mentioning how soft infrastructure is understood and what role it can play in space, crisis, and sustainability. For Ho and colleagues, soft infrastructure involves values, customs, laws, and institutions, all of which are part of the living environment which conditions how people relate with each other (2023). According to Kavanaugh and colleagues, soft infrastructure includes intangible soft factors like "relationships, safe spaces, trust and hope, self-efficacy, and worldview" (2022, p. 7). They emphasize that to strengthen soft infrastructure it is important to not only build multi-level relationships between people and organizations but also recognize *space* as having a functional and symbolic role attributing value and identity (pp. 1 & 4, my emphasis). Therefore, physical space or infrastructure is intertwined with soft infrastructure.

Isabel Gutierrez Sanchez conducted an ethnographic study in Athens, Greece, and revealed that grassroot initiatives can reshape "networked infrastructures" by engaging factors like relationality, care, and repair— stressing the role of soft infrastructure—in achieving sustainability for life in crisis (2022). Here, the notion of infrastructure in general is examined through the concept of "infrastructuring" which is defined as a "practice of connecting people and things in socio-material relations that sustain urban life" (pp. 2458-2459). Gutierrez Sanchez argues that grassroot initiatives can engage in "infrastructuring care through commoning," by which she means creating social "systems where resources, capacities, agencies and affects are in constant circulation and reconfiguration, accommodating to emerging needs and desires" (p. 2470). The idea is that grassroot initiatives can play a role in proposing alternative notions of care and organizational models with the potential of decentralizing traditional hierarchical and bureaucratic institutions for the purposes of achieving sustainability, especially in a situation of crisis (pp. 2458 & 2471). This is important to emphasize when thinking about how medical volunteers and the community at large can develop sustainable humanitarian care for transient migrants in a transnational border setting, as per the previous sections in this literature review.

Moreover, in a methodological study Omer and colleagues highlight that infrastructure in general is typically tested and put on trial in moments of crisis where it is possible to identify its capacity for resilience (2014, p. 565). They specifically focus on how this is the case for soft infrastructure, which they understand as "the institutions and enterprises that are crucial for social and economic continuity" (p. 566). For them, resilience in soft infrastructure involves not only having emergency plans but, also, an "organizational foundation" (p. 566). Additionally, they make the case that factors for achieving an organizational foundation for soft infrastructure includes leadership, awareness, flexibility, preparedness, and culture (pp. 566-567).

2.8 Debates on Humanitarianism & Neutrality

There is a debate on what humanitarianism is and whether it should be politically neutral to maximize its goals in different social contexts (Bortolotti, 2010; Hoekstra, 2021, p. 1). Dan Bortolotti discusses the difference between humanitarian and human-rights organizations, distinguishing that the latter is more activist-oriented while the former tends to remain neutral for the purposes of accessing the diverse spaces where humanitarian help is most needed, which tend to be violent spaces difficult to enter (2010, pp. 9 & 287). However, achieving neutrality is often a challenge, if not impossible. For example, through a systematic review, Broussard and colleagues identified that the most common ethical challenges faced by humanitarian healthcare organizations (not necessarily volunteers) includes providing high-quality care, protecting workers, and minimizing unintended harms, all while having "neutrality" to be the most common humanitarian principle that is challenging to uphold (2019, pp. 4-6 & 9). According to Castañeda and colleagues, humanitarian practices cannot be neutral because they are not separated from the political; for example, volunteers, activists, and NGOs for migrant care who typically respond to controls and regulations of human mobility (2016, p. 8).

Furthermore, humanitarian intervention, especially international, is understandably criticized given that it has been the excuse colonial powers have to invade territories or inflict violence on people (Bortolotti, 2010, p. 51). For example, Polly Pallister-Wilkins highlights that apart from having "a history intimately linked to colonialism, abolition and whiteness," humanitarianism is also "a product of the same paternalism we can observe in the global colour line by which, in both cases, there is an assumed hierarchy between those who can care for themselves and those who cannot" (2022). Moreover, focusing on the Arizona-Mexico border throughout the years since 2000, Jill M. Williams discusses the emergence and development of

what is known as the "humanitarian border," which refers to organized humanitarian responses to provide care specifically for transient migrants who experience violence at borders (2015, p. 11). She points out that whereas humanitarian care for migrants at the border represented a type of "exception", it has now taken a shift towards being "contingent", meaning that "care now functions as a technology of border enforcement" over bodies and spaces (pp. 12, 15, & 18).

Additionally, Irmgard Bauer makes the case that medical volunteering throughout the world consists of mixed sentiments and portrayals, particularly regarding the "dark side of international volunteering" where people from the global north travel to the global south to inflict more harm than good in the form of medical care (2017, p. 2). Ethical concerns surrounding international medical volunteering are prevalent and thus different types of criticisms have emerged often condemning the international practice itself. However, as opposed to fully condemning this type of international volunteering, Bauer stresses that constant and critical scrutiny can instead pave the way towards practical modifications and "alleviation" regarding contemporary international medical volunteerism (pp. 1 & 9-10). Henceforth, a careful, complex, and thus non-reductive understanding of medical volunteerism is necessary, especially involving a deeper understanding of motivations, abilities, limitations, and experiences (p. 10). All of this is important to keep in mind moving forward thinking about medical volunteers who may be politically neutral or have good intentions but falling victim to the historical and implicit instrumentalization of their service.

Although humanitarianism can adopt a transnational perspective by extending care across national borders and beyond univocal notions of citizenship, protecting lives outside state jurisdiction can simultaneously reinforce territorial sovereignty (Williams, 2015, p. 18). Similarly, in her dissertation consisting of an ethnographic study involving participant

observation and interviews with medical volunteers providing healthcare to uninsured, undocumented immigrants in the United States, Erin Hoekstra argues that clinics can operate as spaces where border and immigration policies are enforced (2019). These are unintended consequences that stem in part from "a medicalized belonging based on common humanity," which Hoekstra refers to as "biocitizenship" (Hoerkstra, 2019). To this regard, Pallister-Wilkins also mentions that "humanitarianism offers an alternative way of approaching the world, rooted in solidarity with humanity as a whole and thereby challenging the territorially and socially divisive state system and political policies that create and enforce inequality" (2022).

From a critical and historical perspective, Didier Fassin (2012) says that humanitarianism's "invocation is so powerful that it can serve as grounds for military action, allegedly to protect endangered populations" (p. xi). However, this does not mean that humanitarianism cannot be carefully and critically employed. Therefore, Fassin proposes the term "humanitarian reason" to adequately grasp—without mere reductions— the paradoxical relationship between the moral and political aspects of humanitarian intentions and practice (pp. xii, 2, 244, 252). He makes of humanitarianism a mode of thinking that can be used to negotiate the relationship between care and control during humanitarian intervention (Fassin, 2012; Pallister-Wilinks, 2022). This helps justify that medical volunteers can be actively, critically, and consciously engaged in humanitarian work as opposed to being passive, neutral, and reactionary workers.

However, Heide Castañeda points out that humanitarian practices can also limit systems of care and be the excuse that governments have to absolve themselves from responsibility and accountability, which is worth quoting at full length:

> As charities and humanitarian organizations step in to provide necessary services, their work can intentionally legitimize shrinking public safety nets and tend to complicate the

> politics of care, create new forms of inequality. These efforts offer only short-term, improvisational solutions and can translate into absolving the state of its responsibilities. (2023, p. 9)

This is an argument that is similarly shared with Pallister-Wilkins who, thinking specifically from the perspective of the border, says that humanitarian care "remains rooted in operational responses rather than structural solutions capable of challenging the unequal mobility upon which it rests" (2022). Therefore, it is important to recognize potential limitations and unintended consequences that medical volunteers can have in their healthcare provision to migrants at the border.

2.9 Criminalization of Humanitarianism

Criticisms of humanitarianism can go as far as to criminalizing it. This is seen in the U.S.-Mexico border, where the criminalization of humanitarian care, especially for transient migrants, is a common practice (Carruth et al., 2021, p. 3). Furthermore, through a qualitative study consisting of 10 semi-structured interviews from members of NGOs in Slovenia, conducted between November 2017 and May 2018, Vlasta Jalušič discusses the criminalization and restriction of humanitarian practices that provide care to transient migrants (2019, pp. 111-112). She identifies five types of "crimmigration" policies that reduce the space of humanitarian care for migrants: 1) criticism, public attacks, discreditation, and harassment; 2) bureaucratic tightening by restricting access and obstructing work; 3) completely banning access and prohibiting monitoring; 4) labeling organizations or people as "dangerous"; and 5) direct criminalization (pp. 113-117).

Moreover, Mainwaring & Debono focus on the criminalization of NGOs in the Mediterranean Sea between 2015 to 2017 when over 110,000 migrants were rescued (2021, p.

1031). They show how the practice of solidarity for migrants by NGOs was perceived as a form of colluding with human smugglers (p. 1038). With this information, they argue that this criminalization of humanitarian care is facilitated by a "neo-colonial" imagination of the sea as belonging to a few but also as lawless where state responsibility for saving migrants is absolved (pp. 1032, 1040). Additionally, the authors suggest that although the criminalization of humanitarian care may determine its limits, NGOs continue to provide care for migrants and propose alternative imaginaries advocating for human rights (e.g., the right to life and mobility) (p. 1043).

Regarding the Mediterranean Sea more specifically, Fekete documented a conversation among multiple stakeholders about the migrant crisis in the region, ranging from academics and representatives of NGOs to members of the European Parliament, together discussing topics like the "criminalization of solidarity", EU agreements with countries, the role of NGOs, and legal frameworks (2018). The conversation explored the challenges faced by humanitarian organizations that provide care to migrants, highlighting that EU member states have responded to unprecedented numbers of refugees by invoking securitization of borders and criminalization of humanitarian aid (pp. 65, 68, 72). Consequently, when providing search and rescue operations in the Mediterranean Sea, NGOs simultaneously face legal challenges given that their humanitarian care has been increasingly perceived as unlawful resistance (pp. 69, 74-75).

In a more recent study, Dadusc and Mudu provide a critical analysis of the criminalization of humanitarian solidarity with migrants in Europe in the context of border control policies (2022). They argue that a form of autonomous solidarity —or opposition— can exist even when humanitarian practices comply with—or reinforce— border regimes. Also, Dadusc and Mudu differentiate between autonomous solidarity and traditional humanitarianism

where the latter implicitly supports the border regime while the former actively resists it by, for example, refusing to cooperate with authorities. It is emphasized that while humanitarian solidarity with migrants tends to be criminalized through legal arrangements, those responsible for human rights violation and violence towards migrants, particularly at borders, often go unpunished. Therefore, the authors also propose the concept of Humanitarian Industrial Complex to refer to the actors (e.g., NGOs and government) involved in the regulation/control of migration, which often intersects with the so-called Immigration Industrial Complex and Prison Industrial Complex.

2.10 Humanitarian Space & Relationship with Governments

As humanitarianism is criticized and criminalized, there is a preoccupation that the spaces where these types of practices occur are "shrinking" (Allié, 2011, p. 1). As a result of these restrictions, humanitarian practices and spaces are negotiated, which involves "power games and interest-seeking between aid actors and authorities (pp. 2-3). In the case of the international humanitarian organization known as *Médecins Sans Frontières* (i.e., Doctors Without Borders), even its name can lead to suggest that it has the right to freely intervene internationally to provide much needed humanitarian care (Bortolotti, 2010, pp. 151-152). However, Bortolotti emphasizes that *Médecins Sans Frontières* (MSF) first seeks the permission of the local authorities where they plan to intervene (p. 150). This practice stems from the notion that "[b]eing in touch with authorities is one of the foundations of humanitarianism" (p. 152). Similarly, Marie-Pierre Allié, who was the president (2007-2013) of the French section of MSF, emphasized that the organization's

> freedom of action is not rooted in a legal and moral 'space of sovereignty' that simply needs to be proclaimed in order to be automatically acknowledged and respected. It is the

> product of repeated transactions with local and international political and military forces (2011, p. 3).

In this sense, referring to humanitarian action, Bortolotti emphasizes that it "aims to *build spaces* of normalcy in the midst of what is abnormal" (2010, p. 291, emphasis by me). This point is important to consider when thinking about how medical volunteers negotiate and use spaces for humanitarian care at the border.

Furthermore, David Reiff emphasizes that the humanitarian space itself is not fixed and unchanging but, instead, should be perceived as a constant negotiation within the "relations of force and of interest between aid groups and the authorities" (2011, p. 256). Additionally, Reiff stresses that solutions do not involve only securing humanitarian space but recognizing that humanitarian action does not exist independently from the contexts in which it occurs, which implies having to constantly defend humanitarian autonomy by not being politically neutral (pp. 253-254). Similarly, referring to MSF, Bortolotti mentions that

> humanitarianism does not exist in a vacuum, it operates in a dirty reality, and that forces you to struggle with your principles…*San frontières* [without borders] is a mentality—it's always about engaging with ugly realities so that you can get something done (2010, p. 152).

In the context of the U.S.-Mexico border, issues on one side of the border can transcend onto the other side, and to be addressed they require multi-level cross-border collaborations, which is difficult to establish given that national sovereignty limits the development of local border governance (Payan & Cruz, 2020). Border actors from both sides should find ways to develop governance where together they first identify shared needs/interests, then make decisions and coordinate in achieving addressing these "commons," all of which includes developing networks that facilitate collaboration between different levels of society (e.g., public and private sectors) (Jurado Flores & Sarabia Ríos, 2020; Heyman, 2022, p. 10). Josiah Heyman

highlights that by "*creating diverse arenas and spaces* of interested participants having shared practical concerns, and by imbuing these with a social imaginary of being a commons, it might be possible to address this problematic effect of bounded nation-states" (2022, p. 10, my emphasis). Indeed, borders can represent a space of opportunity, especially for those who live there and thus negotiate or, in a way, leverage the micro and macro structures, actions, and values that constitutes borders themselves (Donnan & Wilson, 1999, p. 87).

2.11 Overview

This literature review shows that existing research indeed provides valuable insights into the general types of medical volunteering motivations, corresponding experiences along with challenges, and the role of the community, particularly within the context of crisis. It is clear that medical volunteerism for migrants is conditioned by broader structures and discourses adding layers of complexity that are seen in the ethical dilemmas and perceptions that volunteers encounter. Additionally, the literature shows that humanitarianism is well debated, criticized, defended, and even criminalized. Therefore, humanitarian spaces are typically negotiated with stakeholders and restricted by social structures. Having all of this in mind, the notions of violence, vulnerability, solidarity, immobility, and crisis all provide important insight for my theoretical framework to understand the development of medical volunteerism for transient migrants at the border.

However, pertaining humanitarian volunteering—particularly medical—for transient migrants specifically at the U.S.-Mexico border, a noteworthy gap exists as the literature neglects the explicit consideration of soft infrastructure (i.e., intangible soft factors that facilitate social interactions). Additionally, apart from being relatively outdated (i.e., prior-COVID-19), the

literature focuses on medical students as opposed to more medical professionals volunteering, all mostly in the context of European countries. This gap underscores the need for more exploration and understanding of the soft factors that consolidates and sustains volunteerism for migrant healthcare at the border region. Moreover, because this type of volunteerism occurs within the context of a border region, more research is needed regarding the role that border dynamics may have in the practice itself.

CHAPTER 3: METHODOLOGY

As I was preparing for data collection after having received IRB approval, the Clinic suspended its operations. Consequently, I was not able to conduct participant observation at the Shelter, as I had foreseen. This meant that my data was going to stem mostly from interviews. It was clear to me that inquiring about the sustainability of the Clinic was pressing, particularly from the point of view of the facilitators and medical volunteers.

This chapter presents the research questions for the study and describes its design. I introduce the sample size and illustrate the key distinctions between the participants. Although the primary site of this research is the Clinic in and outside the Shelter, I emphasize the settings that grounds the information collected from the participants. Additionally, I explain my approach in analyzing and organizing the qualitative data stemming from interviews and limited participant observations.

3.1 Research Questions

To focus on the role of soft infrastructure in developing sustainable volunteer-based healthcare for transient migrants at the intersection of the border and im/mobility, this research was driven by the following questions.

3.1.1 Central Research Questions

1. How does volunteer-based healthcare for transient migrant in the border region develop into a sustainable program?
2. What are the challenges in developing sustainable healthcare for transient migrants in the border region?

3.1.2 Secondary Questions

3. How do border dynamics like the interplay between *mobility* and *immobility* shape the practice of this type of volunteerism?
4. How does the framing of formal and informal medical volunteering shape their service?
5. What are the differences in the experience of volunteering among medical students and physicians?
6. How are volunteer medical providers recruited and what are the challenges in doing so?
7. In what way does the social rhetoric of "crisis" motivate (or not) these volunteers to provide healthcare to transient migrants?
8. What moral and ethical principles inform their work in this context?
9. To what extent do local/border dynamics of language and culture influence sensitivity in healthcare for transient migrants?
10. How might the experiences of these volunteer medical providers inform alternative visions for healthcare in the U.S.?

3.2 Research Design

3.2.1 Research Site

This research is qualitative, focusing on the Clinic where I volunteered as a co-coordinator and interpreter between February and December 2023. Part of my job while volunteering included providing transportation to volunteer medical providers from El Paso into the Shelter across the international border. Consequently, I developed a personal and professional network with volunteer medical providers assisting transient migrants in the border region, which is the basis for a purposive sample in this research. Therefore, this is a community

collaboration-based research involving partnership with BSN. This involved crossing the international border into Ciudad Juárez.

Given that I was allowed to access the Clinic's sites of operations and collaborate in them, participatory observation was briefly conducted—not inside the Shelter due to the pause of operations there but outside—where "street" clinics were set up, particularly between the period of January and April 2024. Pictures were taken in these street clinics and were slightly modified to make sure privacy was preserved along with the confidentiality of people. I consulted some secondary sources, like news articles, to reconstruct some events related to the topic of research and contextualize the data I gathered through primarily interviews and some participant observation documented as fieldnotes.

3.2.2 Sample

The sample is purposive and therefore not a representative population. The selection criteria for participants involved: a) being 18 years old or older; b) being fluent in either English or Spanish; c) to have volunteered in the past or be a current volunteer in El Paso and/or Ciudad Juárez; and d) volunteering either providing or facilitating healthcare to transient migrants between the period of October 2022 and December 2023, namely, the time period that the Clinic was active before suspending operations. This included medical students, residents, physicians, and physician assistants, as well as leaders in the establishment and/or management of the program (See Appendix A). Although the Clinic was my primary site, I also employed snowball sampling to seek interviewing people volunteering for other organizations both in El Paso and Ciudad Juárez. This allowed me to expand the scope of the project and allow the inclusion of a preliminary comparative qualitative analysis between soft infrastructures among different

volunteer-based healthcare programs for transient migrants at the border region. Although this research focused on volunteers, I also interviewed people who might have been paid at some point but who nonetheless have taken a central role in facilitating volunteering activities. This helps have a multi-level perspective of the sustainability of a volunteer-based healthcare program for transient migrants at the border region. Anyone who was only getting paid for providing healthcare to transient migrants at the time of the interview was excluded.

3.2.3 Participants & Settings

My sample size is of 11 participants (ages ranging between 25 to 70 years). Therefore, I conducted and audio-recorded 11 semi-structured open-ended interviews, particularly after obtaining participants' informed consent and creating an interview guide informed by the research questions and literature (See Appendix B). The involvement of each participant consisted of being interviewed one time in-person or virtually lasting between 60 and 90 minutes. Two of these interviews were conducted in Spanish and translated by me into English during the transcription stage. For privacy, I will not state which interviews were translated. The structure of the interviews involved a funneling approach, where I began with a general question and then asked more specific ones. No interviews were conducted while volunteers were scheduled to provide healthcare to transient migrants. The time and place for interviews depended on the participant's preference so long as their privacy and confidentiality were secured. As such, some interviews were conducted at the Center for Inter-American and Border Studies or participants' workplaces, provided they had authority to use their workspace in that way.

The 11 participants can be distinguished in two categories: medically trained participants who volunteer without economic compensation; and 2) non-medically trained salaried participants who play a key role in facilitating volunteers' work. The former can be further divided between medical students, physician's assistants, occupational therapist, and physicians. The medical students are Mayra, Emily, and Diego. The only physician's assistant is Henry. Rose is an occupational therapist. Both Henry and Rose are retired. The physicians are Paul, Helen, and Sandra. And the facilitators, Sofia, Thomas, and Francisco (See Figure 2).

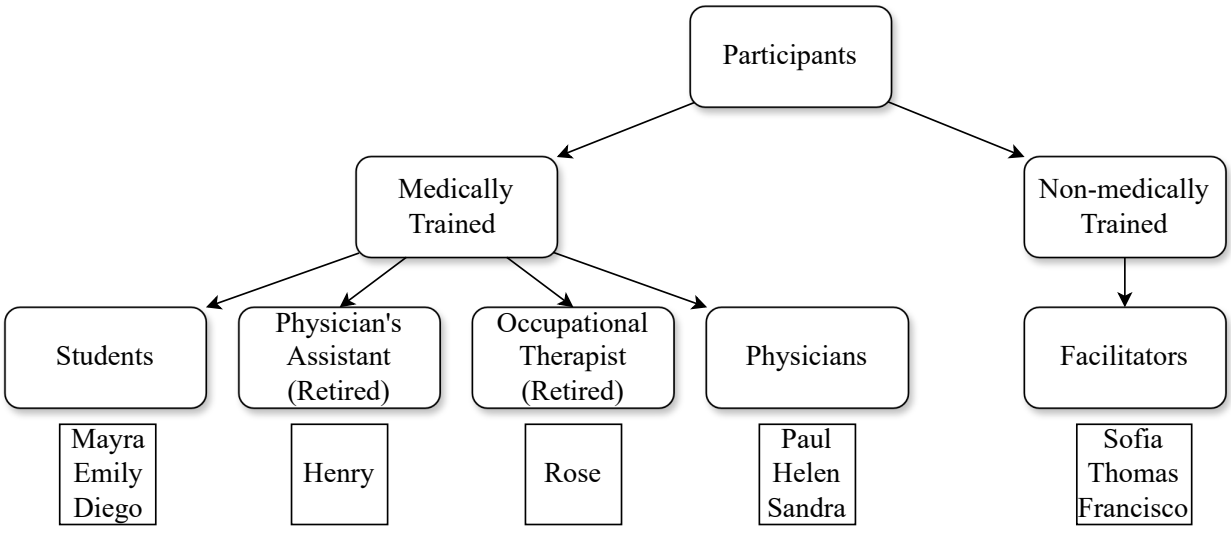

Figure 2 Research Participants

Furthermore, there are multiple settings that ground the content of the results because they are spaces that many participants mentioned as central in their volunteering experiences (See Figure 3). In Ciudad Juárez, the Clinic program would operate inside and outside the Shelter. Inside the Shelter, the Clinic consisted of a stable clinical room with medical equipment and medications at hand. Outside the Shelter, the Clinic would turn into a mobile "street" clinic, meaning an informal establishment consisting of one table, limited resources, and medical volunteers in streets of Ciudad Juárez where clusters of unsheltered transient migrants were

expected to be. The Clinic's operations inside and outside the Shelter are considered the primary settings in this research. In El Paso, there is another program that provides healthcare to transient migrants, which uses a designated space inside a church. In this sense, space is an important factor in this story because it shapes the type of soft infrastructure that is developed among the participants, which will be discussed further in the next chapters.

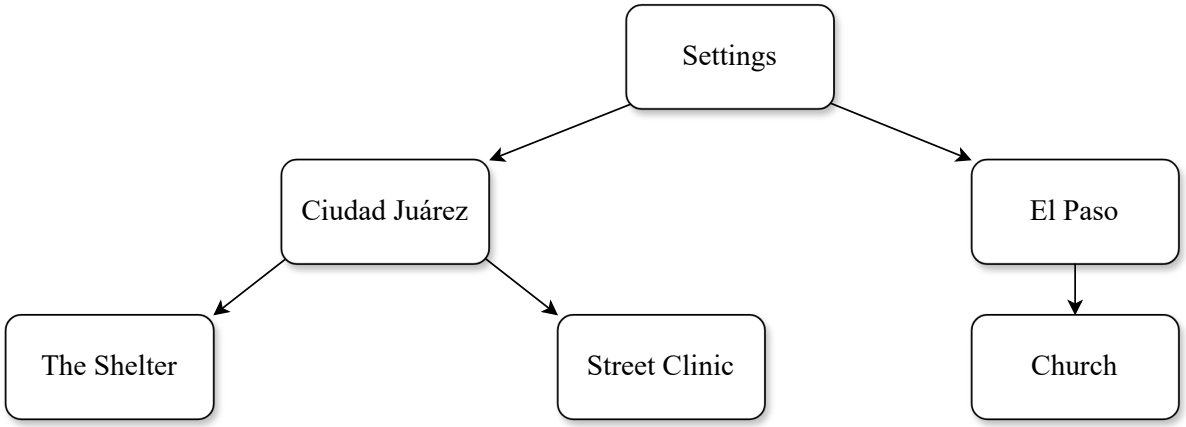

Figure 3 Key Settings

3.3 Data Analysis

Considering the types of questions and scope driving this research, thematic analysis was conducted preliminarily post-data collection (Dusi & Stevens, 2023). The qualitative data was organized, coded, and analyzed thematically and manually. Some of the codes emerged from the data (e.g., medical liability, discussed in detail in the results and discussion chapters) while others stemmed from the notion of soft infrastructure (e.g., motivations, worldviews, and trust). All of the participants' names are pseudonyms. Similarly, to reiterate, the Border Solidarity Network (BSN) is a pseudonym. When referring to a program, organization, or institution that is central to the research, it will be mentioned by having its general noun capitalized (e.g., the Clinic, the Shelter, the Organization, the Local Hospital). The only real names are of the cities El

Paso and Ciudad Juárez. To organize the data and guide the thematic analysis— and given that sustainability is best understood holistically—a socio-ecological model was employed (Simon, 2014).

3.3.1 Socio-ecological Model

The socio-ecological model (see Figure 4) used in this research is adapted from two sources, namely, Ma and colleagues (2017) and the Centers for Disease Control and Prevention (2022). This model is a framework used in multiple disciplines like public health and sociology that helps organize the different levels of a health-related phenomenon, namely, the intrapersonal, interpersonal, institutional, community, and societal levels. The intrapersonal level consists of biological and subjective factors like age, motivations, worldview, and knowledge. Interpersonal refers to social relationships (e.g., family, and friends), behaviors and collective experience. The institutional level is distinguished from community in that the former involves individual organizations or institutions (e.g., schools and NGOs) while the latter refers to inter-organizational networks in a broader region (e.g., the Paso del Norte region). Lastly, the societal level encompasses the broader social factors the grounds the other levels (e.g., policies and cultural norms). As such, this model helps identify the multi-dimensional aspects of volunteer-based healthcare for transient migrants in the border region. It identifies the interconnectedness between the different levels where, for example, worldviews at an intrapersonal level can shape the institutions that emerge within the community.

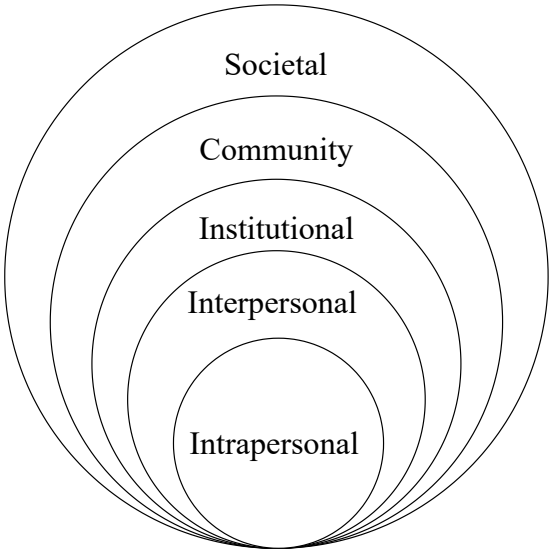

Figure 4 Socio-Ecological Model

3.3.2 Thematic Analysis

While finalizing data collection, the preliminary analysis showed that some participants thought the Clinic had completely terminated while others perceived a pause where learning from mistakes was taking place for the purposes of reconfiguring the structure of the Clinic. Understanding the distinctions in perception regarding the Clinic's existence and future turned into important subject matters moving forward into the overall analysis of the role of soft infrastructure in the development of a sustainable volunteer-based healthcare for transient migrants at the border region. After finalizing data collection and data analysis, the three main themes can be defined as: 1) developing and formalizing an inter-organizational cross-border partnership; 2) building volunteer capacity; and 3) navigating borders of legality pertaining to medical liability. Each main theme has several sub-themes referred to as soft factors, all of which will be described in the next chapter.

CHAPTER 4: RESULTS

In this chapter I set out to show that, according to my findings, the challenges in developing a sustainable volunteer-based healthcare program for transient migrants in the border region are related to the three following key themes: 1) inter-organizational cross-border partnership; 2) volunteer capacity; and 3) medical liability (See Figure 5).

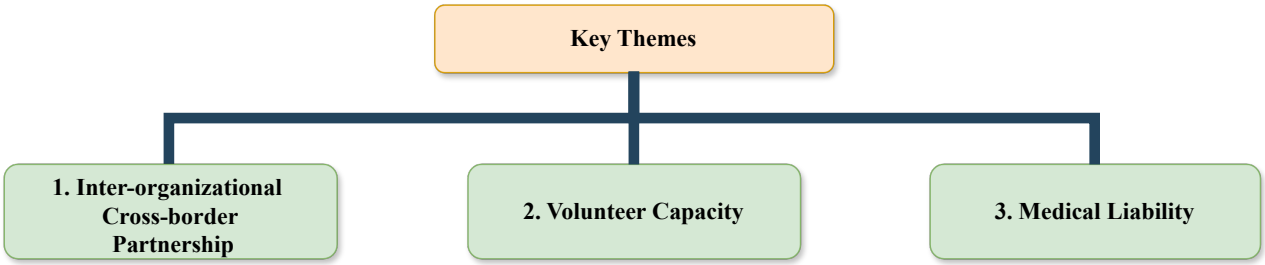

Figure 5 Key Themes

These key themes each consist of soft factors like motivations, worldviews, trust, hope, etc., that are parts of the general soft infrastructure in play. Through the data collected, I show the complex, sometimes contradicting, web of soft factors in developing a sustainable volunteer-based healthcare program for transient migrants in the border region. As such, this chapter is divided in three sections, each focusing on a key theme.

The first key theme refers to developing and formalizing an inter-organizational cross-border partnership, particularly as a reaction to an asymmetrical accumulation of humanitarian needs at the border pertaining to transient migrants. This includes worldviews, motivations, faith, and trust in becoming part of a binational border humanitarian network for the purposes of establishing a volunteer-based healthcare program for transient migrants in Ciudad Juárez. Also, this theme focuses on facilitators because it is them who expanded the binational border humanitarian network and established an inter-organizational partnership from which the Clinic program emerged for medical volunteers.

In the second key theme I address the challenges in building volunteer capacity, identifying three key facets: recruitment, engagement, and retention. In recruitment, I explore the vital role of soft factors like worldviews, motivations, and leadership, showing how the volunteering structure for the Clinic imposed a significant degree of responsibility on one person. The section on engagement is the most extensive one as it consists of: 1) experiences of the volunteers in distinct spaces, primarily the Clinic contrasted with "street" clinics and a clinic in El Paso; 2) informal and formal medical volunteering; 3) building a collective identity; and 4) medical interpretation. Regarding retention, I show that volunteer retention is impacted by emotional burden (e.g., burnout), paid opportunities, and people.

The third key theme focuses on the constraining factor of medical liability, revealing the pathway arranged for the Clinic to operate under the law and the effectiveness of such arrangement. I explore how the borders of legality in relation to morality and hope are navigated by both the facilitators and medical volunteers in the healthcare provision for transient migrants in Ciudad Juárez. Although the three key themes are distinct, they are in some ways interconnected, so there are instances where content overlaps across the different sections (See Figure 6). To emphasize the different socio-ecological dimensions inherent in the themes and sub-themes, I make explicit reference to the relevant levels of the Socio-Ecological Model (SEM) throughout the presentation of data (e.g., SEM: interpersonal level) to contextualize and elucidate the findings.

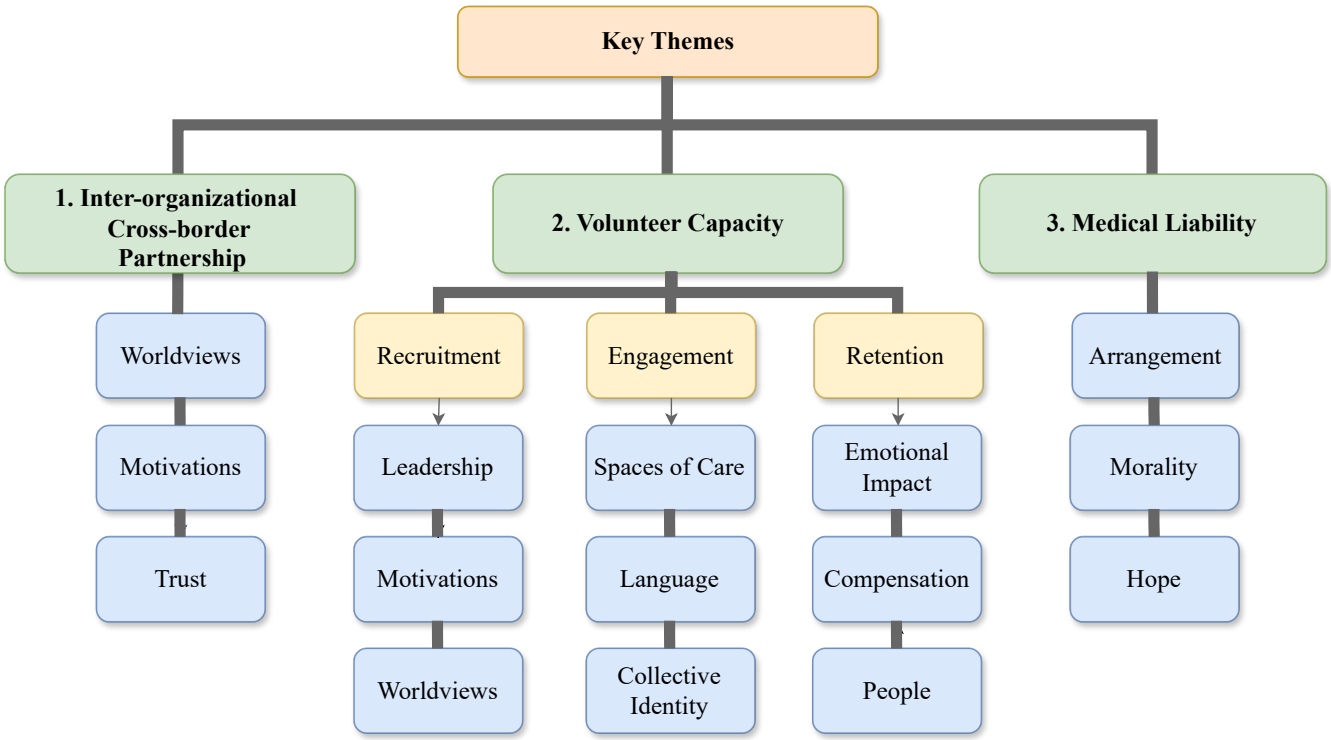

Figure 6 Key Themes & Respective soft Factors

Furthermore, before displaying the results pertaining to each key theme, I will first provide brief descriptions of the eleven participants.

Table 1 Brief Descriptions of Participants

Position	Name	Description
Student	Mayra	First generation U.S. medical student from the north-east with a passion for healthcare access for migrants. Since 2018, she has visited the border region twice and has volunteered on both sides of the border providing healthcare (under professional supervision) to transient migrants.
	Emily	Originally from the U.S. north-east, a medical student living in El Paso. Since 2018, she volunteers helping transient migrants, most recently providing healthcare (under professional supervision) on both sides of the border.
	Diego	Pre-medical student from the border region, living and volunteering only in El Paso providing (under professional supervision) healthcare to transient migrants. Driven by personal experiences of economic hardship due to lack of healthcare access growing up, he is committed to prevent such burdens on others in the border community.

Physician's Assistant	Henry	A retired physician's assistant living in El Paso with an extensive background as a volunteer providing healthcare to vulnerable populations, most recently to transient migrants on both sides of the border.
Occupational Therapist	Rose	A retired occupational therapist who originally traveled to El Paso to learn Spanish and decided to stay permanently to help transient migrants. She volunteers primarily in Ciudad Juárez providing healthcare to displaced populations.
Physician	Paul	Originally from an eastern state in the U.S., now working and living as a physician in El Paso. He volunteers on both sides of the border providing healthcare to transient migrants. He is the co-founder and coordinator for the Clinic.
	Helen	Physician from the U.S. mid-west with experience in global health. Self-funded a month-long stay in El Paso in part to volunteer providing healthcare to transient migrants on both sides of the border.
	Sandra	From a state outside Texas, a physician who self-funded her stay in El Paso in 2023. She provided healthcare to transient migrants on both sides of the border. Coming from a family of immigrants, she is interested in learning more about migrants' experiences at the border.
Facilitator	Sofia	Main coordinator at the Shelter in Ciudad Juárez with a background in international relations and public administration. In Mexico, she has extensive experience in public service, collaborating with various levels of government to support vulnerable populations, especially transient migrants.
	Thomas	Executive Director and founder of BSN, with extensive experience in immigration issues from different levels of government. He now works closely with local communities in the border region on immigration reform and justice issues.
	Francisco	Self-identified as Chicano from the Paso del Norte region. He previously worked and lived with vulnerable populations in Ciudad Juárez, but now works in El Paso on immigration issues. For years, he worked with BSN, which he helped establish and operate.

4.1 Main Theme 1: Inter-Organizational Cross-Border Partnership

To reiterate, this first key theme shows the role of soft factors (e.g., worldviews, motivations, faith, trust) in the developing and formalizing of an inter-organizational cross-border partnership, specifically between BSN and the Shelter. This is important because it sheds

light on how spaces of care for migrants, like the Clinic, emerge within a complex context of cross-border partnership at the border. I first analyze BSN and the Shelter's reaction to an asymmetrical accumulation of humanitarian needs at the border due to unprecedented numbers of transient migrants arriving. Regarding BSN's reaction, I contrast two main worldviews that stem from the two facilitators working at BSN. Then, I describe how the development of a partnership between BSN and the Shelter illustrates cross-border synergy. Finally, I focus on how the *idea* of the Clinic emerged and the soft process of materializing it inside—and in partnership with— the Shelter.

4.1.1 Reacting to an Asymmetrical Accumulation of Humanitarian Needs at the Border Region

An important insight that contextualizes the results stems from the firsthand accounts of Thomas and Sofia regarding an asymmetrical accumulation of humanitarian needs on the border region since 2019. The needs for humanitarian responses gradually became concentrated in Ciudad Juárez, which did not have the infrastructure to manage the unprecedented numbers of transient migrants arriving there. According to Thomas, this humanitarian predicament was exacerbated by the U.S. Migrant Protection Protocols (MPP) policy's role in halting transient migrants' mobility and forcing them to remain in Mexico indefinitely (SEM: societal level). As he explained:

> In 2019, we had the rollout of MPP here in El Paso…what that meant for the community was that a lot of the work of hospitality and care for vulnerable people on the move in El Paso—the burden—…was transferred to Ciudad Juárez, which at that time didn't really have the same infrastructure…when that happened, there were a number of leaders locally who thought—especially in the faith community [in El Paso]— who felt the need to do something in the humanitarian space for migrants [in Ciudad Juárez]…there were migrants who, because of MPP, were forced to stay [in Ciudad Juárez] for significant periods of time, many, many months. (Interview, February 6, 2024).

This extract is pivotal because it also sheds light on the reaction of El Pasoan leaders, including the faith community, and their willingness/motivation to help address the increasing humanitarian needs by crossing the border into Ciudad Juárez (SEM: community level).

Additionally, regarding the significant "burden" that Thomas attributes to Ciudad Juárez, Sofia confirmed by saying that, due to the unprecedented numbers of migrants arriving, the city and all its government and non-government organizations "didn't have much context…on what they were now facing" (Interview, January 24, 2024). As a result, Sofia took the role of reacting on behalf of the Shelter by establishing collaborations with organizations at different levels of government (SEM: community level). To this regard, as the Shelter was emerging in 2019, she explained: "It was up to me to start all the collaborations with civil and governmental organizations…the need arose to start collaborating with everyone to be able to bring more and more services closer to us." In this sense, Sofia's role seeking and establishing collaborations for the Shelter to respond to increasing humanitarian needs resembled the reaction from organizations like BSN in El Paso who were committed to cross the border to help manage the migrant related emergent needs in Ciudad Juárez.

4.1.2 Worldviews in Becoming Part of a Binational Border Humanitarian Network

In this sub-section I contrast two main worldviews in becoming part of a binational border humanitarian network that stem from the two facilitators (Francisco and Thomas) working at BSN. On the one hand, Francisco believes that borderlanders like him are "bridges", namely, people living at the border who facilitate international connections (SEM: interpersonal level). Moreover, he stresses that non-local individuals seeking to initiate projects at the border often rely on borderlanders to obtain credibility and become part of the local network through connections. These

connections, according to Francisco, can perpetuate harmful ideologies and practices of extraction onto other spaces across borders. As he said:

> Border-crossers, in general, we are bridges. We are often the ones who, simply by vocation, are bridges, we connect things…people who are not from the border but who want to generate projects at the border do so successfully by looking for a borderlander who can connect them and build a bridge…with certain forms, with certain interests….and there are key people [borderlanders] in the region who can help [them] have some credibility…we can talk about extractivism…it is this border from which they draw, from which ideas are extracted, from which artists are extracted from the strongest ideological currents of thought (Interview, January 18, 2024).

On the other hand, Thomas believes that the border region is "a binational community" and, therefore, invokes "binational solidarity" to justify BSN crossing the border and acting on the shared responsibility of caring for transient migrants arriving to the region (SEM: institutional level):

> As a binational community, BSN had to shoulder responsibility for the needs of vulnerable people passing through, and the burden couldn't be on one side [of the border] …there had to be an effort of binational solidarity to meet these challenges.

Additionally, apart from addressing the humanitarian needs that emerged across the border, Thomas emphasizes the construction of connections, new spaces, future, and "world"—through faith—as motivating factors that can help transcend the divisions that have been established by "systems of injustice" (SEM: societal level):

> There are so many things that divide us as a border community because of the wall and immigration policy…we do need to conscientiously build linkages across a border which has represented so much injustice…We need to be about the construction of a different world in the midst of that injustice…that's one of the things that really motivates me in all my work, is that: in the midst of these systems of injustice, how are we expressing our humanity and how are we building spaces of humanity and building seeds for a brighter future? And I think that faith can be a motivating force…It can give us images and ways of thinking about the future that motivate us to push beyond the injustice and fight for something better.

These extracts are important moving forward as they highlight deeper understandings of the different ethos and worldviews involved in crossing the border and becoming part of a binational border humanitarian network.

4.1.3 Developing and Formalizing an Inter-Organizational Cross-Border Partnership

In this sub-section I show that the development and formalizing of a partnership between BSN and the Shelter illustrates how cross-border synergy was grounded in trust, flexibility, consistency, and oscillation between formal and informal practices. As Sofia and Thomas explained, since the Shelter opened, BSN had promptly responded to its needs by crossing the border into Ciudad Juárez and providing material and social resources along with coordination of support. This, according to Thomas, granted BSN with the reputation of being "flexible" and "reliable"—qualities that Thomas attributes to BSN being a "small" organization— which was crucial credibility for formalizing a partnership with the Shelter (SEM: institutional and community levels).

According to Sofia, collaboration between BSN and the Shelter had "already been going on in many ways" during the launching and development of the Shelter. "BSN collaborates with us and has always supported us," Sofia said. Confirming Sofia's comments, Thomas mentioned that when the Shelter was established in 2019, BSN quickly initiated "a very productive and collaborative relationship with the Shelter…providing, at different times, food, supplies, blankets, infrastructure, washing machines," among other things. For example, during 2022, Thomas further explained:

> When they [the Shelter] were having outbreaks of chickenpox [in 2022]…they asked us if we [BSN] would be able to arrange for vaccination clinics to take place to address those outbreaks. And we did… multiple times. So, I think they saw us as a trusted partner, a reliable partner, a flexible partner that was able to marshal different resources to meet different needs…we met those medical needs by mobilizing doctors and getting some resources working with the [Chihuahua] state department to get the vaccinations that were needed, et cetera. We were able to act quickly where for other partners maybe it was a little more harder for them to act flexibly and quickly. We could do that as a small organization.

Additionally, Thomas highlights that, regarding formal or informal relationship-building across the border, BSN operates "across the spectrum…it's been fluid. There's been a transition from sort of informal to more formal" (SEM: institutional level). He emphasized that BSN formalized a

partnership with the Shelter specifically to establish the Clinic, which was "rare." More specifically, when asked about what it took to establish a formal partnership with the Shelter for the purposes of providing a volunteer-based healthcare for migrants, Thomas said: "It is very complicated….the Mexican government does not make it easy for non-Mexican [doctors] to provide medical services within Mexico….we're realizing what we did actually was very unique" (SEM: community level).

Francisco similarly highlighted that the Clinic is the only program he knows that is volunteer-based and focusing on providing pro bono healthcare to transient migrants in the border region. When asked if he knows of other similar programs or if the Clinic is really the only one, Francisco answered: "The only one, yes. I can say that this is the only one." Moreover, when asked if he thinks it is vital for organizations like BSN to collaborate with other organizations across the border to make programs like the Clinic possible, Francisco answered "100%."

The peculiarity of this inter-organizational cross-border partnership stems from the fact that the Shelter is run by the Mexican government and, hence, is stricter in establishing partnerships with other organizations. However, one of the reasons given as to why the Shelter is not easily available for partnerships is because their migrant guests are vulnerable populations. As Sofia explained:

> Look, we've had a few experiences with volunteering. The Clinic is one of them, of course, on the subject of health...It's quite complicated to open the shelter to everyone who would like to come and collaborate. We cannot lose sight of the fact that many of the people who are our guests are people who really have quite complex situations of persecution and where security is at risk. We cannot lose sight of the fact that the city itself [Ciudad Juárez] has a high rate of trafficking and violence by the cartels towards shelters. So, I think there are a lot of factors to take care of before opening the doors to any organization, to any visit.

This quote highlights that Sofia is very careful controlling what the Shelter does, who they partner with, and who is allowed to enter (SEM: institutional level). However, this does not deter the Shelter from establishing multiple partnerships. When asked to what extent she thinks partnership with other

organizations is important to establish programs like the Clinic, referring to the Shelter, Sofia answered:

> It's vital. One of the reasons for this space is to serve as a collaborative nucleus with government agencies…and civil society, because there are so many needs that go through the migratory phenomenon that a single actor could not cover them all. The moment you don't accept help, it's lives that are being affected. On this issue of working with people, I think it is very important that we do not lose sight of the fact that if things go wrong here, it is not like dividends at the end of the month, like closing a company, or that a machine is going to break down. In other words, here the daily decision-making has to be made from the analysis of how it is going to affect lives.

At the Shelter, trust in potential partners is measured, at least partially, according to how the lives of the migrant guests might be impacted (SEM: institutional level). This approach prioritizes the safety and wellbeing of the migrant guests at the Shelter. Regardless, for better or for worse, it was an attitude that limited the Shelter's partnership with BSN in establishing the Clinic.

4.1.4 Establishing the Clinic

The *idea* of the Clinic as a volunteer-based healthcare program for transient migrants in Ciudad Juárez sprouted from a collaborative effort between BSN and Paul. BSN's persistent engagement in the "health space" (as Thomas puts it) in Ciudad Juárez converged with Paul's aspirations to learn more of—and assist—the healthcare services available to transient migrants in the border region. According to Thomas, regarding the *idea* of the Clinic,

> it was an evolution from that trajectory of BSN's engagement in the health space [in Ciudad Juárez] that's gone back to 2019. Then, also, an entrepreneurial engaged individual, Paul, who said, 'let's take this to the next level'.

Paul had observed a notable absence of healthcare services for migrants in Ciudad Juárez, saying:

> I started asking around and trying to understand the healthcare landscape for migrants [in El Paso]. There are some resources on this side of the border, but I realized there wasn't really anything in Juárez… maybe the only big Mexican border community that didn't

> have an NGO healthcare presence….Juárez didn't really seem to have any international NGOs providing healthcare [to transient migrants] (Interview, January 23, 2024).

Similarly, Thomas perceived Ciudad Juárez to be a city that lacked sufficient spaces of care for transient migrants, saying that BSN's cross-border intentions were to "support new shelters that were [emerging] because, at that time when MPP was put in place, there really was only one stable migrant shelter in Ciudad Juárez."

These extracts shed light on the worldviews that Paul and Thomas had of Ciudad Juárez, regardless of whether they are correct (SEM: intrapersonal level). What is important to point out is that Thomas and Paul's perception of humanitarian capacity in Ciudad Juárez informed their motivation to respond and develop cross-border interventions. Instead of joining an already established healthcare program for transient migrants in Ciudad Juárez, if any, Paul and Thomas decided to create their own, debating whether the Clinic should be mobile. As Paul said:

> I connected with Thomas at BSN. I walked into the meeting just wanting for him to help me identify a place to volunteer, and we left with the idea to start the Clinic. That's kind of how this whole project got started….We talked about having a mobile clinic, like in a van or something. We talked about traveling to different shelters.

Eventually, Thomas and Paul realized that it was more practical to provide healthcare services at the Shelter as a way of supplementing gaps there. The rationale was, according to Thomas, that the Shelter "was a site in Juárez where there were more migrants in a congregate setting. So, it's a place where BSN could make the best and most effective intervention. And the Shelter agreed."

Sofia explained that although the Shelter always has nurses available for their migrant guests, doctors are not always available on the weekends, saying "if we don't have a doctor on Saturday, then on Monday there would be a doctor, and on Saturday and Sunday here we have staff nurses. Health staff are available 24/7." Therefore, BSN and Paul thought they could

supplement the gap of weekend coverage by establishing a volunteer-based healthcare program—the Clinic—that could bring doctors from El Paso into the Shelter. Although the Shelter agreed with the value of the idea of the Clinic, Sofia disagreed that the Shelter is a place where most of the needs for transient migrants in Ciudad Juárez are concentrated precisely because the Shelter always has available healthcare at least from nurses. To this regard, Sofia shared a verbal exchange she once had with Francisco asking him to consider distributing the Clinic's support onto other spaces:

> At some point I came to Francisco and said "hey, the Clinic had two consultations… if the Clinic wants to go to another space, I understand because it's also not right that all the support is concentrated here [at the Shelter]; here where there are already three [Mexican] doctors during the week."

Additionally, Sofia emphasized that the Shelter is government-led and, therefore, suspects that it might seem more prestigious to collaborate with the government over targeting spaces that need more help: "Here [at the Shelter] is cool because, well, we're governmental, and maybe in terms of accountability it's cooler to say that you're collaborating with the government, but it doesn't mean that the need is concentrated here."

However, sharing his rationale for why the Shelter was the best place for the Clinic to be established, Paul emphasized the existing infrastructure and partnership that helps bypass bureaucratic hurdles (SEM: institutional level):

> It made the most sense to start in this location, the Shelter. I think it's the largest migrant shelter in Juárez…run by the government…The Shelter asked for providers for the weekend. And it just made sense to start there because a lot of the heavy legwork we could skip. Like, they already had a clinic space. They already had basic supplies. They already had medications there. And by partnering with the government, we could skip all of the kind of bureaucratic red tape.

Ultimately, BSN "signed a formal agreement with the [the Shelter]" in order to establish the Clinic, according to Thomas. Sofia explained that the Clinic emerged "as the co-

responsibility of both institutions," namely, BSN and the Shelter (SEM: community level). This was an agreement in written form that, according to Sofia, "more than a collaboration-agreement as such, there were guidelines of cooperation." She highlights that this included the Shelter asking BSN-derived medical volunteers to "stick to the schedule," participate in filling out their database, alert the Shelter of any "situation that could pose a risk," and recognize that a Mexican doctor will always be "monitoring the praxis of the rest of the volunteers." Henceforth, the inter-organizational cross-border partnership between BSN and the Shelter to establish the Clinic formally took place. BSN collaborated with Paul having him recruit and guide medical volunteers. Together, under the support of BSN, Paul and future volunteers would operate the Clinic on Saturdays at the Shelter.

4.2 Main Theme #2: Building Volunteer Capacity

Although the Clinic emerged from a formal collaboration between BSN and the Shelter, the volunteering experience was not itself strictly formal. Henceforth, this second key theme on volunteer capacity explores the sometimes-informal building of volunteer capacity from the point of view of the volunteers themselves, showing the role of soft factors of soft infrastructure (e.g., worldviews and motivations) that are at play at the intra and interpersonal level in relation to space. This second key theme is the longest given that most of the participants are medical volunteers. Some remarks from facilitators will also be mentioned, especially when discussing the building of volunteer capacity to make a program like the Clinic sustainable. Building volunteer capacity consists of recruitment, engagement, and retention, each of which will be examined in its own sub-section along with their respective soft factors.

4.2.1 Volunteer Recruitment

This sub-section begins showing how Paul's leadership role was pivotal in the recruitment and guidance of medical volunteers. The section not only reveals the challenges that Paul undergoes as a recruiter but also the positive appraisals that some recruited volunteers have for him as a leader. Additionally, the section displays different worldviews surrounding Paul's difficulty recruiting volunteers, highlighting the general volunteer environment in El Paso.

4.2.1.1 Leadership

The medical volunteer recruitment process for the Clinic does not have a formal structure nor sufficient institutional support and occurs mainly by word of mouth with Paul identifying and contacting potential volunteers (SEM: interpersonal level). He personally reaches out to medical residents through email and social media while occasionally receiving supplementary support from BSN who has a broader reach in—and beyond—the community (SEM: institutional level). To this regard, Paul shared:

> Initially it was just me sending out emails and posting in [social media] groups for medical residents… just reaching out personally to people I knew and kind of creating a list of people that would be interested…Then, on social media, there's been a couple of times that BSN has put out calls for volunteers, which has actually been really helpful because BSN has a wider audience than I do, so they'll be able to find volunteers from around the country to come in. We had a couple of those instances. Sometimes people would see something I wrote for a magazine or wrote for a local paper, and they'll just contact me on social media or find my email address somehow or contact BSN and ask how to volunteer.

Volunteer recruitment for the Clinic has rested primarily on Paul, which makes the process more challenging. The recruitment process is followed by an informal orientation for the medical volunteers delivered by Paul. For instance, Helen thinks that Paul satisfactorily prepared her for volunteering for migrants at the border prior to arriving to El Paso. To this regard, referring to Paul, she said:

> He… was a huge help in making my experience possible…preparing me for what I was going to expect [at the border]. He put together a full document to make me aware of the political background there, the economic background, and then of different resources…to learn about the patients that I was going to be seeing, which I think was very important and super helpful…there was literature on it…about the history of El Paso and Juárez (Interview, January 17, 2024).

In most cases, like Mayra, Sandra, and Helen, their trip to El Paso was self-funded. However, Helen also emphasized that Paul provided her with housing: "I was very lucky in that Paul let me stay with him, so I didn't have to pay for housing, and then I just drove down there [to El Paso] and paid for everything else on my own."

Similarly, Paul provided Mayra not only with housing, context, and friendship, but also with emotional support, which she found very helpful. Mayra explained:

> When I was there [at the border region]…I mostly just relied on Paul…he is an incredible physician…I was so lucky to have the privilege to stay with him and his wife...I just relied on them for a lot, like emotional support, advice (Interview, January 15, 2024).

Paul, on his end, confirmed expressing his enjoyment sharing the Clinic project with volunteers and orienting them (SEM: interpersonal level):

> I really enjoy being able to kind of share this [the Clinic] project with [volunteers] and giving them the context, kind of helping shepherd them through this experience that I think is really meaningful to them. I really enjoy that.

Additionally, despite having volunteers like Helen and Mayra join the Clinic, Paul shared that it has been difficult to recruit people who share the same passion, interest, and commitment to volunteer helping address the issue of migration at the border where he recognizes is pressing. He finds this lack of interest in volunteering unexpected and disheartening:

> I didn't expect [volunteer recruitment] to be this hard to organize. Because this is something I'm very passionate about, I kind of expected … other people to become passionate about it, too, who would want to volunteer every weekend. And it's difficult, maybe discouraging, how hard it is to get people interested in this issue. We have one of the largest humanitarian crises of the western hemisphere right at our doorstep and getting to get people to help, I guess, that's been frustrating and discouraging.

However, Paul's difficulty finding medical volunteers willing to help migrants contrasts the general volunteer environment that other participants attribute to El Paso. Sandra, for example, referring to her temporary visit in El Paso said she was "pleasantly surprised about how everybody was so collaborative with each other and everybody was willing to help" (Interview, January 18, 2024). Similarly, recounting her first impression arriving to the city, Rose shared that she was "impressed with El Paso, with the different groups that were able to come together because [migration] was a bigger crisis…because it was so unexpected" (Interview, January 29, 2024). Thomas, not as a volunteer but as a facilitator, confirmed that "El Paso has been doing work to receive people on the move for decades, so there's an established system of hospitality, and there are established relationships and networks to provide different services to migrants who are passing through" (SEM: community level).

All of this is acknowledged by Paul himself who, contrasting his own difficult experience recruiting medical volunteers, said that by living in El Paso and volunteering helping migrants he gets to "meet all sorts of interesting people doing this sort of work," making Paul feel like everyone who does this is "on this journey together" (SEM: interpersonal level). Therefore, while recruiting new medical volunteers is challenging, the people who are already working (paid or non-paid) for migrants in El Paso do so in ways that, according to Paul, are "meaningful and fulfilling." This leads to the question: why is it challenging to recruit new—especially medical—volunteers, in El Paso?

4.2.1.2 Motivations

The participants have different reasons pertaining to motivation regarding why it is difficult to recruit new volunteers in the provision of healthcare for migrants. From the perspective of the medical volunteers, when asked, most of them explicitly agreed that health and healthcare access is a human right (SEM: intrapersonal level). While this was stated to be a motivating factor for volunteering helping migrants, Diego specified that he volunteers to help people in general and not necessarily migrants. As he said: "I don't volunteer specifically to help out migrants. I volunteer to help out people" (Interview, February 2, 2024).

From the perspective of facilitators, there is Francisco, on the one hand, who thinks that there is a lack of commitment to volunteer providing healthcare to migrants it is due to a lack of "will." He addresses the need for alignment of wills in different domains. When asked about what it takes to have programs like the Clinic work, he quickly emphasized:

> Will. That is the word. Political will, spiritual will, personal will, the will in all its factors. The central word for things to work bilaterally, politically, economically, socially, whatever you want, is will.

Additionally, Francisco stressed that not everyone can be considered a volunteer, and that volunteerism comes in different forms. For example, for him, there is "the volunteer who is a tourist, the volunteer who comes looking for these *instagramable* experiences…experiences that are no longer aesthetics, that are flirtatious experiences."

Similarly, Sofia made a critical distinction between volunteers who help unconditionally and those who have other intentions seeking something in return. Referring to the Shelter, Sofia explained:

> When it comes to volunteering…we've had them limited…not because we don't lack the [needs]…[Some volunteers] don't know how to help anymore without uploading it to [social media] networks…[They] don't really come with the will to do what you have to do, but rather, want a little more protagonist-cut there, and [the Shelter] is not the space.

For Francisco, “genuine” volunteers are motivated by the desire to contribute “from the heart,” which can only occur when one is impacted by the suffering of others and therefore increasing a sense of empathy for them. Francisco explained by first distinguishing between “mental health, bodily health, and spiritual health.” Working for vulnerable populations at the border for over a decade, Francisco said that he has been affected in all of these areas of health, especially spiritually. To this regard, he shared the deep emotional impact upon witnessing the desperation of a family similar to his own that was deported to Ciudad Juárez:

> In 2020, deported to Juárez, a family just like mine. It was the same man with the same woman, the same children, crying out to heaven because God had abandoned him when God did not abandon him, and his world came crashing down...and he left me… [pause]… it left me very shocked for a long time. It left me thinking: [with some tears and cracking voice] “Why? Why does he have to go through that, and I don't?” So, yes. Yes, you cannot—after those experiences— not dedicate your life to helping, because you know that very few people do it from…the heart.

With this said, Francisco is expressing his belief in the importance of spirit and empathy in human welfare, especially for the border region. However, regardless of whether the volunteering is “genuine,” the recruitment of volunteers for the provision of healthcare for transient migrants is challenging also due to the border, at least when it implies crossing into Ciudad Juárez.

4.2.1.3 Worldviews

As a local pre-medical student, Diego said he is “concerned of our streets [in El Paso] becoming less safe” (SEM: intrapersonal level). He explained:

> Even though I see patients from a perspective where they need help,…I do realize that it is dangerous to allow people who we know nothing about to come and live in the same city as us or come through the city where they could be gang-related or they could be just bringing bad stuff to us or to the community.

On the other hand, as a non-local physician, Helen has never felt unsafe during her experiences as a volunteer (SEM: intrapersonal level). She recognizes that US volunteers can have biases when crossing borders. She said:

> I think we as Americans have different biases of when we cross borders and go into different countries….But I think you just have to be aware of your surroundings and aware of your patient population and know what they're dealing with and just treat them as you would any other patient.

For Mayra, as a non-local medical student, the border has an "emergency style [where] everyone is in need of immediate things: food, shelter, clothing, water, medical care." Conversely, regarding the issue of migration, Mayra thinks that further away from the border, people are "more settled and the needs are less emergent, they are less panicked, and so you are trying to figure out long term solutions." Additionally, for Mayra, because the border dynamic is perceived as one where high concentrations of needs are found, any level of knowledge is considered a resource. She said, "because there are so many emergent needs, once you kind of have this role and people know that, and you have even just basic knowledge, they'll kind of direct a lot of questions to you."

Crossing the border into Ciudad Juárez is, according to Paul, not as "convenient" for some U.S. medical volunteers as staying in El Paso. This may be due to an institutional grounding that volunteering may have, which suggests that those who do cross the border have their motivations grounded beyond an institution. As Paul explained, in El Paso "a lot of folks might be just trying to get in their volunteer hours they need for school" and, therefore, "there's more conviction in the volunteers that work in [crossing to] Juárez just because it's not as convenient."

As a facilitator, Thomas emphasizes both sides of the border, saying that the recruitment of volunteers varies because "there are a lot of needs on both sides" of the border. He thinks that

having people motivated to cross from El Paso to Ciudad Juárez can imply overcoming perceptual and emotional barriers related to their worldview or, as he puts it, "a conceptual road" because "they need to overcome sometimes emotional obstacles" (SEM: intrapersonal level). For example, Thomas explained the perceptions of fear that people tend to attribute to Ciudad Juárez:

> There are a lot of people who are intimidated to go to Juárez because they don't know it…Juárez represents a big scary place for a lot of people…There may be layers of fear associated with Juárez just because it's unknown.

Moreover, Thomas thinks that negative-connoted perceptions can be attributed to the migrants themselves, indicating the type of perceptual landscape that exist in the provision of humanitarian care for migrants at the border : "sometimes there are connotations with certain migrants" because some people tend to feel safer working with migrants who are released by Border Patrol in El Paso as opposed to "those who are arriving for the first time, on the other side of the wall" in Ciudad Juárez.

Additionally, because health and human healthcare access is considered a human right Mayra and Emily advocate for Mexican volunteers to be able to cross into El Paso to help as opposed to strictly the other way around. As Mayra stated:

> As much as volunteer physicians from the U.S. side should go over to the Juárez side and work alongside Juárez trained physicians to provide care to migrants, Juárez physicians should be able to come over to the U.S. side and work alongside US trained physicians to provide care to migrants on the US side.

Similarly, Emily said:

> We are so Western-centric, and we have just gotten to a point of power and influence in the world where an American doctor is assumed to be welcomed anywhere, but a Mexican doctor would not be welcomed walking into a U.S. clinic to provide volunteer services. So, why is it that we are able to do that?... I find that frustrating, and I think that *that* is not right…I think that if there's a need—and there obviously is—and there's understaffing, et cetera, that it's very good to have volunteers come in, but we should be able to have volunteers from anywhere, especially with regard to medicine (Interview, January 22, 2024).

In explaining why healthcare provision is restricted at the border, Francisco, as a facilitator, shared a reason beyond the personal, thinking of a broader, structural, reason (SEM: societal level). More specifically, Francisco suspects that the notion of *whiteness* controls the local healthcare system:

> In El Paso, Texas, the dominance of the white— to define it as something like power beyond the color of the skin, but as a position—you can't deny it…And this has to do with the issue of health. Who dominates and who controls? Who has the power of health? According to whom? Who lives and who doesn't? Who decides who has access to health care and who doesn't? The only one who can is the one with the purchasing power; the other doesn't…Because there is economic control…here in the region we have chieftains who control health, who control medicines, who control the devices to do tests, and not all of them have it.

4.2.2 Volunteer Engagement

This sub-section begins by displaying the impressions that medical volunteers have of the different settings where they have volunteered providing healthcare to transient migrants in the border. The Clinic being the setting of focus is briefly contrasted with the El Paso clinic. Street clinics are also discussed, showing how spaces of care are arranged playing a role in soft infrastructure. Additionally, this section shows the role of language interpretation as a soft skill that constitutes volunteer engagement. Lastly, the development of collective identity is emphasized and discussed.

4.2.2.1 Spaces of Care

Despite the challenges recruiting volunteers, there were consistent volunteers who would go to the Clinic on Saturdays during 2023. From the participants, Paul and Emily were consistent volunteers given that they live in El Paso. Their experience at the Clinic provides insights into the soft factors impacting the program's sustainability. As Paul said, "there's a handful of

people, like three or four people, that are repeat volunteers at the Clinic that come a lot." Emily, as a consistent volunteer, verbally walks us through the experience traveling and arriving at the Clinic inside the Shelter. She points out the time, the setting, and people involve (SEM: institutional level). She mentioned that the Shelter is secured by gate and security personnel.

> 7:30 in the morning. 7:45 we'll take off, and it'll take about 5 minutes to get to the border. It'll take about 5 to 10 minutes to get over the bridge, and then from there, it'll take about a 10 to 15 minutes' drive to get to the shelter. You'll roll up outside of the gate. Several police officers and military are standing outside the gate. They will forget and have new personnel there every single time, so you'll always have to explain what the Clinic is and, once you're done explaining again what the Clinic is, and they talk amongst themselves, they'll let you in the gate. And then you park your car. You get out with your backpacks and your supplies, and you leave your personal form of identification with an officer, and they will give you a pass to hang around your neck. You'll walk into the clinic past groups of families, teenagers, and adults who are generally, if it's good weather outside, they're hanging there. There are sinks and bathrooms outside the door. There are areas where one can relax with their cigarette. There are areas where the children can play with the soccer ball in this large parking lot. There is no grass, of course…As soon as you get in, usually you can hear all the voices of the people inside the building echoing around the concrete walls. And you can tell sometimes how busy it is just by how many people are requesting services at the front desk or seem to be crowding around the social workers' tent or who are lined up for the other food services on the other end of the hallway. But you'll take a sharp right, and you'll go into a very narrow hallway that's separated by a door from this other larger warehouse space. This is where you have two physician offices. You have a nurses' office. You have a restroom. You have a closet that keeps all the medications, which is under lock and key. And then you have one room which has two desks in it, one laptop computer, one desktop computer, and one exam table with a small curtain divider around it. And that is the shared space where you will be seeing patients.

This excerpt reveals the importance of different types of settings like the bridge, the gated and surveilled perimeter around the Shelter, the exam room, and "shared space."

Regarding the Clinic's space, it contains multiple levels of sovereignty given that different organizations were part of its establishment (SEM: community level). Paul, for example, provides an anecdote of the day the Clinic was inaugurated, revealing that people from different sectors of society were involved. Additionally, Paul's account of the inauguration of the

Clinic reveals the very busy type of doctor he is despite being the main recruiter and coordinator for the Clinic (SEM: intrapersonal level).

> This was a month when…I was working like 100 hours a week and I got special permission to have like 6 hours off in the middle of the day to go to do the first clinic…I thought it was just going to be "we show up and work a couple hours", but then also Thomas came. Francisco was there… and so I looked terrible. My eyes are bloodshot, I hadn't shaved in like a month, and I hadn't washed my hair in like a month. I looked terrible and I just think we're going to go take care of a couple of migrants and then head back to El Paso. But I show up and we walk into the Shelter, and they've cleared out the front area, and there's a table…They asked me to sit down…Everybody sits down. It's like two people from the government…They all make speeches and…after all that, like an hour of all this…, we were able to start seeing patients.

Apart from the Clinic itself, Mayra, Emily, Paul, Sandra, and Helen mentioned volunteering on both sides of the border, including also the El Paso clinic that operates in a church. They shared their perspectives on each setting (SEM: institutional level). Emily, for example, when she reflected on her experiences between the Clinic in Ciudad Juárez and the El Paso clinic, described differences in organizational structure and patient care. She said that "the way that the appointments are run and are staged, and the waiting area, and the staffing, and the flow of the appointment, and the way that medications are given, all of it is different." She explained that on the one hand, the El Paso clinic is medical-student run and, therefore, compromises the quality of care for migrants over the learning experience for medical students. On the other hand, the Clinic in Ciudad Juárez is run by medical residents who determine the level of involvement for medical students, which allows for a more personalized and patient-centered approach to healthcare provision. As Emily explains:

> I wanted to provide care to people in any capacity, and I didn't feel that I was doing that at the El Paso clinic. I felt that their quality of care was being sacrificed for our learning. In Juárez, the Clinic program is resident run, not medical-student run. The residents go in, the medical students are merely there to support. Depending on whether or not the resident feels comfortable, they are going to say, "hey, do you want to do part of this exam? Do you want to ask them some questions? I'll tell you what you missed." Or they might just say, "I'm going to do this exam, can you write my note?" But it doesn't matter.

> It's entirely up to the resident, and there's no structure for it. So, it's much more personal …you see as many patients as you can and you help as much as you can, and you're helping doing what is needed in the situation. You're not helping by doing what helps you. And I think to me, even though I might get less hands-on experience, I prefer that because it makes me feel like I am literally helping patients more directly.

Helen contrasts Emily's remarks by saying that the clinics on both sides of the border operated similarly as they both provided medications for migrants, maintained documentation, and has nurses available. Referring to the El Paso clinic, Helen said that it

> really functioned very similarly to the Clinic…in Juárez …We had medications that we could give to the migrants. We kept documentation on both sides. We had nursing staff that was able to do vitals…on both sides. So, it really functioned fairly similarly on both sides. I wouldn't say that there was any big changes besides really just where the migrants were kind of in their journey.

Diego, who volunteers only at the El Paso clinic said that, apart from the clinic being free for migrants, there are no issues with the operational structure:

> I feel like the system right now, the way it is, is just run perfectly. I don't know how else it could be improved because it's a free clinic… pretty structured, pretty organized…having the system definitely helps out.

Diego put me in contact with the director of the El Paso clinic, so I was able to personally visit the setting. My field notes show that apart from the lack of securitization, the El Paso clinic is operated by an international NGO interested in developing volunteer capacity and inter-organizational cross-border partnership for the purposes of establishing operations in Ciudad Juárez:

> Visiting the El Paso clinic and meeting its director was quite interesting…When I arrived at the location, which is a church, I entered the building and immediately felt a heartwarming environment. I thought it was interesting how there was absolutely no security personnel surrounding the building, unlike the Shelter…. Inside the church, medical students and physicians were chitchatting and laughing at the end of the hall. As I was approaching them, I heard Diego to my left. When I turned my head, he was in a room sitting down next to the director of the clinic. They were both very welcoming. After explaining the purpose of my research, the director mentioned that there are a lot of things related to soft infrastructure that are pivotal in the development of the El Paso clinic. Using the example of a pipeline, the director stressed the importance of always having a constant stream of volunteers….The director mentioned that the International

> NGO [a pseudonym] runs the El Paso clinic, which is the only program or presence that the organization has inside the United States… When I told the director that I know Francisco and Thomas, the director expressed also knowing them both and that the International NGO has been working on finding ways to collaborate together to cross the border into Ciudad Juárez….The director said "we want to be there," referring to the Shelter where the Clinic operates…The director also mentioned that finding consensus and establishing collaborations in Mexico is more difficult and takes longer…I was also told that the Clinic's liability arrangement in Mexico seems like something that would not be allowed inside the United States, but considering that "it is Mexico," these types of arrangements are more allowed. (Fieldnotes, February 13, 2024)

The different views of the clinics across the border are important to document because it reveals that the spatial arrangement of healthcare provision for transient migrants differ across settings (SEM: institutional level). However, the data also suggests that healthcare provision for transient migrants is peculiar not only regarding space but also time in relation with space. For example, when comparing healthcare provision for transient migrants in El Paso to Ciudad Juárez, Paul observes that while in El Paso migrants typically stay for a significantly shorter period of time before continuing their migratory journey, in Ciudad Juárez migrants can stay there for months, which can allow follow-up primary type of care:

> In El Paso, I think there's less of a need. Most of the migrants, once they're in El Paso…they're only here for a couple of days or maybe a week or two before they're able to go to their final destination, so the healthcare seems to be a little different…it's really "who's too sick to travel and who can we treat right now with just these medicines we have available." In Juárez, it's different because the migrants tend to be there for months at a time, sometimes longer…it's more kind of chronic care, some primary care. And I think the need is greater in Juárez as well.

At the Clinic, Emily says that the time it takes to see patients depends on who she is helping. If Emily is working with the Shelter's Mexican doctor (who receives economic compensation working there) healthcare provision is faster compared to when she is helping U.S. volunteers. As she said:

> If I'm working with [the Mexican doctor]…he just does not ask very many questions. He goes straight to the diagnosis and straight to the point. With the [U.S volunteer

> physician], I tend to have a little bit more time….they're also very detail oriented with their exams. So, they'll often take longer to do exams."

In this sense, the time it takes to provide healthcare for transient migrants at the Clinic fluctuates depending on who is the physician and if they are a volunteer (SEM: interpersonal level). Rose explicitly emphasizes that significant time limitations is a general factor that impacts the healthcare provision to transient migrants. According to Rose, medical volunteers only have one opportunity to provide healthcare to transient migrants precisely because this population is always on the move. Therefore, because "you just got that one visit," Rose stressed implementing a pedagogical value to the healthcare provision. She said, "you just have to try to give them as much information as you can and hope that they're able to follow through themselves."

Furthermore, unlike other medical volunteers, Paul and Mayra volunteered providing humanitarian assistance for transient migrants in the border region before explicitly focusing on providing healthcare. What they expressed learning as volunteers is that the border region at large is a space where improvisation is required, which is why their healthcare provision is at times informal involving distinct settings. For example, Mayra mentioned randomly navigating through different settings (e.g., streets, shelters, and churches) and identifying any instances where she could help in the provision of healthcare, thus making spaces of care mobile. Once a week she was "doing random street outreach missions…seeing who [regarding migrants] needed things. And more often than not, people did need things." To prepare for these outreach missions, she said, "I just kind of carry my little vitals gear around and see if I could be of use in any way."

These outreach missions sometimes occurred in collectivity, especially through the so-called street clinics, which occurred typically on Fridays and were informal ad hoc types of

healthcare establishments for unsheltered transient migrants. Street clinics involved traveling near the Rio Bravo River, on the Ciudad Juárez side of the border, by the port of entry known as Puente de Las Americas. These street clinics consisted of medical volunteers and interpreters who would also attend the Clinic (See Figure 7). Among the participants, this included Mayra, Paul, and Helen. Even though they at first mobilized independently to assemble these spaces of care, BSN eventually joined the project, thus making street clinics part of the Clinic's operations.

The spatial arrangement for these street clinics involved pulling resources from among the volunteers themselves (SEM: interpersonal level). Paul mentioned having to spend over "one hundred dollars" out of his own pocket to buy "a lot of medications" that consisted of "antibiotics for common respiratory infections, throat infections, urinary tract infections, which are commonly prescribed." Therefore, the street clinics prepared primarily to provide symptomatic relief. Additionally, Paul has bought out of his own pocket material tools like "basic supplies to take vitals, a blood pressure cuff…thermometer, low finger pulse oximeter."

Figure 7 Medical volunteers from El Paso and Ciudad Juárez working together providing healthcare to unsheltered transient migrants during a street clinic in front of the Rio Bravo River in Ciudad Juárez. (Picture taken by Paul)

As a medical student, Mayra thinks that "the most difficult thing about pop-up [street] clinics is follow-up." She explained that follow-up healthcare in street clinics often occurs through social media, and the decision-making for diagnosis typically involves assumptions, all of which is better than not receiving any type of healthcare:

> From the street clinic perspective, we did a lot of our follow-ups over [a social media platform] or just utilize the local resources to get [patients] free labs or free things…And there's also a way to practice street medicine where you kind of make certain assumptions and take certain steps with regards to care when you don't have access to tests that you might not otherwise do in a more developed setting. So, if someone's had a fever and has been vomiting for seven days, you might give them an antibiotic. Empirically treat what's going on and give them an antibiotic, even if you can't really prove…that it's a bacterial infection. Whereas in a clinic setting you might not do that. You might wait for the test to come back before treating it. But I think that's okay because a lot of the time people who come to those street clinics are not going to get any care otherwise…. There's, I think, a way to cut corners in a way that still preserves a standard of care for patients and, in some ways, will make the standard of care better for these migrants who are only going to be there once and then never again.

As a physician, Helen, discussed the challenges in operating an ad hoc space of care in "lower resource settings." This includes having limited medications and, therefore, treatment options. However, despite these limitations, Helen highlights that the fundamental practice of medicine remains the same:

> The pop-up [street] clinics are…lower resource settings, so that makes it more challenging because you only have the medications that you bring with you, and so you have less options on what you're able to provide to the patient. But I think overall, the practice of medicine is kind of the same. You still get your history, you still do your physical exam. You're just limited on treatment options… then follow up makes it more challenging, too, because…you're not really sure where they're going to be, and you're not sure if they're going to be able to get follow up.

Additionally, the street clinics require paying a closer attention to historical and biological factors and manually identifying a diagnosis instead of using technologies typically available in formal clinical settings, which is an experience with pedagogical value (See Figure 8). According to Helen: "It is a good learning experience for medical students…you have to be more

confident in your history and physical exam taking, and you can make the diagnosis with that versus ordering tests."

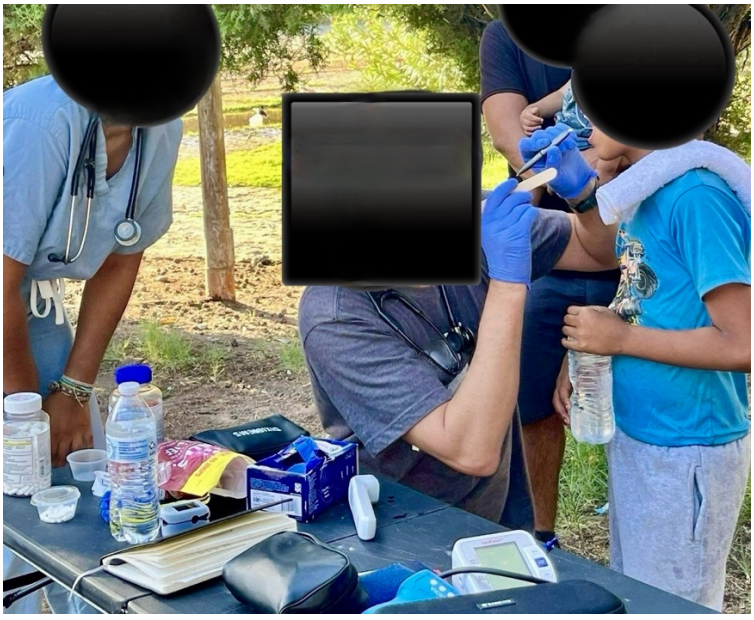

Figure 8 A volunteer medical student observes a volunteer physician providing healthcare to a family of transient migrants in Ciudad Juárez during a street clinic session. (Picture taken by Paul)

4.2.2.2 Language

Medical interpreters can have different roles in the healthcare provision for transient migrants at the border. However, there are few volunteers who know Spanish fluently, professionally, and technically in relation to medical practice (SEM: intrapersonal level). Regarding the role the interpreters play at the Clinic, Paul thinks that "most of our volunteer physicians need one." He specified that typically a "[medical] student or community volunteer…. [has] two roles: the scribe and the interpreter. So, while you're doing the exam and while you're talking to the patient, they're writing everything down." Additionally, Paul said, "when times when I don't have an interpreter, it just goes so much slower with me trying to either figure it all out or having to use Google translate." Similarly, when asked if he typically

uses a medical interpreter when providing healthcare for migrants, Henry says “I use Google translate” (Interview, January 29, 2024).

To explain why he sometimes prefers not using an interpreter, Henry emphasizes he has had issues with interpreters, but “not the professional ones” (SEM: interpersonal level). With non-professional volunteers, Henry shared that he was once working with an interpreter and, when he requested the interpreter to ask specific details about the patient’s medical history, the interpreter responded saying “I’m not going to ask her that.” Similarly, Rose mentioned that some interpreters may bring biases into healthcare provision, leading them to withhold—or refrain from—certain information. To this regard, she shared an anecdote from her medical volunteering in the border region, particularly in Matamoros:

> It was in Mexico and what [volunteers] were trying to do was support the community. So, they were hiring interpreters out of the community…the Haitian interpreter in Matamoros…because a woman was sick and she wasn't feeling well, and she was nursing her baby, and I said, “wanted to make sure she wasn't pregnant”, and he [the interpreter] had a temper tap: "she's not pregnant, she's nursing.” It's like [Rose said], "you *can* get pregnant.” But [interpreters] would bring their own prejudices in, or they would say, "I'm not going to tell them that, or that. I'm not going to say that.”

When referring to the interpreters that she has worked with during her medical volunteering for transient migrants in the border region at large, Rose said:

> They’re not formal volunteers. They’re not certified volunteers…when you’re interpreting medicine and somebody’s not a medical interpreter per se, they’re just a Spanish [speaker]….Do they really understand what you’re saying in English? Do they understand what you mean and are they interpreting it correctly? You don’t really know. I think sometimes if somebody was from Turkey, I would have them call a family member that spoke English… there is a lack of an interpreting system.

Regarding the role of interpretation at the Clinic, Emily said “I often was the one having to be the interpreter, which I wasn’t totally comfortable with all the time, but I tried my best.” Although Emily did not share an example, she did emphasize that she tried her best, indicating a

strong commitment to respond to the needs at the Clinic (in this case, interpretation) despite her discomfort. Regarding her experience with interpreters on both sides of the border Helen said:

> I was very lucky. I think all of the interpreters we had [on both sides of the border] were really great. They were good at making sure they interpreted exactly what both parties were saying, because I think that can be something that can be challenging with interpreters that I've used in the past. If you're not interpreting exactly what both individuals are saying, then the direction of the conversation can get misconstrued, and then you go off on a place that you weren't planning on.

Helen does not know much Spanish, but she thinks her "Spanish got a lot better while being in El Paso taking Spanish lessons." Similarly, Rose was taking Spanish lessons in El Paso.

There are also some volunteers who say they know sufficient Spanish but who either misinterpret or interpret in ways that can deviate from the central topic in the provision of healthcare and the physicians' requests. Regarding his experience with interpretation at the El Paso clinic, Diego emphasizes that:

> the patient is in a very vulnerable state when you're talking to them. So, making a little mistake on translation or just not understanding what the patient is telling you can lead to an awkward situation where you can answer the wrong way or you can answer a follow up question from the wrong angle that the patient can give you more information…. [For example], there was a patient once that had diarrhea, and I was translating to a nurse….Somewhere along the line, she mentioned pain on the leg with diarrhea. So, with those two being mentioned back-to-back, when I translated to the doctor, he asked me from which side, and I got confused, and I said, "you're talking about the diarrhea or the leg pain." And so… another volunteer… giggled because she thought I was asking about the diarrhea, not the leg pain.…So, there's no way I'm going to ask the patient from which side was the diarrhea coming from. So, it was actually the leg pain that we were referring to, but just a small mistake could have made the patient uncomfortable.

Furthermore, despite the challenges of not being able to fully understand the stories of all his patients, Paul thinks his inability to speak fluent Spanish may have positive effects given that he can disregard harsh details of some trauma (SEM: interpersonal level). To this regard, he said:

> I think it's easier for me because of the language barrier. My Spanish isn't perfect, and it's easy for me to tune it out...I think some of our volunteers, fluent Spanish speakers…probably have it a lot worse and are more affected than I am. But I think I've become good at compartmentalizing, and I think it's a skill that you develop.

4.2.2.3 Collective Identity

The building and sharing of a collective identity among medical volunteers occur at the Clinic (SEM: interpersonal level). For example, Emily notes that on the Saturday mornings when volunteers are traveling to the Shelter, they engage in a behavior where they build a "shared identity", especially when they do not know each other:

> I don't know if it's conscious or subconscious, but even though it's so early in the morning, when we're all driving over the border together, in those 25 to 30 minutes before we get to the Shelter, everybody's talking constantly. And I think it is in large part because, even though everybody's tired, we know that we don't know each other. And I think subconsciously there's this desire to create a shared identity before stepping into the Clinic.

Paul confirmed saying that the current volunteers have a close bond that is shared with recently joined volunteers, particularly because they all "care" about the issue of migration:

> We [current volunteers] have grown pretty close. There's a lot of [volunteers] that it might be their first time (or maybe they volunteered six months ago) that most of the time get along pretty well with the [current] volunteers. Obviously, they came because they care about this issue and tend to have a lot in common, and we have a lot to talk about.

Additionally, referring to the broader border region, Paul thinks that many of the people he has "met along the way that do this sort of work" are "idealistic" and have a "shared mission" for serving this community, which makes Paul feel like he is not "alone." The symbolic and material experience of collective identity engages volunteers in what they refer to as forms of sharing. For Mayra, this involves sharing a generational outlook, saying:

> the volunteers I've worked with at the border have been incredible… most… have been really young volunteers, like early twenties to early thirties…we all share this mentality of "we're trying to make it better for our generation. We don't want to keep living in a country where these [immigration] policies are actually hurting people." We kind of generationally recognize that this is wrong and want to do something to make it better.

More broadly, as a facilitator, Thomas emphasized a deeper belief rooted in faith, stressing the importance and implications of a "shared humanity" against social enmity:

> My faith conviction is that we need to be about the business of building a wider we… that we find in the other a shared humanity. And when we respond to that shared humanity…And that other view to me is dehumanizing. We're diminished when we think like that in terms of "us" versus "them" or it's a competition for resources that diminishes us.

4.2.3 Volunteer Retention

This sub-section focuses on three areas impacting volunteer retention in providing healthcare for transient migrants through the Clinic: emotional impact, compensation, and the people themselves. First, the emotional impact that this type of volunteerism can generate is taken into consideration. Then, the distinct opinions that volunteers have regarding the work they do vis-á-vis an economic compensation is displayed. Here, the idea of having salaried medical professionals providing healthcare to transient migrants at the border is negotiated. Lastly, the notion of the people themselves being the most important factor for volunteer retention is explored.

4.2.3.1 Emotional Impacts

Working in the provision of healthcare for transient migrants in the border region can have an emotional impact (SEM: intra- and interpersonal levels). Mayra, for example, highlighted the mental and emotional challenges that come with this type of volunteerism. However, she also emphasized the role that having social support has for dealing with the emotional impact. For her, it is important to share this burden with others. As she said:

> the mental and emotional toll that this work can take on you is pretty dramatic, so it's really important to have people working alongside with you who can kind of bounce those ideas off of you or work through those emotional conversations with you.

Helen concurred that volunteering for migrants can be "emotionally taxing," and it is "more helpful to have other people around…and being able to bounce off ideas off them" while providing healthcare for transient migrants.

However, being emotionally impacted by the volunteering experience does not necessarily imply that the impact is merely negative. For example, Sandra expressed both negative and positive emotions from her experience as a volunteer, particularly involving the trauma experienced by migrant children. To this regard, she shared:

> I was positively emotionally affected. I really enjoyed being with the migrants, and the children, and the workers, but it was also disheartening to see so much of the trauma that the children experience while they're there, mainly outside of the [El Paso] shelter….sometimes the environment is not the best for children…there was an unfortunate thing that happened to one of their children when a child bit [a girl], and then [the girl] and her mom started crying, and then another child that was witness to it was just shocked and in awe and said to me, "I've never seen anything like this. I've never experienced this before." [The mother] was like in a state of confusion and a state of sadness that this could be happening. That was certainly sad to see.

In the case of Emily, she thinks that having emotions, whether they are positive or negative, is considered important but should not impact "identity." She explained:

> I don't believe that it is right that you should feel nothing. I also think that it's not right that you should allow your identity— or that you should allow the core part of yourself— to become affected, because if you do, then you can no longer provide good care.

Diego, on his end, thinks that you should not do medicine unless "you know what you are getting into."

However, "burnout exists," according to Sofia who, as a facilitator, reflected on how her job at the Shelter involved multiple emotions while witnessing the experiences of transient migrants:

> It's like an accumulation of a lot of emotions. It's a job that I live with a lot of emotions…On personal levels,….we could all go through something like [transient migration]…First, it hurts a lot and then it gives a lot of courage and then it gives a lot of compassion. Then you find out that migrants, they are people with the capacity for

> agency, who are only at this moment in their lives going through a situation from which no one is oblivious. So, empathy.

Despite all of these challenges involving emotions, Paul emphasizes that "it is important to be able to transform that suffering and trauma into something meaningful…into action." In this sense trauma and suffering become motivators for the type of volunteer work that Paul does, and he thinks other volunteers should do the same. This sentiment related to empathy is similarly shared with Francisco who, as it was aforementioned, feels a strong commitment to help people in need after witnessing their suffering, particularly after meeting a family that resembled his own. After helping transient migrants at the Clinic, Paul sometimes has a "demoralizing" experience that is "mentally fatiguing" because, as he said: "I am able to cross the border every day and sleep in my safe house…it's demoralizing having to leave all these people. They're stuck there [in Ciudad Juárez]. But I can come and go as I please." However, even though Paul has "felt close to burnout several times," he thinks that to avoid burnout "you have to know your limits." For Paul, it is important "to leverage any sort of emotional angst into action, into something productive."

4.2.3.2 Compensation

The data reveals debates on whether having salaried workers can help guarantee professionalism in the healthcare provision to transient migrants at the border (SEM: institutional level). Given the challenges of recruiting, engaging, and retaining volunteers, Mayra proposes that perhaps relying on mere volunteers is in itself not sustainable and, therefore another reason why retention is difficult. For her, although it is very important to have humanitarian volunteers who are merely motivated by "the goodness of their hearts," it is not enough. She explained by saying that it is crucial to have salaried medical professionals who work full time and therefore

guarantee healthcare access for migrants at the border, which can also help avoid unintended consequences. To this regard, Mayra compared the medical structure—or lack of— inside the shelters where she has volunteered in the border region, highlighting that professionalism is a varying factor. On the one hand, referring to the Clinic at the Shelter in Ciudad Juárez, she said:

> The way that shelter is run is absolutely incredible. They have salaried professionals who are there to take care of the mental health of migrants, the health needs of migrants, salaried physicians taking care of them on a daily basis. They have 24-hour nurses available. They can provide up to like IV rehydration level of care.

On the other hand, referring to two shelters in El Paso where she volunteered, Mayra said:

> First of all, there are no professionals who are salaried working at these shelters. Everyone is a volunteer. Second of all, there are no medical professionals of any kind… I was the person with the most medical knowledge in the room….and it leads to really scary, scary things, like people being administered the wrong medications, people being told that medications do things differently than they actually do, or not explaining the side effects of certain medications, volunteers overdosing certain migrants on medications, not understanding when something is an emergency versus not.

Therefore, Mayra thinks that it is an issue that some shelters in El Paso do not guarantee paid medical professionals. Consequently, according to Mayra, there should be at least one government-run shelter in El Paso—just like the Shelter in Ciudad Juárez—that guarantees healthcare for transient migrants. To this regard, she said:

> Growing up I was like, "oh my God, the US is so progressive." It was like this idea that was embedded in my brain. And I think nothing has shattered that image of the United States more than witnessing the discrepancy in healthcare that is provided on the Juárez side of the border versus the United States side of the border for migrants.

Similarly, Emily mentioned that transient migrants "deserve a professional" in order "to be able to provide the most quality service."

However, while Mayra and Emily, as medical students, think that there is a gap for having more paid professionals in healthcare provision for transient migrants at the border, Rose, Henry, and Francisco are more cautious about having salaried professionals. Rose, as a retired

occupational therapist, notes a shift in how organizations are now providing paid opportunities for the provision of healthcare to migrants as opposed to relying solely on volunteers, which she thinks is shrinking the volunteer "spirit" (SEM: intrapersonal and institutional levels). Referring to these organizations, Rose said they are "starting to pay people, and it's getting harder and harder to get that true volunteer spirit." She thinks that there is a potential trade-off between administrative relief and volunteer motivation. For her, having salaried professionals is, "from an administrative standpoint, easier to manage. You get a longer-term commitment, but you lose people with a lot of enthusiasm." In this sense, volunteer retention is impacted by the force of economic compensation. Henry, as a retired physician's assistant, echoed Rosa's sentiment by stressing the impact of introducing paid positions in spaces of humanitarian care. He thinks that receiving a "paycheck changes attitudes."

Sofia, as a facilitator, also highlights how the issue of migration generates economic compensations, saying: "The tragedy of migration is monetized. I mean, not that migration is a tragedy per se, but in the contexts in which we are living, we could consider it." Drawing from personal experience as a facilitator, Francisco agrees with Sofia and expands by venting his concern regarding the trend of employing salaried workers in humanitarian care for transient migrants. He described what he calls "humanitarian industrialization," referring to individuals who are both instrumentalized and motivated by financial gain rather than "voluntary" reasons. Francisco's experience has exposed him to

> seeing that reality, that it's already instrumentalized. I call it *humanitarian industrialization*. Already, people are on this path for money because they pay well, because working in a shelter already pays you well. It's not like it used to be: voluntary. And, well, there is a whole industry behind mobility now.

For Francisco, paying people to commit to humanitarian practices for migrants at the border deviates the adequate motivations needed, which for him includes faith. As he insists by

summarizing, “political interest prevails before human interest. Economic interest is put first over human interest [and] the genuine interest of the Gospel, or what we are supposed to preach, which is serving and helping others.”

On the other hand, also as a facilitator, Thomas emphasized the importance of maintaining a balance between professionals and non-professionals in humanitarian care for transient migrants. For him, if humanitarian care was solely professionalized, many non-professionals would miss out on the personal growth and leadership roles that stem from the learning experiences working for those in need. Therefore, for Thomas, it is crucial to diversify humanitarian care for migrants:

> For how many people, if it were professionalized and you only had a small coterie of professionals that were working on this, you wouldn’t be able to provide that experience to a lot of other people who are able to dedicate some time and who are motivated primarily for philanthropic reasons. But all of a sudden, they become leaders in the area of immigrant justice or people who have a much more broader horizon than they would have had otherwise. I don’t think that we would ever want to sacrifice that dimension of providing [non-professional] people with the experience, the opportunity to experience that.

In this sense, people in general have the potential for growth and development of skills that can play a role in the development of humanitarian care for transient migrants.

4.2.3.3 People: The Most Important Factor

This section provides participants’ perspectives that shed light on the notion of *people* as the most important factor for improving the retention and effectiveness of the Clinic. Overall, the perspectives include the notions of manpower, consistency, leadership, and resource allocation (SEM: intra- and interpersonal levels).

For Mayra, one of the biggest gaps in the healthcare landscape for transient migrants at the border is “manpower,” namely, having more people in general, whether they are volunteers

or not. Additionally, when asked what is important for volunteering at the border, Mayra said "find the right people to volunteer with." When asked what is needed to improve the Clinic in general, Helen emphasized the importance of expanding the pool of volunteers, especially those who also advocate for migrants: "growing the base of individuals [volunteers] that work with this population, being advocates for them and sharing experiences so that it can grow at a larger level, whether that be on a government level." In general, Francisco agrees emphasizing the life-giving role of volunteers: "the volunteer gives life. The volunteer injects life into the [border] region."

On a different note, Sofia, as a facilitator, thinks that in addition to having volunteers, what is truly needed is consistent and thus reliable volunteers, which is expected to ensure a steady operation of a volunteer-based program like the Clinic. In other words, inconsistent volunteering can lead to disruptions in the provision of healthcare for migrants, at least at the Shelter. Regarding the Clinic's volunteers, Sofia, on behalf of the Shelter, said:

> We couldn't always count on them. Sometimes we already had an appointment scheduled for Saturday and the [U.S.] medical volunteer would say "sorry, I couldn't get volunteers." Since it was voluntary, I could not demand either. So, sometimes they came, sometimes they didn't….Since the Clinic was established, I don't think we had a month in a row…and we understand it perfectly. It's just a volunteer issue, but then that also has an impact.

Additionally, according to Sofia, there were some migrants at the Shelter who

> for some reason felt more empathy with the Clinic's doctor and, during the week they didn't seek an appointment with the other two [Mexican] doctors that the Shelter offers, but it would turn out that [the Clinic's volunteers] didn't come.

Paul confirms that on multiple occasions the Clinic would get cancelled. As a medical provider, he explained:

> We would have to cancel because I didn't have time to organize volunteers or I'll typically go and work if there's no volunteers, but if I'm working and I can't trade my shifts, then the Clinic might fall through.

Paul adopts multiple roles for the operation of the Clinic. Therefore, apart from recruiting more people, Paul thinks that volunteer retention relies on a structure that defines leadership and distributes responsibilities (SEM: institutional level). To this regard he said: "there's no real formal leadership structure…the success of the Clinic kind of fluctuates on my availability."

Although the program emerged from a collaboration between BSN and the Shelter, the recruitment of volunteers for the Clinic is not guaranteed for every weekend because it depends primarily on Paul who bears the responsibility for doing so. This negatively impacts not only the sustainability but also the operations of the Clinic itself. For example, Paul shared:

> Earlier, there was an incident…it was maybe three months into the Clinic last year when we had a missed [Saturday session]. There was some breakdown in communication between us and the Shelter… arranging follow up for a patient, and there was a bad outcome. I'm not sure where the blame lies, but part of it is me not paying enough attention and making sure it was communicated effectively, just because I was so busy. So, I think, part of the challenges is kind of lack of clear leadership structure, and that's one of the goals for this year… to kind of formalize a leadership structure, formalize responsibilities.

Later in the interview Paul shared more details about the "bad outcome" involving an anaphylactic reaction. As he recounts:

> There was a guy…that came in [to the Clinic] and he had a big abscess…and I was with a medical student, a visiting medical student…so I guided her through drying the abscess, and we gave him oral antibiotics, and then he left… he came back 3 hours later, right after he'd taken the antibiotic, and he had had an anaphylactic reaction to it, which was terrifying. That can be life threatening. The medicine for it is epinephrine, and I asked for it, and the nurses [at the Shelter] told me they had just run out of it… so I gave him other medications, and we put him on oxygen. Luckily— it took us a while to figure out how to work their [the Shelter's] oxygen machine— and luckily, he did all right. But he was one of the ones we had to call the ambulance for. It was kind of terrifying…waiting 30 minutes for the ambulance, and that was an occasion when I realized we didn't have the resources we needed. So, since then, I've been taking epinephrine [medication to treat severe allergic reactions] and a couple of other emergency medications…I don't want to risk it if the Shelter's run out of it again.

Furthermore, regarding retention, without physicians, the Clinic would simply not operate, and the scheduled volunteering session would get cancelled. In regard to the sudden

cancellations of volunteering sessions, Emily said: “I really want to keep volunteering, but because of the inconsistency of the Clinic, I’m almost wondering if I need to start …investing in starting a connection and a relationship with another clinic that has a more reliable schedule.” The retention of volunteers is impacted by the consistency of the volunteering sessions. Moreover, on a different view, professionalism and being able to “get along” with people can help volunteers stay consistent in their programs. This is the case for Diego who said: “I stick with [the clinic in El Paso] because I find the students and the people that I work with super professional, and it’s just a group of people that I really get along with.”

Similarly, as facilitators, Francisco and Thomas shared their views. For Francisco, “more than financing and more than any economic resource, we need human resources, that is, people who are already aware of reality.” Thomas points out that what is needed is not only people but also time and adequate program structure. As he puts it:

> In reality, the expenditures associated with the provision of services are not as big as you might think….the expenditures are less in things like medicine, and they’re more in terms of staff time to dedicate to things like recruitment and making sure that you’ve got the right processes in place to deliver the care.

For Thomas, what matters is to invest in staff time, coordinate, doing the requisite paperwork, data entry, recruiting, and making sure retention is maximized (SEM: institutional level).

4.3 Main Theme #3: Medical Liability: Borders of Legality

This third section is the last part of the results, focusing on arguably one of the most important challenges in sustaining a volunteer-based healthcare program for transient migrants specifically at the border region, namely, medical liability. Therefore, in this section I show that there have been instances of go-arounds or alternative pathways to navigate the borders of legality regarding medical liability at the intersection of morality.

4.3.1 Arrangement: Strategies to Navigate Challenges

Discussing the legal and institutional framework for volunteer-based healthcare programs for transient migrants at the border, the participants—primarily facilitators—reveal the following challenges and considerations: legal and institutional barriers, liability concerns, and the role of good will (SEM: societal and intrapersonal levels). For example, expanding from the previous section on what is needed to make a program like the Clinic work in a sustainable way, Sofia agreed that money is "not needed as such." Instead, Sofia highlights the pivotal legal and institutional barriers that have to be overcome, which includes navigating regulatory requirements, liability concerns, and the need for formal legal agreements. Reflecting on the Clinic's sustainability, Sofia said:

> What is needed is to address legal issues. The truth is that it is no longer going to be possible—perhaps it will be more complex—for the Clinic to be enabled this year, because, well, there are authorities such as health authorities…The volunteers, for starters, are not yet doctors. They're kind of studying…Even though [U.S. physicians] are doctors, the laws in Mexico didn't allow them to practice medicine here [in Ciudad Juárez]….At the end of the day, that's where the big challenge is, which is very complicated because there are many offices to have to go through to unlock these permissions….There are, at least I remember six, institutions that we would have to sit down with and find a way. And then not just finding the way. All of this is already in law, including some constitutional law. Federal and state legislators would have to be sought to translate the agreements into the federal and state constitutions. And then from there, it would be ruled and ordered to be changed…it seems almost impossible.

While Sofia saw uncertainty about the future of the Clinic at the Shelter due to different factors like the legal (liability) challenges, the need for more committed volunteerism, and a formalization of operational procedures if a legal pathway was found, Paul's views of the situation was in some instances contrasting. For example, he thought there was a legal arrangement already in place, although he never saw a formal statement showing such arrangement, which was another reason why some volunteers would be deterred from crossing the border to volunteer at the Clinic. To this regard, he said:

> My understanding, like a lot of things in Mexico, it's kind of like a handshake agreement. They're saying, "it's all fine, don't worry about it. Don't worry about the liability." I think a lot of it, the reason why this has worked for so long is because I think I have a higher risk threshold than a lot of other doctors might. I think coming from an American healthcare background, we live in a very litigious society. There's a lot of risk of being sued if anything goes wrong in America. And so I think a lot of providers won't have even started the project until they, in writing, they had something guaranteed absolving them of liability if something went wrong…. I kind of just had faith in the Mexican authorities just to, I guess, shield us from that liability even though nothing was.... I don't think there's...this is one of the things I'm asking [BSN] to do now, to make sure there's something in writing protecting us from liability, because that's a question I get from a lot of volunteers: "What does the liability look like?" And I don't think there's anything specifically in writing.

This extract is pivotal because it stresses that U.S. doctors are accustomed to a litigious environment, which is a point that Thomas mentioned while he explained the arrangement that was established with the Shelter to abide to liability. As Thomas said:

> American doctors in particular come from a very litigious environment, very sensitive to issues of liability. And so, it was something that we realized we had to address. In the case of the Clinic, we do have guard rules in place whereby there is a Mexican physician that's contracted in order to basically be the doctor of record for all of the medical interventions that the physician is going to come in the Clinic. And that's a process that was established in partnership with [the Shelter], and it seems to set up the appropriate guardrails and satisfy a lot of the concerns that many of the American doctors have around liability. It's one of the things that impedes a lot of doctors from doing more in the El Paso sector from doing more in Juárez because they are very conscious of the liability questions.

In agreement with Thomas, Francisco recognizes that "the American doctor is not licensed to practice medicine in another country." Therefore, as a way to justify the practice of medicine by US doctors in Mexico, the Shelter hired a Mexican doctor specifically to address liability concerns (SEM: institutional and societal levels). Francisco said, "a way was found in which there was a person in charge through the institution to which [U.S. medical volunteers] provided the service." Regarding the Mexican doctor's role at the Clinic, Francisco said "he would have to corroborate the information… that's what he was hired for: to be the legal backup." Similarly, regarding the street clinics' volunteering structure and arrangement, Paul emphasizes that he

"always makes sure there's at least one Mexican [volunteer] physician that's there whose license gives [U.S. medical volunteers] permission to work under his license." This is an attempt to overcome liability concerns outside the Shelter.

From a different angle, although she also considers good will to be important, Sofia thinks it is not necessarily legal. When asked if she has seen or heard of instances when practices were done outside the legal framework for humanitarian purposes, Sofia affirmatively answered saying these practices stem from

> the good will…I think it's a matter of good will within the path of humanitarian work for migrants. At the end of the day, we are people, you connect, and you have already met a person from an organization that you like and, perhaps, outside the office you can meet and do a project. So, I think it's a matter of good will….it's both Thomas, Francisco, and me, we're kind of passionate about this and it was, as always, to try to make it possible, possible, possible, in whatever way. But we also can't lose sight of the fact that at the end of the day there are things of a legal and institutional nature."

Although Sofia points out that good will can lead to social humanitarian mobilizations outside the workplace, she also stresses that the legal regulations of humanitarian work are important (SEM: intrapersonal and societal levels). She shared:

> The praxis of each territory, of each state, and much more of each country, is very regulated and I think it has to be because, well, then, how, for example, could you imply legal responsibility to a doctor with a bad practice? Even if I were doing it voluntarily, then there wouldn't be a tool. How do you ensure access to reparation and justice for the victim? I don't think it's as simple as a matter of goodwill in issues like court, where life and one's own health is at risk."

4.3.2 Morality

In this last sub-section, I provide statements that illustrate the complex dynamics surrounding the legal and ethical frameworks in providing healthcare as a volunteer to transient migrants at the border. I refer to this intersection as the border of legality, where volunteers navigate healthcare provision. Medical volunteers who are physicians, like Paul, prioritize

"moral urgency" over concerns of liability (SEM: intrapersonal and societal levels). Paul did not feel concerned nor deterred from volunteering regarding the liability implications of his work in Ciudad Juárez because he was working in agreement with the Mexican government. However, without the presence of the government, Paul feels less secured volunteering outside the Shelter (SEM: intrapersonal and institutional levels). As he said:

> I don't feel like that because we do have the agreement with the [Mexican] government and they [the Shelter] invited us in. So, I think we were able to skip through some of these bureaucratic hurdles, but I think outside of that setting, if we weren't in [the Shelter], I don't think we could do what we were doing there without a lot of additional clearance and paperwork from the government….I guess it doesn't deter me...I'm more careful now than I think I was in the beginning. It doesn't deter me. Like, for me, the moral urgency comes first. Like, there's a moral urgency and there's a need to help, and that comes first, everything follows that. So, we're doing our best to operate as upfront as possible, to be above the law as possible, but it's been a big hurdle with getting the [local] medical school involved. They want that specific paperwork acknowledging that they're shield from liability. And for me, that's not something that stops me. I think just because I have faith in our Mexican partners. It's a lot, like I was saying, it's a lot kind of like a handshake agreement.

Additionally, Paul's moral compromise is shared with other volunteers at the Clinic, especially the consistent volunteers. As he said:

> for American volunteers…I think the ones that volunteer in Juárez, especially the repeat volunteers that come back multiple times, they have more kind of that moral conviction. They feel the same sort of moral urgency that I feel. And, here [El Paso], when I volunteer [at the El Paso clinic], it seems there may be less of that.

This "moral urgency" that Paul mentioned is related with the type of hope that is employed in the humanitarian care for migrants at the border: "I believe the work we're doing does forge hope for these migrants. And I think that's something that's very powerful. I think the most important thing in life is to be able to serve others."

Furthermore, for medical students, like Mayra, the idea of the border as a place of emergency simultaneously implies a tolerance to certain requirements like having "qualifications." As she said regarding her impression of the border: "everyone who was

providing this kind of emergency care [for migrants] didn't really have the qualifications that they necessarily needed, and this is kind of allowed in this circumstance because all the needs [at the border] are so emergent." However, although Mayra emphasizes that migrants at shelters come up to her seeking medical assistance, she understands that she "cannot be practicing medicine without a license, which is incredibly immoral" (SEM: intrapersonal level). She always makes sure she has a professional guiding her medical practice. Paul would guide her, even if by phone, when she would do the informal volunteering, for example. As Mayra stated, she

> relied on Paul for the medical support because I don't have a license yet. So, even though people were coming to me with all of these concerns, I can't be practicing medicine without a license. I think that's incredibly immoral. And so, I would kind of do it under his guidance and make sure that there weren't things I wasn't accounting for or people weren't in such emergent situations that they needed to be seen by someone else. And so, I'd give advice under his supervision.

These were ways of navigating the borders of legality in regard to medical provision for migrants. However, for other types of humanitarian assistance that does not necessarily involve healthcare, Mayra was more flexible. For example, she said:

> It's illegal to transport a migrant, but I wasn't going to not drive someone to the hospital if they were dying just because they were undocumented….I'm not going to follow the law so strictly if it means that I'm putting people in danger.

Furthermore, because liability regulations make organizations or institutions hesitant to create partnerships, it can lead to making key officials operate informally (SEM: institutional and societal levels). For example, Thomas said:

> It can be very difficult to overcome the bureaucratic obstacles because there's a recognition that there is a need for medical services, but that the framework doesn't always make it easy to meet that…Even the officials with whom we've worked have conceded that sometimes it's better to do things more informally.

To this regard, Rose raises the notion that shelters may not always be sufficiently flexible and can have strict rules that may keep migrants out (SEM: institutional level). She discussed the

lack of systematic follow-up and resources for migrants in shelters, highlighting the need for better collaboration and coordination among different organizations and the absence of a nationwide healthcare system for migrants (SEM: community level). Rose said:

> I think that's the problem. I have seen too much structure…you get more layers and barriers in place as well. And I think they're important to be there. But if they start impeding what needs to be done, I think you just have to make your moral choice that it's more important to do what needs to be done than to follow a law...I think a lot of people feel that way, and I understand the need for. But I think right now there's a lot of different agencies on the border doing a lot of things, and they're coming up with a lot of rules."

For Helen, it is important that non-professionals or medical students "are practicing within their scope and not doing things that they shouldn't be doing." She said:

> Technically, on the Mexican side of the border you don't need a Mexican license to be providing health care because we were technically working under the Mexican attendings there. So I guess that was sort of the workaround there…I think just ethically, every person that's volunteering just needs to be very aware of how vulnerable this population is, more so than even in our everyday work, and then just be aware of your practice and making sure you're doing things for the right reason.

For Diego, health and healthcare access is "more like an ethical or moral duty than a right." For Francisco, this involves committing to certain practices that may not necessarily be legal. Despite the possible legal irregularities that the Clinic engage with, Francisco underscores his firm belief in the importance of helping people, even at the risk of facing legal obstacles. Francisco said, "you ask me if we were committing irregularities and illegality, and I don't care. I would do it again because I'm helping people." This, however, is not a practice that all volunteers commit to. Sandra, for example, was very concerned of being identified as a volunteer providing healthcare to transient migrants, especially in Mexico. Before and during her interview, she explicitly requested her privacy to be protected due to concern of liability. This sheds light into the fears that medical volunteers can experience during this type of humanitarian healthcare for vulnerable populations (SEM: intrapersonal and societal levels).

4.3.3 Hope

With the aspirations that the participants shared, it is possible to glimpse at a vision for the future of the Clinic and general volunteer-based healthcare provision for transient migrants at the border. In this regard, the participants reflected a commitment to long-term impact and community empowerment (SEM: interpersonal level). Whereas some participants like Sofia and Francisco think the Clinic was not continuing (as it was aforementioned in previous sections), we have Paul, for example, envisioning the expansion of the Clinic into, ideally, "some sort of institute for humanitarian health in El Paso." He never wants to "sacrifice standards of care" just because he is providing healthcare to migrants, so Paul thinks that through the Clinic, migrants can "receive close to the standard of care they would expect in a clinic in the United States."

Mayra emphasized the significance of space in developing sustainable healthcare provision for transient migrants, pointing out the role that local knowledge and resource accessibility play within space (SEM: intrapersonal and institutional levels). As she puts it:

> I think the ideal would be to have a migrant specific free clinic…like a walk in clinic where people can come with any sort of complaint and we fulfill, like, 10-15 patients per day…I don't think there will be any challenge fulfilling a full schedule for a physician with walk-in appointments in El Paso…like downtown, near the border, near one of the shelters would be great. That way people know where it is…once people know where to go for something, if they know, "oh, I have to go to this building that's like 20ft away"…they're going to go there every single time, and then they're going to tell people, and more and more of the migrant community is going to know. So, the location is really important. And…the physicians who work there should be salaried. They should be employed there because they should be doing that full time.

Additionally, like Paul who came back to El Paso to stay long-term, Mayra plans to return to the border region and continue volunteering helping people who are in pressing need. One of the reasons why she plans to come back is because she trusts people in El Paso. Therefore, she intends to abide to medical liability by getting a Texas medical license to continue employing her skills and leveraging the social network she has developed as a volunteer. As she said:

> I have someone who I trust [in El Paso], who is doing good work, who is local, who is doing it in a sustainable way, whose work then I can supplement or augment. And then secondly, as I get more knowledge, I'm going to want to go back multiple times, if not stay for a period of time…I definitely plan to come back as a full grown doctor someday and give those professional skills in settings that might not otherwise have access to them and go the extra mile and make sure that I have my license certification in Texas and make sure that I have connections to the resources that are needed to help provide adequate-sufficient medical care to migrants in the community of El Paso. And that's going to come from utilizing a lot of local organizations and a lot of the connections that I've made.

Moreover, challenges are still considered moving forward. For Henry, as a retired medical professional over the age of 70, he assured that, as a volunteer, he will "do migrant medicine forever." However, for him age and the border are limiting factors, saying "age is a reality. Moving is a reality. The border is a reality." In the case of Emily, she stressed for the Clinic to become a more formalized program that needs to "seem like a thing," and also warns future volunteers to confront the "white savior complex." Additionally, thinking about the future, Emily shared the challenges she is going to be facing regarding balancing her medical studies and avoiding being overwhelmed with responsibilities:

> I don't know whether I'll be able to do [volunteering] during my clinical rotations because I've heard that you round and work for like 12 hours and then you're supposed to go home and you're supposed to study even more. So that's where I don't know. I do need to make sure that I am taking care of myself and maybe that would involve more "me time" and less volunteering too. So, the future is unclear.

Similarly thinking about being overwhelmed, as a facilitator, the reason Francisco recently tried to remove himself from these issues is because he got tired of the position he had, but not necessarily the issue of migration. He said: "I got tired at the [rank] level I was, which I think was very high [in terms of politics]." Now, Francisco wants "to keep thinking" and give himself "time to build" while at the same time work "in people's direct care, listening to them, providing them with whatever they need…recognizing again the 'why I am here'."

Lastly, as the executive director of BSN, Thomas shared that moving forward regarding the Clinic, "the [Local Hospital] has asked [BSN] to partner so that [the former] could provide physicians on a stable basis. But they've asked [BSN] to engage in negotiations with the Mexican government to make that happen [at the Shelter]" (SEM: community level). As negotiations continue, Thomas also recognized that because receiving asylum in the United States is "so difficult to obtain," it is possible to engage with "medical physicians in bolstering asylum claims if they provide affidavits." This can be another project for the Clinic, which Thomas believes can involve having BSN operating under the supervision of an attorney who could "train the core of volunteer medical professionals to be able to do that type of work" (SEM: institutional level). Additionally, according to Thomas, BSN has more explicitly recognized that "not everybody [who is a transient migrant] has somewhere to go [in the U.S.] and they need accompaniment beyond Juárez, beyond El Paso." Therefore, moving forward regarding care for transient migrants, BSN plans to develop a program that can provide "enhanced wraparound care as they make their journey into the United States."

4.3.3.1 Leadership Training

As I was closing my data collection, I was invited to attend a leadership training event at BSN. While the Clinic was considered discontinued by some participants, hope remarkably reemerged for strengthening their volunteer capacity (SEM: interpersonal and institutional levels). The descriptions that follow come from my notes and observations of the event.

BSN hosted a leadership training for primarily medical students and physicians who were interested in volunteering providing healthcare to transient migrants in the border region. This leadership training was a form of resistance that sought anyone who could be a medical doctor, nurse, midwife, resident physician, etcetera. It also allowed interested members of the

community to join, especially as interpreters. However, the stress was undoubtedly for medical volunteer recruitment. Thomas, Paul, and a new facilitator now working for BSN gave presentations. The purpose: to restart the Clinic and "relocate onto other spaces" outside the Shelter, as Paul stated. The primary reason for relocating was to target spaces where humanitarian needs for transient migrants in Ciudad Juárez are concentrated, where less healthcare access is available to them. Thus, the emphasis is now on street clinics, namely, to provide healthcare for unsheltered transient migrants on the streets of Ciudad Juárez.

The training initiated with Thomas providing a history of the humanitarian efforts that have developed in El Paso since 2018. He emphasized not only that migrants were unprecedently getting dropped off by border patrol in downtown El Paso during 2018, but, most importantly, the moral action that has taken place at the border region. He shared the Guatemalan saying "*Tu eres mi otro yo* [you are my other me]", to stress that liberation is mutual in the context of humanitarian assistance for vulnerable populations. The vision for this type of humanitarian assistance has the "migrant at the center" in the pursuit of expanding leadership and binational collaboration.

Paul talked about the history of the Clinic and its impact since its establishment in 2022. During its first year, the Clinic:

- Operated 44 times.
- Provided healthcare for over 500 transient migrants.
    - The patients were from ten countries in Latin America and the Caribbean
    - Ranging in age between 3 months to 77 years.

- Treated mostly communicable diseases (e.g., viral gastroenteritis, viral upper respiratory infections, varicella, and tuberculosis) and some chronic conditions (e.g., diabetes mellitus, hypertension, and asthma).

Moreover, Paul talked about "political pathologies" to highlight the political determinants of health that migrants face and stressing that if pathology is political then the response should be too: "the pathology is political, the solution is too." To this regard, he emphasized that the approach to healthcare at the Clinic involves not only medical but also moral care. The juxtaposition of medical and the moral is a response to the data Paul shared regarding the number of migrant deaths in the El Paso sector since 2008. He attributes these deaths to the border wall from which many migrants fall. Those who survive go to the Local Hospital, which since 2019:

- Treated over 1,100 cases of border wall falls.
    - 38% requiring multiple surgical interventions.
    - 88% not receiving follow-up healthcare.

Other injuries that migrants experience when crossing the border stem from border patrol pursuits, assaults, concertina wire, the environment (e.g., hypo/hyperthermia and drownings), sexual assaults, untreated chronic conditions, and falling from the train known as "La Bestia."

Additionally, an immigration lawyer was at the leadership training to present on the high importance of medical affidavits inside immigration proceedings. This lawyer explained that a proper documentation of biological/physical markers attributed to violence of persecution is almost irrefutable evidence in favor of asylum seekers. Pursuing such documentations is important, according to the lawyer, because helping transient migrants is already "a losing game, so the few wins are worth celebrating." Therefore, as a form of hope for migrants and their

providers, the Clinic will also shift their operations onto conducting and providing medical affidavits to asylum seekers.

4.4 Summary

In this results chapter, the role of soft factors like worldviews and motivations in the development of a volunteer-based healthcare program at the border region has been put forward from the perspective of facilitators and medical volunteers of mostly one microcosm, namely, the Clinic. During this process, I identified the different socio-ecological levels throughout the data. Regarding the challenges impacting the sustainability of the Clinic, three key areas were identified along with respective soft factors. The first involved the establishment of an inter-organizational cross-border partnership, specifically between BSN and the Shelter. This partnership was formalized in the context of an asymmetrical accumulation of humanitarian needs at the border region. The soft factors in play that were identified involved worldviews, motivations, trust and faith. The second key area consisted of volunteer capacity which consists in at least volunteer recruitment, engagement, and retention. Here, the key soft factors include leadership, worldviews, motivations, collectivity, language, emotions, salary and people in general. Last, but not least, medical liability was identified as the third key area regarding the challenges impacting the sustainability of volunteer-based healthcare for transient migrants at the border. In this section, I displayed the operational arrangements that are established as pathways to abide to medical liability and how participants navigate the borders of legality at the intersection with morality. Ultimately, I show how despite all the challenges that were identified, participants continue to envision a future, some thinking about alternatives. Visions for the future include long-term impact and community empowerment, strategically thinking about space and

location, professional development, and more inter-personal and inter-organizational partnerships. These visions for the future began materializing as the Clinic recommenced with a leadership training for future medical volunteers.

CHAPTER 5: DISCUSSION

The twofold aim of this study has been to investigate: 1) the role of soft infrastructure in the development of volunteer-based healthcare programs for transient migrants in the border region; and 2) the challenges in developing these types of programs in a sustainable way. The results indicated three key areas of challenges that impact the sustainability of a volunteer-based healthcare program for transient migrants in the border region. These are: 1) inter-organizational cross-border partnership, 2) volunteer capacity, and 3) medical liability. In this discussion I set out to show how these three key areas of challenges are interconnected. Together, the three key areas of challenges form a nexus within the border region. To explain the nexus, emphasizing the border-space, this discussion is divided into the three following dimensions: 1) building inter-organizational cross-border partnership & volunteer capacity; 2) medical liability & building inter-organizational cross-border partnership; and 3) volunteer capacity & medical liability (See Figure 9).

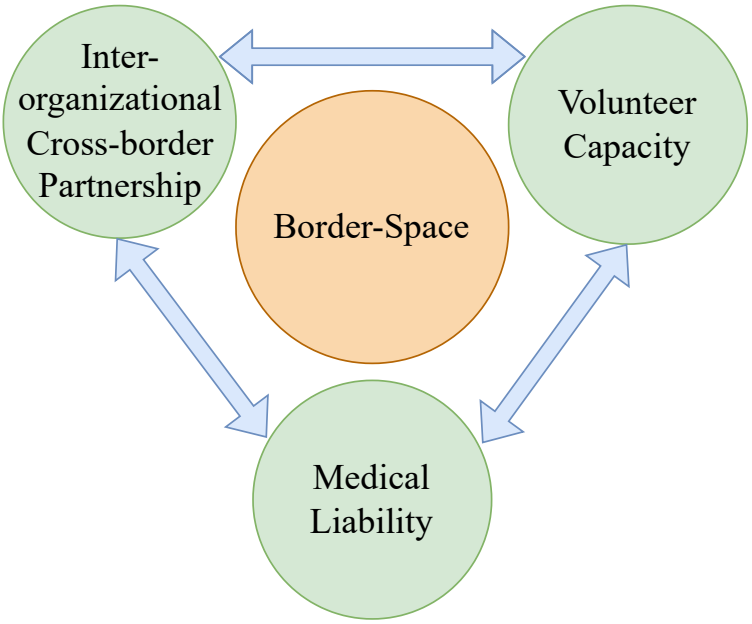

Figure 9 Nexus of Key Themes

Understanding the interconnectedness of the three key areas of challenges includes showing the interplay between the soft factors in each key area and, by doing so, conveying the role of soft infrastructure. The soft factors identified in the results are *parts* of the changing *whole* of a soft infrastructure that has played a role in the development of a volunteer-based healthcare program for transient migrants in the border region. All three dimensions of the aforementioned nexus have motivations, worldviews, and morality as common soft factors. I employ the socio-ecological model to show how these, and other soft factors, assemble a soft infrastructure. Showing the role of soft infrastructure will help answer the research questions and how the results contribute to the existing literature.

The first dimension discusses inter-organizational cross-border partnership vis-á-vis volunteer capacity. It also includes trust and faith as crucial connectors at an inter-personal and community level. As it is shown in the literature review, formalizing these types of connections—or "commons" (Heyman, 2022)— is a unique challenge at the border, so I explore how the spatial dimension of the border grounds the soft factors. By doing this, I set out to answer my research questions regarding im/mobility, alternative visions, recruitment, and language. Additionally, this dimension of the nexus is devoted to discussing the importance of partnership between people and organizations on both sides of the border in establishing volunteer-based healthcare programs for migrants in this region. I highlight the challenges that are faced in building and sustaining cross-border partnerships and explore how volunteer capacity is influenced by the strength and effectiveness of inter-organizational partnerships, particularly regarding volunteer recruitment and retention.

The second dimension of the nexus juxtaposes medical liability and building inter-organizational cross-border partnership. Here, I set out to answer the research questions

regarding morality, in/formality, and worldviews. From the point of view of the facilitators who establish programs for volunteers, I examine the implications of concerns involving medical liability in the development and sustainability of a volunteer-based healthcare program for migrants at the border. I discuss how legal/regulatory frameworks on both sides of the border shape the structure and operation of such types of healthcare programs. These include the instrumentalization of Mexican physicians as legal backups. Conversely, I also explore the role of inter-organizational cross-border partnerships in addressing medical liability, such as the establishment of formal agreements and protocols to mitigate risks and ensure medical practice compliance. Here, the soft factors in play involve mutual understanding, trust, and accountability.

The third dimension of the nexus shows the intersection between volunteer capacity and medical liability, focusing on the soft factors involved in navigating the borders of legality. I answer more concretely the research questions regarding im/mobility, in/formality, alternative visions, recruitment, and ethical and moral principles. Here, soft factors at play include mentorship, leadership, and peer support, all of which foster confidence, competence, and resilience in the face of medical liability. Lastly, after showing the three dimensions of the proposed nexus, I discuss the role of soft infrastructure in the development of a sustainable volunteer-based healthcare program for transient migrants in the border region.

5.1 Developing inter-organizational cross-border partnership and volunteer capacity

Building inter-organizational cross-border partnership at the border helps build volunteer capacity. A strong volunteer capacity facilitates the building and sustainability of inter-

organizational cross-border partnerships. At the center, as the data supports, “people are foundational resources” for program success (Kavanaugh et al., 2022, p. 3).

The data consistently show that addressing the challenge of volunteer capacity is crucial because the volunteers are considered one of the most important resources for making volunteer-based healthcare programs work. From the point of view of facilitators, especially Sofia, the lack of volunteers—reflected in the inconsistency of the weekly operations of the Clinic—discouraged the Shelter to continue partnership with BSN. The capacity and commitment of volunteers was highlighted as determinant factors for the sustainability of the Clinic program. In this sense, volunteer capacity played a pivotal role in sustaining the partnership that BSN had formalized with the Shelter, specifically for the Clinic. On the other hand, however, the data also suggests that volunteer recruitment can improve if, in Emily’s words, the Clinic “seems like a thing,” meaning that it appears like a program sustained by a sufficiently formalized inter-organizational cross-border partnership.

The sustainability of the Clinic was also measured to some degree by its geographical context. Situated in Ciudad Juárez, some participants stress that the Clinic is typically perceived in El Paso as not the safest volunteering opportunity. One of the rationales involved the social rhetoric or worldview of Ciudad Juárez as an unknown and dangerous city, which certainly deters potential volunteers who, thus, perceive the Clinic as not a safe volunteering opportunity in the border region. This is why Paul would emphasize during volunteer recruitment that the Clinic was inside the Shelter, which is run by the Mexican government and, as described by Emily, is militarized and secured. Knowing this, some volunteers would agree to traveling to the Shelter from El Paso, but others would not. The volunteers who would go to the Shelter would not only trust Paul but also have the motivation to cross the border into Ciudad Juárez. This

reflects the notion that "trying something new takes personal courage and only happens with trust, support and encouragement" (Kavanaugh et al., 2022, p. 4). Additionally, the data suggests that potential volunteers are deterred from the Clinic due to mere convenience, particularly for medical students who volunteer as part of their academic requirements. Therefore, fostering relationships at the interpersonal and community level has been crucial for promoting trust, ensuring safe spaces, and encouraging cross-border mobility in the midst of worldviews about the border.

Regardless of how people perceived Ciudad Juárez and the Clinic, the data also shows that the politics of im/mobility halted the movement of transient migrants arriving at the border, which played a significant role in the accumulation of humanitarian needs in the region. More specifically, while humanitarian needs were increasing on both sides of the border, Ciudad Juárez was experiencing most of the "burden," as Thomas puts it. While this adds a significant burden to the Mexican side of the border, the data suggests that it also allows some transient migrants to receive follow-up healthcare, sometimes by the same medical provisioner in the same settings (e.g., the Shelter).

Moreover, the humanitarian accumulation at the border region was asymmetrical having Ciudad Juárez carry most of the stress and to some extent depending on humanitarian help from across the border, which is a phenomenon that historically characterizes the border at large. For example, although focusing on economic examples, the historian Oscar J. Martínez argues that the U.S.-Mexico border is "a good example of strong asymmetrical interdependence" (1998, p. 9). In a more recent text, he specifically focuses on Ciudad Juárez and how it has been asymmetrically depended on the historical processes and developments that have constituted the United States (2018, pp. 5, 8). Due to the asymmetrical accumulation of humanitarian needs in

the border region, organizations on both sides of the border reacted in search of strengthening the humanitarian network in the region and collectively respond to the needs. This was the case with BSN invoking "binational solidarity" by crossing the border and developing an inter-organizational partnership with the Shelter.

Indeed, BSN and the Shelter had a shared need and interest of helping transient migrants in Ciudad Juárez. Their partnership stems from having identified a "commons" or a "shared fate," which is what borderlanders can do (Heyman, 2022). Therefore, the data supports the notion that, at the border, "interdependence provides both advantages and liabilities, prompting some segments of the border population to capitalize on opportunities where they exist, and other segments to minimize the negative consequences that often arise from the asymmetrical relationship" (Martínez, 1998, p. 50). Some of the participants perceived El Paso as a place where there is a more developed humanitarian network for transient migrants compared to Ciudad Juárez. This perception influenced the humanitarian motivation to cross the border and volunteer helping transient migrants in Ciudad Juárez. It was a form of employing cross-border mobility and solidarity for transient migrants experiencing immobility at the border. However, due to the worldview of Ciudad Juárez as a dangerous and inconvenient place to enter, other volunteers did not cross the border despite their interest, which suggests that worldviews can hold sway over motivations.

To ensure the sustainability of the Clinic, more people were required, especially motivated and committed professionals. However, there are important challenges in recruiting volunteers at the border, especially when the volunteering involves crossing the border itself. Cross-border mobility tends to be a time-consuming activity, which can be incompatible for medical professionals who, as Paul and Emily expressed, are typically very busy people.

Additionally, the worldviews of insecurity and inconvenience about crossing the border can be deterrents. Therefore, developing soft factors like trust, safety, motivation, and knowledge can be helpful in making a program like the Clinic sustainable.

Moreover, to ensure sustainability, the responsibility for building volunteer capacity cannot be attributed to one person. For example, during some weekends, the Clinic would not operate because Paul was not able to recruit volunteers. When lacking volunteer physicians, Paul would try to go to the Clinic, but this was not always possible because he is also a full-time physician. Furthermore, apart from recruiting more people, the data suggests that to have a strong volunteer capacity it is also crucial to have a volunteer structure that defines leadership and distributes responsibilities at the Clinic. However, for a volunteer structure to become stable, volunteers need to be recruited and retained. Therefore, while volunteer capacity must be strengthened with a clear volunteer structure, it is difficult to guarantee a volunteer structure without a developed volunteer capacity (See Figure 10).

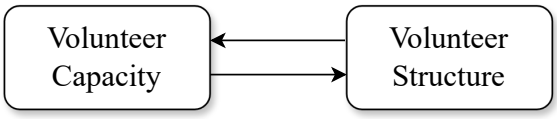

Figure 10 Volunteer Capacity-Structure Nexus

Overcoming this loop is a challenge that impedes developing volunteer capacity, which then impacts inter-organizational cross-border partnerships that rely on volunteers.

The data suggests that recruiting and retaining volunteers is also difficult because humanitarian care for transient migrants in the border region is increasingly involving economic compensation. This raised concerns for some participants who think that receiving economic compensation “changes attitudes” or perpetuates “humanitarian industrialization,” which is

perceived to weaken the soft infrastructure needed for program success. This perception confirms the warnings by Kavanaugh and colleagues that "funding processes can cause harm…[disrupt the] ability to create long term relationships and trust" (2022, p. 5).

Furthermore, there are volunteer-based healthcare programs for transient migrants on both sides of the border, having the Clinic in Ciudad Juárez and the El Paso clinic. Some volunteers in El Paso gravitate towards helping transient migrants across the border, whether it is due to moral conviction, motivations, worldviews, trust, or sense of safety. This creates a fragmentation where some volunteers stop volunteering in El Paso—or do so less frequently—in order to cross into Ciudad Juárez and help there instead. This is possible because an opportunity—the Clinic—emerged that invites U.S. medical volunteers to cross the border to practice medicine in the provision of healthcare for transient migrants. The volunteer opportunities/programs on both sides of the border emerged from established partnerships between different organizations and institutions. However, the way each program operates differs depending on the nature of the inter-organizational partnership.

On the one hand, the inter-organizational partnership founding the El Paso clinic allows medical students and doctors from a medical school to volunteer in the provision of healthcare for transient migrants sheltered in a church. In this sense, their volunteer capacity is benefited by the inter-organizational partnership, given that it helps ensure a consistent flow of volunteers who are recruited through a medical school and replaced by new students as the older generations graduate. This volunteer structure is criticized by some participants because, like economic compensation, institutional reward (e.g., fulfilling academic requirements) for conducting humanitarian activities can deter the attitudes or soft factors that are needed in such delicate practices with vulnerable populations.

On the other hand, in Ciudad Juárez, the inter-organizational cross-border partnership that established the Clinic was "rare." This has implications on volunteer capacity because having to cross the border regularly to help migrants is not a conventional form of medical volunteer engagement, at least in the border region. Occurring at the intersection of nation-state boundaries and requiring medical volunteers to cross the border, the Clinic represents a space of tension given that multiple state-bounded systems intersect (e.g., medical practice liability, language, norms). Therefore, because entering new socially bounded areas implies entering into new symbolic systems, crossing the border can also be a form of resistance (Donnan & Wilson, 1999).

The medical volunteers who cross the border to help migrants also undergo a pedagogical process where they acquire practical knowledge and develop cross-border partnerships that strengthen soft infrastructure through trust, worldview, motivation, and hope. The contents and changes that stem from these experiences become valuable and reflect the "tense and conflictual ways in which the border shapes the lives and experiences of subjects who, due to the functioning of the border itself, are configured as bearers of labor power" (Mezzadra & Neilson, 2013, p. 20).

As a form of binational solidarity, the Clinic not only symbolizes the partnership between organizations from different sides of the border, but also partnership between individuals from different backgrounds. U.S. medical practitioners meet Mexican counterparts, which further fosters cross-border partnership and volunteer capacity. Developing interpersonal and inter-organizational relationships involves people who cross borders and manage to develop relationships through shared time and experience, that is, where soft factors like trust, commitment, consistency, and credibility can develop. This is important given that today "[t]he

foundations of social solidarity and communal responsibility have been sapped [and] the idea of social justice compromised" (Bauman & Donskis, 2013, p. 63). Having robust cross-border interpersonal and inter-organizational relationships fosters creativity and motivation, ultimately enabling flexible and effective collective navigation of border dynamics.

5.2 Medical Liability and developing inter-organizational cross-border partnership

Inter-organizational cross-border partnership has paved the way to navigating medical liability in ways that are not conventional. As the data shows, the Clinic occurred despite the limits and restrictions of medical liability, making the program "rare" by pushing the boundaries of medical practice regulations. This did not occur by chance. Instead, pathways were found through creativity, flexibility, commitment, and motivation vis-á-vis established relationships of trust.

Notwithstanding, medical liability was precisely one of the most important factors that impeded the Clinic to continue operating at the Shelter, which weakened the inter-organizational cross-border partnership that created the Clinic in the first place. Therefore, legal regulations pertaining to cross-border medical practice restricts and limits a binational volunteer-based healthcare provision for transient migrants at the border, impacting trust, confidence, commitment, and motivation. It deters the building of inter-organizational cross-border partnership. In this sense, medical practice regulation impacts the sustainability of volunteer-based healthcare programs for transient migrants at the border.

Moreover, as the data suggests, to formalize and sustain inter-organizational cross-border partnership, it is not enough to find adequate legal pathways to comply with medical liability. It is also important to negotiate and secure safe spaces where humanitarian assistance can be

conducted without fear of further consequences. This supports Jalušič's findings that the legal regulations of humanitarian care for migrants reduces or restricts the space of humanitarian care (2019). The Clinic inside the Shelter, along with the street clinics, can be considered settings on which soft infrastructure develops and is actively at play. As the data shows, they are settings that emerge from an inter-organizational cross-border partnership on the basis of trust, motivation, and creativity.

In the specific case of the Clinic inside the Shelter, the usage of space consisted of different levels of jurisdiction and sovereignty. On the one hand, the Shelter is part of the Mexican government, which also consisted of the Mexican National guard along with other government-derived entities. On the other hand, BSN is a non-government non-for-profit organization in the United States that, with the crucial help of a U.S. medical doctor, recruited U.S. medical volunteers who would then operate the clinical space inside the Shelter. The jurisdiction and sovereignty stemming from the nationality of each person and organization intersects within the space of the Clinic inside the Shelter.

Keller Easterling's definition of infrastructure space as "a site of multiple, overlapping, or nested forms of sovereignty, where domestic and transnational jurisdiction collide" (2016, p. 15) is useful here. For Easterling, it is through this infrastructure space that "extrastatecraft" emerges, which she defines as "the often-undisclosed activities of, in addition to, and sometimes even in partnership with statecraft" (p.15). Therefore, it is possible to understand the Clinic inside the Shelter as extrastatecraft. The idea is that the usage of space to create diverse and complex types of settings designed to provide healthcare to vulnerable populations stem from inter-organizational cross-border partnership. As this partnership navigates the borders of legality vis-à-vis medical liability, the details of what occurs inside the Clinic are not often

disclosed to the public. Therefore, these settings can bypass high levels of surveillance and be spaces that potentially foster community building, knowledge exchange, and cross-border partnerships.

Furthermore, new settings can also function as spaces where new practices or visions are explored, including pathways to overcome the limitations of medical liability, especially in a border context. The data suggests that knowledge is a key resource that facilitates the navigation of border dynamics, building cross-border partnership, and leveraging other soft resources. Knowledge is shared among U.S. and Mexican medical providers or between volunteers and facilitators, all of which helps improve partnership and capacity. In this sense, "information/knowledge are made more valuable when relayed locally" (Kavanaugh et al., 2022, p. 1).

5.3 Volunteer Capacity and Medica Liability

There is an interconnectedness between volunteer capacity and medical liability. On the one hand, the threat of medical liability deters or negatively impacts volunteer capacity. However, on the other hand, volunteer capacity can temporarily suspend the constraints of medical liability, especially through soft factors like worldviews, motivations, and morality.

Medical liability was a factor that deterred some medical volunteers from crossing the border from El Paso into Ciudad Juárez. The fears of medical liability also restricted the space and volunteer engagement across the border since the Shelter was considered the safest space in terms of protection from medical practice regulation. In this sense, the Shelter became a setting that pulls in or includes U.S. medical volunteers to become part of the humanitarian assistance for transient migrants in Ciudad Juárez while simultaneously excluding other settings that are not

government-led and may have greater needs. This supports the notion of differential inclusion, which refers to "how borders establish multiple points of control along key lines and geographies of wealth and power, [in which] we see inclusion existing in a continuum with exclusion, rather than in opposition" (Mezzadra & Neilson, 2013, p. 7).

Nonetheless, the borders of legality were often crossed by medical volunteers. This is a practice that was justified by an ethical and moral motivator superior to the legal. For example, some participants mentioned having a higher threshold in terms of being concerned about medical liability. This higher threshold stems from not only an awareness that the U.S. has a litigious environment but, also, from faith and the worldview that everyone deserves healthcare access and good quality of care. Liability issues enter into tension with the ethical and moral principles of medical volunteers. It is in this tension where formal and informal volunteering occurs. Regarding the latter, the mobility and flexibility of volunteer-based healthcare provision for migrants resulted in the informal usage of space (e.g., street clinics) where volunteer capacity was strengthened through learning and trust.

The street clinics are settings where the borders of legality enter in tension with the ethical and moral principles of medical volunteers, which becomes a space with pedagogical value. The data suggests that medical volunteers, especially medical students, learn medical approaches that are less technology- and resource-driven and more manual and intuitive. By also learning alongside Mexican medical providers, the pedagogical value of the street clinics supports the notion that regardless of how border crossing occurs, the act of crossing implies a shift of systems that are somehow grounded on a state or national entity (Donnan & Wilson, 1999). These systems could be related to value (both material and idealist), and people who enter a bounded space represent individuals that could either benefit or harm the systems in question,

which in this case includes different legislative systems, culture, language, and medical approaches.

Moreover, the pedagogical value of working not only in street clinics but with transient migrants in general consists of being impacted by the reality of the Other. The encounter with the Other has the potential of exposing people to realities that then shape worldviews and commitments to altruism. This is possible, according to Emmanuel Levinas, because the Other intrinsically resists objectification, "resists possession, resists my powers," not violently but by demanding "absolute alterity", which "has a positive structure: ethical" (2002, p. 517). In the words of Jules Simon, the "Levinasian demand is a demand for personal, intimate, and responsible involvement in the life of another" (2009, p. 134). The process of attending to Otherness involves shifting from a "self-centered" to an "other-centered" approach, especially through empathy, which refers to the capacity to perceive the needs of others and the intrinsic value of helping them (Gomez et al., 2020, p. 6). Participants developed their commitment, worldview, and motivation from encounters with vulnerable populations (i.e., the Other), and embodying the ethics of identifying and attending to the humanity of those in need. This also includes helping other people experience and learn to do the same. By doing so, volunteer capacity is fostered, which then influences navigating legal regulations by disregarding laws that impede or do not prioritize humanitarian care when needed.

Some medical volunteers perceive what they do as right, good, and highly needed, even if medical liability is a limiting factor. In a way, they realize that not helping transient migrants is an expression of "evil...in failing to react to someone else's suffering, in refusing to understand others, in insensitivity and in eyes turned away from a silent ethical gaze" (Bauman & Donskis, 2013, p. 9). In this sense, evil is the loss of sensitivity of the ability to employ empathy.

Additionally, medical volunteers experience a sense of fulfillment that further fosters volunteer capacity. This reflects what Henry David Thoreau said in his essay *On the Duty of Civil Disobedience*: "it matters not how small the beginning may seem to be: what is once well done is done forever" (1849, p. 187).

Moreover, as the literature review shows, there are some debates regarding relying on volunteers to address long-term issues like migration. One of the most pressing arguments against using volunteers in the provision of healthcare for migrants is that doing so can absolve the State from its responsibility (Castañeda, 2023, p. 9). While it is surely possible for this negative consequence to occur, there can also be positive outcomes from relying on volunteers. The data suggests that volunteerism can expose people who are not professionals (e.g., non-medical students) to contexts that can make them leaders in immigration and social justice issues, which is an idea that cannot be underestimated. Additionally, medical volunteerism often has the ability to be flexible and quickly adapt to changing contexts and emerging needs, fostering unique (practical) knowledge and a soft infrastructure that develops without economic compensation or strict bureaucratic (e.g., governmental) structures.

5.4 Nexus: Soft Infrastructure

In the previous sections I have focused individually on the three dimensions constituting the aforementioned nexus. I have explored the interconnectedness between the soft factors that each dimension contains. In this section, I emphasize the interconnectedness of all the soft factors in play (i.e., the role of soft infrastructure) in the development of a volunteer-based healthcare program for transient migrants in the border region. This includes making a few remarks about soft infrastructure in the border in relation to the literature.

There are instances in the nexus where the data seems to have contradictory statements; for example, that volunteer capacity is intertwined with volunteer structure where they both need each other for sustainability. To this regard, it is important to emphasize the paradoxical spatial dimension on which the data emerged and point out that borders are multidimensional phenomena that can have multiple effects that prompt the people there "to confront myriad challenges stemming from the paradoxical nature of the setting [the border]" (Martínez, 1998, p. 25). Additionally, instead of thinking in terms of paradoxes to understand the aforementioned nexus, it is helpful to think of dialectics. More specifically, the three key areas of challenges impacting sustainability for the Clinic are all dialectically connected, informing and impacting each other, as it was discussed throughout the chapter thus far. Soft infrastructure becomes part of the world and the code that shapes relationships at an interpersonal and community level. This supports Paul Farmer's remarks that in healthcare provision for vulnerable populations, "the whole draws on the parts, but firmly transcends them" (xvi).

Indeed, the role of soft infrastructure in the development of volunteer-based healthcare programs is reflected in the healthcare itself that is provided to transient migrants in the border region. Soft infrastructure consists of a complex matrix of both tangible and intangible resources that are given a meaning or purpose and then leveraged by the community. To this regard, it is worth quoting at full length an extract by Kavanaugh and colleagues saying that considering soft infrastructure is

> a deeper understanding of the way communities themselves develop local capacities for problem-solving. Resources can be thought of as things that communities need to function effectively and undertake change/improvement. They take a variety of forms, including: people and their knowledge, skills, and relationships; settings, which provide venues for interaction and action; and events, which help to build identity and foster group values. Narratives that a community has about itself may also be thought of as a resource for community health improvement (2022, p. 2).

Soft infrastructure is not fixed and is, instead, constantly changing. This is due to the fluctuating nature of the border reality and the fact that, as the literature review shows, humanitarian care does not exist in a vacuum. The Clinic did not exist independently. Instead, it emerged in a complex border region where the dynamics of im/mobility are often unpredictable and multiple systems collide (e.g., culture, language, medical liability, worldviews). This is important to point out given that, as Kavanaugh and colleagues state, it is crucial to "better appreciate the complex interactions between programs and contexts" (2022, p. 2).

Therefore, soft infrastructure's development towards sustainably and in addressing the issue of migration—which is a long-term need— adopts a non-ideal theory of justice, which tells us that, precisely because we cannot abstract ourselves from the complex—often paradoxical—nature of the world, we can only move *towards* a world of justice (Stemplowska & Swift, 2012). It implies identifying from the world *what* are the particular injustices here and now. In this sense, through its dynamic development at the border, the role of soft infrastructure helps recognize some strategies being more effective than others in strengthening human relations, addressing needs, and mitigating suffering. The idea is to do the best that justice permits in a non-ideal world. Although Heyman calls it a "utopian vision," it is certainty one that drives action, which, as he affirms, is not strange given than nation-states also attempt to realize utopia when they long for fixed geopolitical demarcations (2022, p. 10).

Ultimately, it is hope that binds soft infrastructure. The visions of a better, more just, world have practical effects because hope persists. In this sense, hope is a political driver of social relations, in this case, medical volunteers providing healthcare to transient migrants at the border region. To this regard, it is worth quoting a few words on hope that Achille Mbembe shared in his lecture at the 9th *Mostra Internacional de Teatro de São Paulo* in 2024:

> When you read the South African constitution, it is absolutely peculiar in the sense that it is trying to put forward…a kind of affirmative politics which entails/requires the production of social horizons of hope. Hope is a key political category in the South African constitution. Hope not just as a pious way of dreaming but as a concrete political commitment not only to care where carelessness was the norm but also to repair that which has been damaged, beginning with the body…which —it was believed—required the total mobilization of the creative possibilities that had not so far been activated, in particular, among formally oppressed communities….In the world we live in today, which is characterized by the acceleration of various forms of brutalism…it is very important to hold on to the signs of hope and the reservoirs of good will as they have manifested themselves at certain moments of our common history because those moments of openness are usually very quickly followed up by moments of closure.

The importance of having a sustainable system for the healthcare of transient migrants can be justified by a political and necessary type of hope that attends to the needs of bodies in the midst of different forms of violence. Additionally, the impact of care that the Clinic was able to have in spite of challenges shows that volunteer-based healthcare is relevant and helpful. Despite all of the challenges that the Clinic faced, the program per se has not strictly ended. Part of the reason for not being officially terminated must be attributed to the foundational and developing soft infrastructure consisting of soft factors like hope, which binds faith, trust, morality, motivations, and worldviews. With this soft infrastructure, failures are understood as opportunities for lessons-learned, reflections, improvement, and continuation of the struggle to repair the suffering of life itself.

CHAPTER 6: CONCLUSION

In this concluding chapter I summarize the purpose of the research, its importance, and key findings. Additionally, I discuss the contributions and limitations of the research.

6.1 Summary of Key Findings and Contributions

This study explored the development of sustainable volunteer-based healthcare for transient migrants in the El Paso-Ciudad Juárez border region, focusing on the perspectives of medical volunteers and some of their facilitators. Examining the experiential and interpersonal processes within the Clinic as a case study, this research addressed better understanding volunteer-based healthcare programs for transient migrants amidst U.S.-Mexico border dynamics. By focusing on soft infrastructure, this study highlights the role of key intangible factors that shape the effectiveness and sustainability of volunteer-based healthcare programs.

Answering my first central research question, I have found that realizing a sustainable volunteer-based healthcare program for transient migrants in the border region involves developing a strong soft infrastructure underpinned by flexibility, leadership, empathy, and collective action. Answering the second central research question, I identified three key areas of challenges impacting the sustainability of the program. These three areas were categorized as main themes: 1) developing an inter-organizational cross-border partnership; 2) building volunteer capacity; and 3) navigating medical liability. Together, these themes form a nexus because they influence each other. Moreover, each of these three key themes consist of soft factors that together form a soft infrastructure. The key soft factors include motivations, worldviews, trust, morality, safe spaces, faith, hope, language, and policies.

The contributions of this research lie in arguing that when soft infrastructure is developed, interpersonal and inter-organizational partnerships flourish, volunteer capacity

improves, and programmatic adaptation becomes more flexible and responsive, especially in the face of broader societal factors like policies affecting local dynamics. By creating a volunteer-based healthcare program, not only do transient migrants receive healthcare but medical volunteers grow personally and professionally developing skills to: 1) be sensitive to fluctuating contexts; 2) become leaders in immigration and border justice issues; 3) foster worldviews of empathy countering the discrimination and politization of migrants; and 4) work and learn collectively with fellow volunteers. In this sense, medical volunteerism has humanitarian and pedagogical value that extends beyond the economic dimension of these types of volunteer-based activities. Preserving these opportunities is important as they are spaces that foster key soft factors and spaces of care at a community level, especially at the border where the politics of care intersect with the politics of immigration and border enforcement.

However, this research has also identified key challenges in sustaining a volunteer-based healthcare program for migrants at the border region, emphasizing the need for innovative solutions grounded in the principles of soft infrastructure. Addressing these challenges for programs like the Clinic requires not only collaborative vision and action but also recognizing that the challenges are interconnected. In other words, successfully overcoming challenges implies doing so collaboratively and as a whole. By answering my secondary questions, it is possible to think about solutions for the Clinic to become more sustainable. This is the case because the Clinic was studied in relation to the border context and themes like im/mobility, informality and formality, worldviews, morality, and alternative visions.

I have shown how the politics of im/mobility have been significantly responsible for an asymmetrical accumulation of humanitarian needs at the border region, creating a heavier burden on Ciudad Juárez. In turn, driven by worldviews, motivations, and morality, inter-organizational

cross-border partnership was unprecedentedly established for the purposes of addressing and managing the increasing local healthcare needs of transient migrants. The Clinic thus emerged in the midst of crisis having a significant impact helping hundreds of people who are part of a population at risk of not receiving healthcare because they are constantly moving. Run by medical volunteers, the Clinic faced important challenges developing volunteer capacity and abiding to medical liability in a cross-border context. Informal and formal approaches to healthcare emerged often in tension with medical liability and morality. Although the challenges have been impactful to sustainability, they also contribute to developing alternative visions. For example, a now re-envisioned Clinic is aiming to expand and strengthen operations through leadership and volunteer training to prepare medical affidavits for asylum seekers while still providing healthcare.

Lastly, it is worth mentioning that the contributions of this research implicitly caution humanitarian workers against the emergent threat of the criminalization of humanitarian assistance to transient migrants. In this research, the tensions that emerge from potential medical liability reflect the broader political environment where humanitarian care is criminalized, especially in relation to the notion of a border crisis that generates wary and ambivalent sentiments regarding security. This contrasts the worldviews of volunteers and leaders of local border organizations who focus on providing care and hospitality rather than fear and threats. Nonetheless, criminalization of humanitarianism—from the government's perspective—generates a sense of insecurity that can deter potential volunteers. In the context of El Paso, the recent criminalization of humanitarian care for transient migrants has impacted the local humanitarian network in at least a twofold way. On the one hand, negatively as it creates a sense of threat of termination or suspension of humanitarian activities. On the other hand, positively as

it makes local people and organizations come together, strengthening their network. Indeed, hope for a more caring world mobilizes the local community's soft infrastructure.

6.2 Limitations & Recommendations

My hope is for the information in this research to have practical value and contribute to the improvement and sustainability of healthcare programs for migrants in general. However, I understand that this research has important limitations. I focused on the Clinic because, to the participants'—and my own— knowledge, the Clinic is the only volunteer-based healthcare program for transient migrants in Ciudad Juárez that consists of inter-organizational cross-border partnership. Therefore, a richer understanding of the broader medical and soft infrastructures throughout the border region for transient migrants would greatly contribute to the literature.

Additionally, a larger and more diversified sample size is needed that also pays closer attention to the socio-demographic characteristics of the medical volunteers and facilitators. Different study designs could help better understand not only the role of soft infrastructure but also its dynamics as it changes through space and time. For example, longitudinal studies on the experiences of facilitators and medical volunteers helping transient migrants at the border can help better identify and target the soft factors that needs more development for the strengthening of soft infrastructure. Lastly, this research was limited by time constraints, which impeded the collection of a larger and more varied sample size and extended participant observation.

Moving forward, based on my results, I provide some recommendations for future research and practical applications:

1. It is important to distribute responsibilities in volunteer-based healthcare programs for transient migrants. This can help avoid burnout and interruptions building volunteer capacity.
2. Before expanding the program, it is important to patiently build and strengthen its soft infrastructure. In other words, recognize that relationships (i.e., interpersonal, and inter-organizational) are vital, and they take time and attention to develop.
3. Strengthening volunteer recruitment involves institutional support, especially when building cross-border partnerships, both at an interpersonal and community level.
4. While this research focused on soft infrastructure as positive and productive in the development of a volunteer-based healthcare program, future research can consider negative and destructive factors. The tensions between worldviews, policies, morality, etc., can be as productive as they are destructive in terms of, for example, decreasing trust or diffusing connections. As the results chapter suggests, examples of potentially negative soft infrastructure could include competition for funding.

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APPENDIX

Appendix A: Invitation

Purpose:
The purpose of this study is to understand the experiential and interpersonal processes of developing volunteer-based healthcare for transient migrants in the El Paso-Ciudad Juárez border region. The objective is to collect and analyze qualitative data on how sustainable volunteer-based healthcare for transient migrants in this border region can develop from the perspective of the volunteer medical providers.

Inclusion/Exclusion Criteria:
You are being asked to be in this study because you are: a) currently—or have been at some point between October 2022 to-date—in the El Paso-Ciudad Juárez border region either providing or facilitating healthcare to migrants in transit; b) 18 years old or older; and c) fluent in either English or Spanish. This may include medical students, nursing students, nurses, physicians, physician assistants, as well as past or current leaders in the establishment and/or management of the program. Anyone who is currently getting paid for providing healthcare to transient migrants will be excluded. I aim to interview between 10 to 25 participants.

Procedures:
I am interested in understanding why you have decided to provide or facilitate healthcare for migrants in the border region, your experiences, and hopes for the future. If you decide to participate in this study, you will be asked for an interview estimated to last between 30 and 90 minutes. The interview can be conducted either in-person or via Zoom, based on your availability and preference. I will seek your permission to audio-record the interview, which will not include video recording. Additionally, the content of some informal conversations and observations may be used to supplement the interview. This, however, will not be audio or video recorded and will instead be documented on a separate notepad without any personal identifiers. I will observe and document data as written notes about your healthcare provision to migrants while you are volunteering.

Risks & Confidentiality:

Taking part in this study is voluntary and confidential. Your name will not be recorded or attached to any documentation or data filed under this research. Information will be encrypted so that responses or other data cannot be traced back to individual participants like you. I will instead use random pseudonyms. If at any moment you decide to not take part in the study, there will be no penalty or loss of benefit. You will not be compensated for taking part in this research. The risks associated with this research are no greater than those involved in daily activities.

Contact:

If you have questions, you may call for the Principal Investigator, Daniel Avitia, at the Center for Inter-American & Border Studies at (915) 747-5196 or email at daavitiapac@miners.utep.edu

Appendix B: Interview Guide

General Questions About the Interviewee

- Tell me about yourself, where do you come from and what brought you to this place (geographically and professionally).
- How did you become aware of the opportunity to volunteer in the healthcare to migrants in El Paso or Ciudad Juárez?
- For how long have you volunteered in healthcare for migrants?

Motives

- What motivates you or has motivated you to volunteer with migrants? And why do you think this is important? Do you think religion plays a role or influences your motivation to volunteer in any way? How so?
- Why do you choose to help migrants, in particular (as opposed to other vulnerable populations in the community that may also need medical care)?

Geographical Position (shedding light on volunteer mobility)

- Do you cross the border to volunteer providing healthcare to migrants?
- If yes, do you intend to continue crossing the border to do the same type of volunteer work? Why cross the border? What are the pros and cons of crossing the border for this reason?
- If no, have you considered crossing the border to help migrants in the same way but in Ciudad Juárez? Why or why not?
- If you have volunteered on both sides of the border, how do you compare your experiences?
- If you have volunteered providing medical care for migrants outside the border, how do you compare those experiences with the ones at the border?
- If you are not from the border, did your volunteering experience differ from your expectations of the border? In what sense did it change (or not)?
- What is it about working at the border region that you think makes medical volunteering for migrants unique or not?

Identity/Experience

- In what ways do you think volunteering has helped you grow personally and professionally? Can you share some of the most memorable experiences for you while volunteering for migrants (whether they were particularly good or bad)? What makes these experiences memorable to you? How have they shaped your views on healthcare, for example?

Experience as a Medical Volunteer

- Can you describe what an average day as a medical volunteer for transient migrants looks like from your point of view and experience?
- What are the most common medical issues that you have encountered while helping migrants?
- What has stood out?
- To your judgement and experiences, have these main medical issues changed? How so?

Space: Clinic Experience

- How do you approach providing healthcare for migrants?
- How much do you get to find out about each patient? How much do you get to follow-up when needed, if at all?
- What technologies and tools do you mostly use in the clinic? Anything you think should be added or improved?
- What about patient record keeping, are you tasked with any aspect of that process? How so? Do you know what happens to this information after you record and archive it, if applicable?
- Whose support do you rely on for your medical volunteering? How adequate is that support in your experience?
- Do you typically need a medical interpreter?
- What are the instances when you feel you need an interpreter?
- Can you describe an average (most common) experience with medical interpreters?
- Have you had any issues with medical interpreters in the process of healthcare for migrants?
- Could you tell me more about the aspects that work best, those that need improvement and those that might be putting you and/or the patient at potential risk?

- Do you think you have been mentally or emotionally affected by your volunteering providing or facilitating healthcare to migrants? Why or why not?

Trust

- Tell me about your experiences working with other volunteers. Has there been any challenges that stood out? Have you faced situations where a lack of leadership affected your volunteering? How important is it for you to rely on your fellow volunteers? Can you share any examples where working with peers made a difference?
- Have you ever felt uncomfortable either with other volunteers or with the patients that you help while volunteering?

Intersection between Healthcare for Migrants and Law (which sheds light to the "enabling environment" & trust)

- Have you experienced issues with your personal safety, in any way, or felt like what you do is not legal when volunteering for transient migrants in El Paso or Ciudad Juárez? Could you tell me more about it?

Perception

- Do you think working with migrants at the border has made you feel or think differently about the nature of migration? Why or why not?
- Do you think providing medical care to transient migrants has made you practice medicine any differently than the ways you would usually care for patients? How so? Can you share an example?
- How do you think your volunteering experience differs from the medical training you have received?
- What do you think of the quality of the healthcare you provide to migrants in the region compared to the quality you provide at your regular job or training place?
- Do you know of other places where you could also volunteer providing healthcare to transient migrants in the El Paso-Ciudad Juárez region? Which ones?
- Do you know any medical volunteers working in these other places? If so, how often do you communicate with them? How strong do you think is your relationship with them? To what extent do you find these relationships helpful for providing better healthcare to migrants in the region (e.g., better coordination, maybe sharing of resources like medication, etc.)?

- Do you recommend volunteering for migrants? What advice would you offer to someone interested in becoming a volunteer medical provider for transient migrants in the El Paso-Ciudad Juárez region?

Ideology/Worldview

- To what extent do you think health and adequate healthcare is a human right?
- How would you respond to someone who thinks that migrants deserve medical care less than the "local community"? [(Leave room for answer without probing. If they ask to explain the question I can say: "for instance, someone who think that it is not fair to use local taxpayers' money on people that, apart from not being U.S. citizens, are expected to be here for a very limited time"]. If needed, follow up with: Could you explain your rationale?
- Where do you get most of your information related to the border? (e.g., cable news, newspapers, NGOs/advocacy groups). Can you tell me any particular stations, channels, papers, or source that you typically consume?

Future Prospect (Hope)

- Do you plan to continue volunteering providing healthcare for migrants in the region?
- If so, what are your hopes and long-term goals volunteering as a medical provider for migrants (professionally and/or personally)?
- How do you think your volunteering work can be improved?
- What does the ideal volunteering opportunity for migrant healthcare looks like for you?

Questions for Administrators, Organizers, Managers, etc.

- Can you tell me how did you became involved with the program? How did it all start and what did it take? Can you walk me through the process?
- What is/has been your role?
- What were the major barriers that you encountered and how did you overcome them? What barriers do you think are currently in place or emerging and how do you plan to address them?
- How do you think the bi-national context shapes a program like this?
- In your view, what would it take for this program to run in a sustainable way into the future?

- What do you think would happen if this kind of support through your program was not in place?
- What kind of funding and resources is needed to have this voluntary based healthcare program running? How do you access these resources?
- What is the process of recruitment of volunteers for this program?
- How vital is the collaboration with other organizations to set up a program like this?

VITA

Daniel Avitia is interested in border phenomenology, ontology, and epistemology as means to assemble repairing care for all captured lifeforms. Daniel has dwelt with the issue of human migration throughout the years, participating in local projects and formalizing his studies. He holds a B.A. in Philosophy with a minor in Inter-American & Border Studies. Now, he will hold an M.A. in Latin American & Border Studies along with a graduate certificate in Public Health.