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The Linkage of Life Course, Migration, Health, and Aging: Health in Adults and Elderly Mexican Migrants

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Abstract

Migration is a phenomenon that impacts individuals throughout the life course. Particularly, Mexican elderly migrants show evidence of lifetime accumulations of the effects of migration on health conditions. **Objectives:** Examine how the relationship between historical time and individual time explains different factors impacting the health of Mexican adult and elderly migrants in Mexico and the United States. **Method:** Data from in-depth interviews with Mexican migrants living in selected locations in Mexico and the United States were used to illustrate the links between life course conditions, aging, migration, and health outcomes. **Results and Discussion:** According to this theoretical perspective and the data, historical time, age at migration, and the conditions under which the migration trajectory developed, show

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different impacts on the health and quality of life of the elderly, as revealed through analysis of labor experience, disease and accidents, medical service, health treatment, transnational networks, and family formation.

Keywords

life course, migration, aging, health conditions, later life

Introduction

This article examines the relationship between health conditions and the migratory experience of migrant men and women 50 years and older originating in Mexico. Using a life course perspective as a theoretical framework, it aims to link migration, health, and aging. This framework is used to identify migration, work and health paths, as well as transitions and turning points that occur and alter the individual's ideal paths. Our analysis focuses on international migration for three reasons. First, Mexican migrants are aging rapidly both in the United States and in Mexico. Second, the migration experience necessitates adaptation and adjustment to U.S. culture among migrants. Third, a wide variety of psycho-social-cultural processes play out in the communities and families whence migrants originate and where they settle.

The study of migration from Mexico is complex because of its sociological and demographic implications. It is further complicated by variations in migratory politics in historical time. Even so, the importance of migration has been linked to its effects on health and the quality of life of the elderly (Angel, Angel, & Markides, 2003; Soldo, Wong, & Palloni, 2002; Wong, 2001). In this context, we seek to investigate the impact of migration on the health of migrants in the states of Guanajuato and Zacatecas in Mexico, both of which are areas with a well-established tradition of migration. Our qualitative methodological strategy was to conduct semistructured interviews using an interview guide based on the life course perspective to construct migration and health trajectories. The data presented here are the initial results from a larger research project examining the impact of migration on the health of older Mexican migrants living in Mexico, Texas, Illinois, and California.

Life Course, Health, and Aging: Theoretical Approach

The life course perspective has gained interest in sociological inquiry is attracting ever greater interest because of the role that it plays with respect to

individual, familial, and historical time. We are interested in understanding how the process of aging is linked to the social construction of health in the elderly stages of life of individuals who have experienced international migration. Thus, we emphasize that aging is a bio-psycho-social phenomenon containing an unquestionable cultural dimension expressed in notions of gender, generation, cohort, race/ethnicity, and age (Arber & Ginn, 1996). There is currently an increasing consensus and understanding about the role of social, political, and institutional conditions in the early and intermediate stages of the life course and how they affect adulthood and old age. Several studies demonstrate that these stages of life represent social constructions not only because of conditions and opportunities associated with generations, but also because of the unique historic experiences for different age cohorts as well as the symbolic structure in which they are subjectively constructed (Angel et al., 2003; Arber & Evandrou, 1997; Izal & Montorio, 1999).

Following this logic, an important segment of research lends support to the link between aging and the life course (Arber & Evandrou, 1997; Elder, 1999; Elder, Johnson, & Crosnoe, 2003). This body of research provides support to our own examination through the use of two indispensable analytic tools for thinking about time without losing the personal, individual, and historical perspectives. We are referring to the concepts of *trajectory* and *transition*.

A trajectory is a path or progression expressed through individual time. There is not one unique trajectory since the individual may experience an interlinkage of a variety of trajectories depending on the institutional environments where he or she participates: educational trajectory, labor trajectory, reproductive trajectory, migration trajectory, health trajectory, and so on. Although these trajectories may exist simultaneously, it is particularly likely in societies where such paths take place in a more or less sequenced fashion (Tuirán, 1996).

Transitions are events experienced in the different trajectories. These events may occur in individual, familial, and historical terms. It can be said that individual and familial transitions are segments that emerge in interaction with historical change (Hareven, 1982). The effect of the transitions experienced throughout the life course results in heterogeneous aging among men and women. As such, cohorts live segments based on sociohistorical formations as they adapt to the circumstances of their own vital experiences as well as their own familial processes and changes. As Hareven (1982) points out, the life course links individual biography with collective behavior and historical transformations.

To show the importance of the life course, we highlight the work of Ferraro and Shippee (2009), who propose the concept of *cumulative inequality* to

complement the life course perspective. This theory incorporates macro and microsociological elements, specifying that social systems generate inequality. Such inequality is manifested in the life course through demographic processes. The perspective argues that personal trajectories are formed through the accumulation of risks, available resources, perceived trajectories, and human agency (Ferraro & Shippee, 2009, p. 334).

Ferraro and Shippee (2009) argue that health is affected by cumulative inequality throughout the life course. It is not only the opportunities in childhood, but also the way in which adolescence and adulthood is lived, that condition the accumulated form of the health–illness processes of individuals. These are clearly manifested when people reach advanced age.

It is currently known that childhood illness, conditions of poverty during extended periods of time, type of occupation, access to health services, as well as the presence of social support networks, are only some of the dimensions that influence people's state of health and contribute to the presence of disease (Berkman, 2000; Cattell, 2001; López-García, Banegas, Pérez-Regadera, Herruzo-Cabrera, Rodríguez-Artalejo, 2005; Pescosolido, 2006; Pescosolido & Wright, 2004; Ruiz-Pantoja & Ham-Chande, 2007; Ydreborg, Ekberg, & Nordlund, 2006). The World Health Organization (WHO) recently indicated that longevity and health in old age is conditioned by a series of factors experienced throughout the life course.[1] Accumulated disease prevention or health-risk experiences lived in the early stages of life modify opportunities and condition the health–illness process (Marmot, 2005; Siegrist & Marmot, 2006).

The role of social environment, social hierarchies, and the positioning of people in the social organization are fundamental contextual variables for understanding and even predicting the varying levels of mortality and the presence of certain diseases (Siegrist & Marmot, 2006). Marmot (2005) not only observes variations in mortality and morbidity but also differences in the aging process and longevity. Internally, the social hierarchy intrinsic to any occupation—such as a white-collar worker, manual worker, university professor, or high-level civil servant—stands out. Some studies suggest that the levels of control at work (work autonomy) impact the probability of coronary risk differently; that the absence of social support at work may be a factor that increases the possibility of poor mental health; and that social status is a good predictor of physical, mental, and emotional health.

If indeed health is conditioned by the economic, social, and biographical factors of the life course, it is possible to think that some trajectories and transitions affect the state of health, mortality, morbidity, and longevity. In

such a way, migration may modify health, not because of the experience itself, but because of the conditions in which it develops. Thus, it is not the migration experience that is problematic, but the conditions from which it emerges, the type of migration, place of destination, and the history of the place of origin, as well as the timing in which these events in the life course occur. In many developing countries, the risk factors associated with such events may cause radical changes in physical and mental health (Cuellar, Bastida, & Braccio, 2004; Salgado de Snyder, 1998, 2007).

Research linking health with migration is scarce and the focus adopted tends to be either global (Moya & Finkelman, 2007) or local (Vilar & Eibenshutz, 2007). This body of research has explored various aspects associated with migration, for example, the physical and mental health of persons who do not migrate (Caballero, Leyva-Flores, Ochoa-Marín, Zarco, & Guerrero, 2008; Ramírez, 2009; Salgado & Díaz Pérez, 1994; Van Dijk, 2006) and the physical and mental health of migrants in the place of destination (Angel et al., 2003; Santillanes, 2009; Wong, 2001). Some research indicates that linguistic, religious, or cultural differences are barriers that obstruct the health care of migrants (Goldrin, 2005). It has also been shown that there is a greater presence of disease among migrants in contrast to locals or even in comparison with their counterparts in their country of origin, the case of Latinos in the United States being particularly important (Angel et al., 2003). Migrants also tend to be exposed to new diseases while traveling from country to country, through sexual practices and the social processes of health care mediated by the institutional structure and access to medical services. Others note that this occurs not only because of exposure to new diseases but because of the newness and unfamiliarity of the new context as well as the discrimination, rejection, and hostilities that migrants encounter (Finch, Kolody, & Vega, 2000). Integration emerges as an important theme in understanding the health of migrants. Research also calls attention to the role of infectious diseases, the appearance of chronic illness, mental health issues, cultural beliefs, the role of self-treatment via traditional mechanisms, as well as the relevance of human rights (Goldrin, 2005).

From this theoretical framework and empirical background, we seek to understand how the Mexican migration experience in the United States changes the life course of people, the health-illness process, and the quality of life in old age.[2] In other words, the life course perspective allows us to gain an analytical understanding of how health conditions in old age are affected through migration and work trajectories in Mexico and in the United States in historical time-specific cohorts and individual biographies.

Data and Method

Data and results come from ethnographic research consisting of 86 individual semistructured interviews conducted by the authors from June to October of 2009 and from February to June of 2010 in the states of Guanajuato and Zacatecas in Mexico and in the cities of Los Angeles, California, Chicago, Illinois, and Dallas, Texas in the United States. In Mexico, 38 interviews were conducted with individuals 50 years and older, who had at least once lived in or sought employment in the United States. These are individuals considered return migrants who once migrated to the United States but now live in Mexico.[3] The interviews consisted of 24 individuals in Guanajuato (21 men and 3 women) and 14 individuals in Zacatecas (13 men and 1 woman). In the United States, 48 interviews were conducted with individuals 50 years and older born in Mexico. Of those, 21 were interviewed in Los Angeles (11 men and 10 women), 11 in Dallas (5 men and 6 women), and 16 in Chicago (9 men and 7 women).

The total number of individuals interviewed was determined by a combination of theoretical sampling and snowball sampling. To contact informants, we initially reached out to health centers, workplaces, civil organizations, community centers, migrant associations and churches, as well as recreational and amusement parks. Through these initial contacts, we met "key informants" who alternately helped us locate other informants during the year of fieldwork. Selection criteria were as follows: All informants had to be 50 years of age or older, Mexican by birth, and in the case of Mexican residents, they had to have had at least one experience of migration to the United States.

The purpose of interviewing elderly return migrants in Mexico and elderly immigrants in the United States was to learn about the migration experience throughout different historical periods and stages of the life course, as well as how the prevailing work trajectories and living conditions in both countries distinctly impact health among the elderly. Guanajuato and Zacatecas are two of the principal Mexican states with high migration intensity to the United States. Migrants from these states of origin head mainly to California, Texas, and Illinois—three U.S. states that account for 64% of the Mexican immigrant population in the United States (U.S. Census Bureau, 2008).

Interviews lasted, on average, between 40 min and 2 hr, during which interviewees answered sets of questions regarding: their personal and familial history (education, individual and family medical history, work history, marriage, and reproduction); migratory history to the United States (number of migration episodes, health risks, adaptation, work and health activities,

length of stay, remittances, and social networks); life history on return to Mexico (number of returns and family characteristics, particularly health in Mexico); a self-evaluation concerning migratory and health experiences; and current health, support networks, and expectation of migration in older age.

After finalizing the fieldwork, all the interviews and testimonies were coded using NVivo (3.0), a software suite employed to assist with large-scale qualitative analysis consisting of text, graphics, audio, and video. To ensure anonymity of interviewees, all names were changed and all identifying information (total number in household, place of employment, home and health center addresses, and so on) was modified such that similarities to real life experiences of interviewees is purely coincidental.

From the narratives of interviewees, three analytical groups were constructed according to life course stage, *historic time* during which the *transition to the first migration* occurred, and the development of the migratory trajectory for Mexicans to the United States (*timing*). The first group consists of migrants who began their migratory trajectory during the Bracero Program (1942-1964) who present very different characteristics compared to those who experienced migration between the post-Bracero period and the Immigration Reform and Control Act (IRCA) (1965-1986), and who make up the second group. The third group consists of those who migrated to the United States after IRCA (1987-present). From these classifications, we analyzed the impact of migratory experience on the health–illness process of Mexican migrants in Mexico and in the United States.

Results

International migration, like any life event in the lives of individuals, has a series of benefits and advantages as well as a set of difficult, tense, and stressful situations (Achotegui, 2000). These situations frequently, although not always, translate into negative physical and mental health effects on migrants. If health is conditioned by economic, social, biographical, and genetic factors, it is also undeniable that some transitions and trajectories occurring in different historical contexts and specific moments of the life course of individuals will positively or negatively impact their health (Ferraro & Shippee, 2009; Marmot, 2005; Siegrist & Marmot, 2006). In this way, migration can modify the physical and/or mental health of migrants, not because of the experience itself, but by the personal, family, and contextual situations that it develops, as is shown in the results found in this research. We now turn to the analysis of the three epochs of Mexican migration to the United States.

Bracero Migrants (1942-1964): Health in the Life Course Toward Old Age

The migration of Mexicans to the United States is a social phenomenon in response to economic, political, and social dynamics prevailing in both countries. For example, the migratory phase known as the Bracero Program (1942-1964) emerged from the political and economic juncture of World War II because of the United States' need for labor. In practice, it was a collective work contract negotiated by both governments (Durand, 2006). During this time period, it is estimated that, on average, 350,000 Mexicans arrived annually in the United States to work in agriculture, road building, railroads, mining, and industry in general. Migration was meant to be temporary, consisting primarily of young men originating from rural areas with low levels of education and coming from central–western and northern states like Chihuahua, Durango, Guanajuato, Jalisco, Michoacán, and Zacatecas. Braceros headed toward the states of California, Texas, Michigan, Illinois, Idaho, and Arizona, among others (Durand, 2006; Durand & Massey, 2003).

Although the Bracero Program opened up the possibility to all Mexicans who wished to work in the United States, not all were selected in the hiring centers located in cities on the border and in the central–western part of the country. Those chosen were generally young, healthy, physically and mentally fit men. The interviewees who participated in this temporary worker program experienced the transition to the first international migration and initiated their migratory trajectory between 18 and 30 years of age, that is, in their young adult stage. This phase in the life course is characterized by particular vigor and physical good health. It is also a stage of life in which childhood illnesses and those particular to the Mexican epidemiological profile, such as smallpox, measles, diarrheas, parasitic infections, fevers, were overcome and left behind.

Although the prevalence of disease was scarce during childhood and adolescence, the interviewees who migrated during the Bracero Program had a history of poverty, hunger, and the difficult economic situations of rural life. When they became ill they visited *curanderos* (folk healers), herbalists, and even midwives. Some mentioned suffering falls and fractures during childhood and youth, which—despite having occurred long before—began to manifest their effects as physical disorders in adult life. For many of the interviewees, school attendance was undervalued whereas unpaid family labor was perceived as a way of assisting the family economically. Thus, many respondents exhibit relatively short educational trajectories alongside

long work trajectories. The end of the former almost always coincides with the initiation of the latter.

A few of the privileges that Braceros enjoyed concerned, at least on paper, safety and the right to medical attention. In fact,

> The Bracero Program constituted a substantial advancement in terms of the living conditions and health of migrant workers, as both governments came to formulate agreements and arrangements to guarantee minimum conditions of legality, hiring, job security, social security, housing, transportation and minimum wages. (Durand, 2006, p. 45, translated by authors)

Nevertheless, those who migrated without a contract (undocumented) did not receive the same benefits. Pioneer studies on Braceros indicate that living and working conditions were not always the most adequate (Martínez, 1948). In some cases, Braceros were forced to work for long periods without monetary compensation; in others, they were tasked with completing the most grueling jobs; and, occasionally, they were threatened with not receiving pay unless they finished their assigned tasks. Additionally, the quality and quantity of the food provided for Braceros left much to be desired, and their housing conditions were fairly precarious. For example, those who worked on the farmlands and railroads lived in wooden galleys and train wagons. However, the Mexicans, who adopted a "take it or leave it" stance, accepted these conditions for fear of being expelled from the camps and having their contracts cancelled (Martínez, 1948).

In spite of this, the Braceros did not complain about these conditions, because they did not have to pay rent, they saw the opportunity to make a few dollars, which compared to the Mexican peso, had considerable value. Workers contracted to work in nonagricultural areas were granted the same rights to health care services available to American residents in the areas where they worked. Unfortunately, in several cases, the companies did not offer any medical attention for nonwork-related illnesses. Thus, Mexicans suffered from ailments, discomforts, and other more serious illnesses left untreated for long periods of time to save as much money as possible. When their sufferings became too much for them, the Braceros resorted to private physicians or hospitals, but even then never rested sufficiently to achieve full recovery. Many even returned to work immediately after surgical procedures (Martínez, 1948).

Regardless of these irregularities, for the majority of those survivors interviewed, the Bracero Program permitted the initiation and development of a

solid and uninterrupted migration trajectory—with short interruptions, given that migrants would continuously go back and forth to the United States—even after the termination of the Bracero Program in 1964. Migrants took advantage of the times during the period they returned to Mexico to spend time with their families, visit their friends, and cultivate their lands. However, there were also some migrants that only went to the United States once and never went back, interrupting their migration trajectory for good. In both of these cases (those traveling back-and-forth and those only migrating once), the migration experience is viewed as a positive event that permitted people to improve their economic standing and to overcome difficult situations associated with the poverty and unemployment that predominated in Mexico's rural areas at that time.

In terms of health, respondents report that in general it was favorable that they were allowed to continue migrating and working in the United States. Furthermore, during the Bracero Program (1942-1964), those migrants had better access to health care in the United States than in Mexico, which at that time did not have the social security institutions that exist today. In Mexico, health care principally involved the use of traditional medicine, and western institutional health care was available only to government officials and workers in urban areas.

The bad health experiences, along with the long working hours and the excessive physically demanding nature of the work, did not dissuade people from continuing to migrate to the United States in their youth and adult stages. Nonetheless, the cumulative effect of these circumstances over the life course has manifested itself in their elderly years through body aches mainly in their backs, arms, and legs. There are also other problems that emerge at this stage of life including rheumatism, hypertension, prostate problems, and diabetes, along with mobility, hearing, and vision limitations. Rigoberto reported about his health problems.

> I was picking cotton, grapes, and cucumber, just that kind of work . . . Finally, I worked in a factory. Sure, they provided us with rubber pants and rubber shoes, hat and all, but all day we were wet, wet through . . . I think that's why I have rheumatism . . . Well, I can't, I don't have any strength, and if I bend, it feels as if something's scraping. I've been to the doctor [in Mexico] and they didn't give me medicine for that, they want me to have an operation; but no, the operation costs too much and I don't have [money]. That's one thing; the second: some people get operated on and end up in a wheelchair; so I said I'd do better to do nothing, now at my age what difference [would it make]? (Rigoberto, 86 years old, state of Zacatecas)

In this context, it is logical to think that many of these illnesses and physical ailments that former Braceros experience in their old age are linked to illnesses, accidents, and the life conditions in which their migration experience took place, as well as the type of diet, working hours, stress, and access to and adequacy of health care. The illnesses that our respondents now experience include asthma, rheumatism, hypertension, muscle aches, depression, gastritis, and diabetes.

In summary, through the analysis of this group of survivors who participated in the Bracero Program, it can be said that, although the migration experience is not a life course transition that directly leads to deteriorating health of migrants, the forms of medical and health problems suffered by migrants during their migration trajectory to the United States, represent at least one level of exposure to risk that negatively impacts health in adult life. As such, the effect of migration on the health of migrants, seen from a life course perspective, gives us clues to unravel the enigma of the famous "Hispanic paradox" reported in various studies from cross-sectional data sources, which suggests that migrants have equal or lower mortality rates compared to U.S. natives despite having low rates of health insurance coverage and use of health services (Palloni & Arias, 2004). One reason commonly accepted to explain the paradox is that the migration process is, by nature, demanding and self-selective, and the best suited (i.e., the healthiest) people are the most likely to migrate.

Undocumented Immigrants to IRCA (1965-1986): Health and Old Age in Risk

After the termination of the Bracero Program in 1964, Mexican migration to the United States underwent a complete transformation. On one hand, the U.S. government terminated the Bracero agreement and chose to regulate the flow of migrants through the legalization of a sector of the working population under the quota system and, later, with the launch of the 1986 Immigration Reform and Control Act (IRCA). On the other hand, the U.S. government decided to limit the free movement of migrants through the mass deportation of workers who did not have their documents and the strengthening and monitoring of the border (Durand & Massey, 2003).

People who make up the second analytical group of migrants began their migration trajectory between the ages of 16 and 34, a relatively young age at first migration, as was the case during the Bracero Program. The reasons for migration were basically the same—finding work and better wages to support their families economically, providing education and health to their

children, and so on. In fact, in many communities and towns in Mexico, migration became a “rite of passage” among the inhabitants—everyone wanted to know “the north” of which so much was talked about. Many young people interrupted their educational trajectories to immediately start their migration trajectories to the United States. They felt strong and healthy enough to travel to states such as Arizona, California, Colorado, Illinois, Oregon, and Texas, to any state or region of the United States where they had relatives, friends, and residents originating from their own towns and villages.

In contrast to Braceros in the earlier migration stage, migrants who came during the second stage did not need to sign a contract, but still needed to be physically and mentally healthy to pursue the “American Dream.” These requirements were easily met because, although during the early stages of their life course they contracted typical diseases such as smallpox, measles, fevers, and other infections, they had no serious long-term consequences or motor, visual, or hearing limitations. This can be explained because in those years, when respondents were children or teenagers, there had been significant progress in sanitary and health conditions in Mexico, as well as advances in the control and prevention of communicable diseases. Many respondents noted that in situations of serious illnesses and/or accidents they went to health centers located near their towns and communities of origin. Others, in contrast, were treated with medicinal plants, *sobadas* (a traditional healing technique that involves massage) and home remedies.

The lack of documentation to enter the United States was one of the problems that confronted most respondents. In contrast to Braceros, undocumented migrants in this period were forced to cross the border in increasingly dangerous and isolated places because of the reinforcement and monitoring of the border, putting at risk not only their physical and mental well-being but also their lives. Similarly, because of their undocumented status, their jobs did not provide benefits such as health insurance and access to health care. Thus, when they were ill or suffered an occupational accident, they were typically not treated, as they had to use private medical services or were forced to return to Mexico to meet their health care needs.

During their stay in the United States, the migrants we interviewed worked in agriculture, construction, restaurants, stores, and in the maintenance and cleaning of buildings and sports arenas and stadiums. Many employers took advantage of the undocumented status of migrant workers through the exploitation of their labor, requiring them to work long hours, paying them low wages, and not providing them employment benefits including those required by U.S. law. For most of the migrants interviewed, life conditions and risks

associated with work during their stay in the United States have had consequences on their health status. Some of the migrants, while in the United States, never visited a doctor for treatment or for a medical checkup for fear of being deported. Others noted that in their jobs they experienced health risks from machinery, chemicals, fertilizers, low temperatures, and repetitive physical motion of particular parts of their body, all of which endangered their health. Danilo reports:

> [I] know someone who works there [in the United States] sanding guitars, and a friend who is a painter, he paints the guitars, he can hardly see because the paint affects [his eyes] a lot. The painter handles many chemicals . . . the chemicals in the paint harm him . . . It is hard work; yes, it is well paid, but very hard. (Danilo, 69 years old, state of Zacatecas)

Herminio relays a similar story.

> . . . over there [in the United States] they used a lot of fertilizers . . . for the peaches, for the apricots, for [all] the plants . . . But your eyesight suffers, and so you have to be well covered, all over, so as not to get the poison, the insecticide. (Herminio, 77 years of age, state of Zacatecas)

The good health of Mexican migrants reported in cross-sectional studies becomes paradoxical when offset against the problems caused by a variety of factors, such as workplace accidents and lack of medical attention that appear with great frequency in the testimonies of the people we interviewed. Indeed, various studies have reported that accidents constitute the third leading cause of death among Latinos in the United States (Consejo Nacional de Población, 2009; Lillie-Blanton, 2008; U.S. Department of Health and Human Services, 2008). Many of these accidents involving Mexican migrants occur in the workplace due to this group's exposure to negligent practices as regards protective mechanisms and work security, with Mexican migrants who are undocumented and marginalized being particularly vulnerable. Filiberto relays his story concerning an accident he had on the job:

> [I had several accidents] in one . . . an iron slab fell on me, I was washing it and it fell, it slipped from where it was [supported] and smashed my fingers, one broke, smashed to pieces . . . these [others] turned out fine. There they also sent me to the doctor and the doctor gave me . . . a

> month's disability. In a month the work ended, the accident was in October, by January I was fine. (Filiberto, 68 years old, originally from the state of San Luis Potosi)

Similarly, Mariano points out the dangerous conditions associated with work in construction.

> Where there's really a lot of risk is [. . .] in the construction [industry], often . . . buildings fall, ladders [slip], [workers get] run over by cars, like the people who work on the roads or on bridges, many have been run over while at work; so, in my experience . . . accidents in the workplace, yes, there's a lot of that. (Mariano, 67 years of age, originally from the state of Zacatecas)

The work and health experiences of migrants who legalized their immigration status through IRCA (or at another point in time) have not been altogether different from those of their undocumented peers. Although these migrants can potentially access health insurance and medical care, they do not typically visit doctors for checkups. They indicate that they have not sought such medical attention because they felt well and were not sick. The advantage, they say, is that they could count on access to medical care when they needed it. Women are much more likely to report visits to the doctor and to carry out specific treatments and care that doctors recommend.

There is yet another way that the migratory experience undermines the health of Mexican migrants living in the United States. As their length of residence in the United States increases, these migrants tend to acquire a cultural pattern of unhealthy habits, which negatively affects their health. Obesity, for example, is a very common health problem among Mexicans in the United States and is closely related to problems of diabetes. In fact, diabetes is the fifth leading cause of death among Latinos in the United States (Consejo Nacional de Población, 2009; Lillie-Blanton, 2008; U.S. Department of Health and Human Services, 2008).

In the examination of the illnesses and injuries that migrants sustain over the life course, we find that although they recovered from such ailments around the time that they occurred, their impact becomes manifest in old age. Older adults who worked in construction activities or agriculture in the United States, for example, currently have spinal problems, knee pain, arthritis, and rheumatism, given that such occupations are characterized by highly monotonous and repetitive activities that impact the body and joints. As their mobility is restricted, as noted above, these individuals become

more susceptible to obesity, which is associated with diabetes. Furthermore, diabetes, in turn, is related to visual impairment. Other diseases that Mexican elderly migrants are likely to experience include cardiovascular disease, hypertension, and hernia, for which many have had to undergo surgery, either in Mexico or the United States.

In summary, respondents who migrated in the post-Bracero period encountered a different migration context compared to persons who migrated during the previous period. In particular, these migrants experienced escalated levels of labor exploitation because of the absence of regulations to provide a certain degree of protection and rights. We suggest that such experiences placed migrants in vulnerable situations while living in the United States, which, in turn, affected their quality of life and health. This risk-laden migrant context in the life course results in accumulated negative effects as regards health and old age.

Clandestine Migration After IRCA (1987-2010): Increased Risk and Health Vulnerability

Despite immigration policies and other measures implemented by the U.S. government since the mid-1980s to curb migration, Mexican migration to the United States has increased. It is estimated that in 1980 the number of Mexican residents living in the United States exceeded two million people, and since then the number has doubled every 10 years. Thus, in 1990 the number of Mexicans in this country totaled 4.4 million, and there were 8.8 million in 2000. Currently, it is estimated that just over 11.8 million reside with documented or undocumented status in the United States (Consejo Nacional de Población, 2009).

These trends broke with the traditional patterns that had marked Mexican migration even before the IRCA era. In particular, the composition of Mexican migrants expanded significantly from the original predominance of rural residents, especially men, originating from central and northern states to include women, children, elderly people, and migrants from urban areas and those with higher levels of education. Given the difficulties faced by undocumented migrants in crossing the border, particularly after 9-11, migration from Mexico shifted from temporary to more permanent stays, as the militarization and greater vigilance of the border stemmed the typical back-and-forth transnational movement of Mexican migrants. Put simply, migration from Mexico has become more diversified in terms of demographic composition, length of stay, places of origin in Mexico, and U.S. destinations (Lozano, 2000).

This third analytical group of respondents, whose testimonies we analyze, is characterized by a greater level of heterogeneity in terms of demographic characteristics and migration history compared to the previous two groups. However, it is possible to draw some similarities in their life experiences before and after their initial international migration. Overall, the analysis of different life trajectories indicate that during their childhood, adolescence, and/or youth, these migrants had suffered some of the typical childhood diseases like measles, chicken pox, colds, and fevers, which had been treated in hospitals and health centers in their hometowns. Likewise, they show typical educational trajectories of six to nine years of schooling, which reflect educational gains made in Mexico over the last few decades. In almost all cases, the educational trajectory is interrupted to start work. That is, the transition out of school is linked to their incorporation into the labor force and, in some cases, with the onset of marriage or the formation of unions.

Respondents in this group were between 28 and 53 years of age when they experienced their first migration to the United States. This transition, in their own words, was marked by risks and difficult situations along the trek to, and the crossing of the border, into the United States. As mentioned above, the strengthening of the U.S.–Mexico border forced Mexican migrants toward new migration routes consisting of desert areas, dangerous and remote locations far from border towns (Eschbach, Hagan, Rodriguez, Hernández-León, & Bailey, 1999). Some respondents indicated that they had suffered eating disorders, strokes, falls, cuts, broken limbs, and even abuse at the hands of *coyotes* (human smugglers) and immigration authorities. Thus, for these people, the migration experience involved significant exposure to risks which had consequences for their physical and emotional health. Cipriano illustrates the risks and stress that he experienced in his migration trek to the United States.

> . . . we walked all night, but when the helicopter caught sight of us then we had gotten instructions to get under the bushes and so I got under one [of them] and the helicopter hovered over the one where I was hiding, then it left . . . it lasted a minute but to me it felt like years, I thought: no, here I will be killed, and it was tough. (Cipriano, 62 years old, originally from the state of Zacatecas)

Similarly, Aurelio describes the perilous conditions associated with transit to the United States.

> . . . the movement of people involves challenges and much risk and danger, there is much risk in their lives, many may [die], I have heard many stories of people who have come here [to the United States],

> many come by train, they're really screwed when they arrive, many come walking and they tell me they've found bodies, well corpses, along the route, [they talk about] how the wolves and coyotes howl at night and lots of things. (Aurelio, 73 years old, originally from the state of Guanajuato)

Furthermore, Eustolio describes the harshness of the desert.

> Nogales is the harshest desert, many people have died there. So it's like we're going to war when we cross the desert because [we] don't know if we'll make it or not. It's a lot of walking and very hot. (Eustolio, 55 years old, state of Guanajuato)

Fear of being apprehended and deported at the hands of the *migra* (border patrol; now, Immigration, Customs, and Enforcement [ICE]) and, more recently, with the emergence of worksite raids, has resulted in migrants prolonging their stay in the United States. In contrast to the Braceros who made as many as three trips to the United States a year, recent migrants at best return only once a year, but with much less frequency where the undocumented are concerned. Thus, alongside the problems associated with entering the United States, are the sadness and anxiety that these individuals experience due to long periods of separation from their families. With the passage of time, these sentiments often turn to silent disorders such as anxiety, chronic stress, and depression, although migrants may not be aware that they are suffering these maladies (Alderete, Vega, Kolody, Aguilar-Gaxiola, 1999). In fact, instead of resorting to medical treatment, migrants often try to eliminate and erase such feelings from their mind through the consumption of cigarettes and alcohol. Indeed, various studies report that chronic stress, alcoholism, and tobacco addiction have a significantly negative impact on the health of migrants (Consejo Nacional de Población, 2009; Lillie-Blanton, 2008; U.S. Department of Health and Human Services, 2008).

These more recent migrants experience long migration and work trajectories with greater permanency in the United States than was the case with the earlier two groups of migrants discussed above. Migrants in this stage tend to be working in agriculture, construction, transportation, restaurants, hotels, cleaning of buildings, and health care. This work profile is somewhat similar to that of the second group of migrants who came during the period leading to IRCA. The work that migrants typically perform are characterized as low-skill, low-paying jobs that do not offer benefits at all or, at best, limited benefits. As such, high proportions of migrants do not have health insurance coverage or access to health care. They report suffering, either in the recent

past or currently, from such illnesses as high cholesterol, uric acid, migraine headaches, depression, ailments that if not treated in a timely fashion can affect one's quality of life in older ages. Similarly, worksite accidents represent a constant in the life stories of our respondents. The most frequent accidents that they report include arm fractures, cuts, falls, burns, and even poisoning. Javier, for example, describes the danger associated with meatpacking jobs.

> . . . jobs in meatpacking are dangerous jobs because people often cut off their fingers, their hands . . . .(Javier, 64 years old, originally from the state of Jalisco)

Similarly, Filiberto notes the dangers associated with being exposed to chemicals.

> . . . we wore [a protective mask] for the chemicals, and they used to say they were not very dangerous, but now after so many years of inhaling them . . . it's true, they do become dangerous. The only thing [they'd tell us], so that nothing bad should happen, was "wear the masks;" the masks are sufficient equipment for people not to suffer risks to their health, and yes . . there was actually a . . . how do you say, like a prohibition: if they caught you without a mask you were sure to be dismissed, we had to . . . use a mask for our own good. (Filiberto, 50 years old, state of Guanajuato)

In sum, it can be said that migration at this stage is associated with significant exposure to risk that affects migrants' health either during the migration trajectory, the border crossing, or during the long stays in the places of destination. The work conditions, the lack of access to health care, the low wages, lack of fluency in English, along with the absence of proper documentation, place Mexican migrants in a vulnerable situation. The illnesses and accidents experienced over the extended life course become manifest among those persons who are transitioning into old age, impacting their health and well-being in the latter stage of life.

Conclusions

The last 60 years of migration from Mexico to the United States was marked by three historical periods that are analytically different with respect to their effects on the life course of migrants and on their health status. In this article,

we are guided by the life course perspective to better understand how migration impacts the health of surviving migrants that live in the United States and in Mexico. The act of migration to the United States represents a search for employment, better working conditions and earnings that improve the quality of lives of the families of migrants. To reach their goals, migrants have historically experienced unequal work conditions and access to health care, which increases their exposure to risks intensified in the context of anti-immigrant policies and sentiments in the United States. These conditions have transformed their lifestyles and diets, resulting in the adoption of unhealthy habits, alongside longer work shifts and lengthier stays in the United States, all of which negatively impact the health of migrants.

We use a qualitative methodology in a binational context to gather testimonies from Mexican migrants regarding their life experiences involving migration and health. We identified the age at migration and the sequence of events related to migration and health, which we locate in terms of time and place of occurrence. The evidence showed that historical time (period), the age at migration, as well as the conditions under which the migration trajectory developed, all served to give rise to the subjugated status of migrants relative to native U.S. workers. This social and work inequality, exposure to risk, and the accumulation of disadvantages create favorable conditions for accidents, illnesses, and diseases in adulthood and old age among Mexican migrants. Still others have died attempting to cross into the United States as well as due to accidents and illnesses or the lack of medical care. Those more fortunate returned to their communities of origin either to die or to live the last years of their lives under the care of their family or with the medical support of their communities of origin.

During the Bracero Program, under the bilateral agreement between the U.S. and Mexican governments, Bracero migrants worked for periods of 10 to 18 months with the condition that they return after the work period was complete. Labor contractors secured jobs and access to medical services, although there was exploitation against Braceros. Braceros experienced occupational risks including exposure to toxic substances, fertilizers, chemicals, and accidents due to the dangerous jobs that Mexican migrants performed. Nonetheless, many hid or minimized health problems for fear of being returned home.

In the period from the Bracero Program to IRCA, conditions for migrants became increasingly unfavorable because of the absence of the regulations that were part of the Bracero Program. As such, without this program and labor contractors, Mexican migrants became "free agents," thus becoming even more vulnerable to exploitation, stress, and the failure by employers to

provide access to medical care. Nonetheless, conditions would improve by the late 1980s for those individuals who were able to regularize their status following the passage of the Immigration Reform and Control Act (IRCA) in 1986.

After the era of IRCA, the reinforcement and militarization of the border made crossing it a highly perilous event that increasingly threatened the life and health of migrants. In addition, in the last couple of decades, the emergence of worksite raids and the rise of detentions, deportations, and discrimination directed against immigrants, especially Mexicans, have made living and work conditions more difficult. Such conditions have negative impacts on the physical and mental health of migrants. Finally, because of the heightened security of the border and the increasing difficulty in entering the United States, many Mexican migrants now remain in the United States for long periods of time (in contrast to the earlier continual back-and-forth movement between Mexico and the United States), thus becoming more isolated from their communities of origin and their families and social networks to the detriment of their physical and emotional health.

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Notes

1. Currently, there is a Department of Aging and Life Course at the WHO, which has undertaken recent global goals. For more information see http://www.who.int/ageing/en/
2. We consider the quality of old age as the outcome of relevant variables, similar to those shown in previous studies (Gomes, 2001; Hebrero, 2004; Montes de Oca,

2001; Wong, 2003; Wong, Palloni, & Soldo, 2007), such as the labor trajectory, exposure to work risks, position and occupation in work, nutrition, access to health services, treatment of disease, continuous exercise, the role of social networks and transnational ties, as well as smoking and drinking behavior.

3. We consider return migrants to be those who have at least once in their lives migrated to the United States to live or work and at the time of the interview are living in Mexico. We recognize that they could well migrate again to the United States in the future.

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