The Impact of Migration on Health Outcomes in the United States and Mexico

The histories, economies and politics of the United Mexican States and the United States of America have been irreversibly intertwined for centuries, characterized by bilateral agreements that have defined the everyday reality of their citizens’ lives. Mexico is the United States’ second-largest export market and third-largest trading partner; this amounts to an estimated $1.25 billion worth of trade every day. Mexico also partners with the United States to fight organized crime and drug-related violence; the United States’ government has invested $1.9 billion to date in the “Merida Initiative” (U.S. Department of State, 2012). The overarching forces that shape this relationship are grand in scale, but the consequences are very much felt by the individual. One of the most significant outcomes of the alliance between Mexico and the United States is the creation of a continuous migratory flow between the two countries. The 2,000-mile border is the site of over one million authorized crossings every day (U.S. Department of State, 2012) and an estimated 175,000 unauthorized crossings and 724,000 unauthorized attempts every year (Pew Hispanic Center, 2011). Mexican migrants represent a steadily growing population that is caught between two worlds and advocated for by neither; this community experiences needs that are both uniquely shaped by and go largely unmet because of the process of migration. This research proposal will summarize one factor of migration: the health outcomes experienced by the Mexican migrant populations.

Historical Migration from Mexico to the United States

Mexican migration to the United States has historically been driven by economic factors: the need or “pull” for cheap labor in the North and the intentional erosion of economic opportunities in the South, which serves as the converse “push” factor. The emergence of these “push” and “pull” factors is arguably the direct result of actions taken by the United States government over the years. Two of the most significant triggers of migration in the twentieth century were the implementation of the bracero program between 1942 and 1964 and the passage of the North American Free Trade Agreement (NAFTA) in 1994.

The bracero program was a series of executive agreements between the United States and Mexico that allowed for the recruitment of 4.6 million Mexican agricultural workers, referred to as braceros (García y Griego, 1997). The program stimulated a parallel migration of unauthorized laborers and upon cancellation, left millions of individuals without a “legal” way to sustain their livelihoods. The bracero program marked the only period during which the United States and Mexico jointly managed labor migration. The bracero program was modeled on previous initiatives to admit temporary workers from Mexico to the United States in times of crisis, as during World War I. Braceros were recruited in response to domestic labor shortages upon the United States’ entry into World War II; the federal government needed to maintain production levels in agriculture and industry to support the war effort. The United States recruited contract workers, although unauthorized movement soon overshadowed this migratory flow.

Most of these [unauthorized] migrants entered without inspection and sometimes worked for growers that also employed braceros. Some also were braceros who
“skipped” their contracts, thus becoming nonimmigrant overstayers. For a few years after World War II, some illegal entrants working for agricultural employers were legalized and given contracts (García y Griego, 1997).

Many growers stimulated unauthorized migration by creating a demand for a cheap alternative to hiring braceros in an effort to avoid complying with certain terms of the program. Growers resented covering required labor benefits for braceros, such as living expenses and transportation to and from Mexico, but neither did they wish to increase wages enough to attract domestic workers (García y Griegos, 1997). The bracero program was terminated in 1963, in response to petitions by labor unions lobbying on behalf of domestic farmworkers. The Mexican government objected to the termination, citing grave concerns that foreshadowed the debate that surrounds migration today. Mexican authorities stated that the program did not cause migration, but merely regulated a process that had already been occurring. It was predicted that the cancellation of the bracero program would only facilitate “the illegal introduction of Mexican workers into the United States,” (García y Griegos, 1997) which is precisely what happened.

The passage of the North American Free Trade Agreement (NAFTA) in 1994 produced another significant interaction of coercive “push and pull” factors that preempted a spike in mass migrations. NAFTA created the world’s largest free trade zone and is estimated to link 450 million people producing $17 trillion worth of goods and service (Office of the United States Trade Representative, 2012). The treaty sought to foment foreign investment in Mexico and promote capital mobility, but provisions for worker mobility were strikingly absent. NAFTA also eroded Mexican agricultural subsidies that had previously protected small farmers, forcing them to abandon their livelihoods and creating an enormous pool of displaced labor (Fernández-Kelly and Massey, 2007). One of NAFTA’s largest failures was to equalize economic development among participating countries to facilitate political as well as economic integration. Then-president of Mexico, Carlos Salinas de Gortari, asserted, “the whole point of NAFTA for NAFTA is to be able to export goods and not people. That means creating jobs in Mexico” (Fernández-Kelly and Massey, 2007). Unfortunately, the passage of NAFTA had the opposite effect of eroding economic opportunities in Mexico and incentivizing migration of workers to the United States. The liberalization of barriers to trade and investment resulted in fewer economic opportunities for unskilled laborers; wages and employment for unskilled laborers declined in the years following NAFTA. Conversely, both wages and opportunities increased in the United States-Mexico border region, and even more so within the United States (Hanson, 2003). These events converged to generate conditions that were conducive to a massive migration from the South to the North.

**Current Circumstances of Mexican Migrants**

The process of migration produces a unique level of social vulnerability, characterized by the trauma of leaving one’s home and family to experience disorientation in an unfamiliar and often unwelcoming environment. One of the most salient consequences of migration, for the purposes of this paper, is the negative impact of social vulnerability on health outcomes. Mexican migrants experience difficult departures from their homeland and
even more difficult arrivals in their host country. The migration of undocumented workers is typically planned, but forced by economic necessity; border crossings are illegal, dangerous and difficult. Those migrants who survive the border crossing or whose initial travel to the United States is authorized, but who overstay visas, are disproportionately vulnerable to negative health outcomes.

Social vulnerability, for the purposes of this paper, is defined as the relative lack of protection experienced by a group of individuals when facing potential health risks, threats to the satisfaction of their needs or the violation of their human rights. This lack of protection is produced by the absence or limited presence of resources, whether they are individual, family, community, social or economic (Salgado de Snyder, González Vázquez, Bojorquez Chapela and Infante Xibillé, 2007). Migrants who cross international borders become a *de facto* socially vulnerable group, as they often lack the language competency, cultural knowledge, social networks and economic resources to successfully adapt to their new environs and overcome challenges. Salgado de Snyder et al. identify three factors as determining the level of social vulnerability experienced by Mexican migrants with respect to health outcomes: social support networks, access to health services and the interaction of social context with health promotion – this can range from cultural norms regarding health to the facility or challenges presented by socioeconomic status (2007). Migrants experience negative health outcomes produced by social vulnerability at every stage of the process of migration: in the community of origin, during the journey to the United States and in receiving communities.

**Community of Origin:** Salgado de Snyder et al. cite statistics that identify 53.7% of Mexicans as living in poverty. This group represents the majority of migrants and is characterized as experiencing a severe limitation of resources, including access to health care, education, social security, employment and adequate housing. Salgado and Snyder further report disproportionate incidences of depression and anxiety among the spouses of migrants as well as drug and alcohol abuse among the children of migrants – all attributable to the social instability produced by migration and family separation (2007).

**Transit to the United States:** The American Civil Liberties Union (ACLU) declares the deaths of migrants in the border region to be a humanitarian crisis. “Operation Gatekeeper,” a strategy implemented by the United States government, has contributed greatly to mortality rates: “The strategy concentrated border agents along populated areas, intentionally forcing undocumented immigrants to extreme environments and natural barriers that the government anticipated would increase the likelihood of injury and death. The stated goal was to deter migrants from crossing” (Jimenez, 2009). An estimated 5,607 migrants have died between 1994 and 2009 (Jimenez, 2009).

**Receiving Communities:** The population of unauthorized immigrants in receiving communities is estimated to be 11.2 million; 58% or 6.5 million individuals are Mexican migrants (Pew Hispanic Center, 2011). This group experiences several social disadvantages that put individuals at risk for negative health outcomes. The majority of adult Mexican migrants (74.8%) are Limited English Proficient (LEP), which limits their ability to communicate effectively with health care providers; Mexican migrants
represent the largest proportion of the foreign-born population with less than a ninth-grade education (40.4%) which impacts health literacy; 27.9% of Mexican migrants are estimated to live in poverty and are likely to lack health insurance, as 48.3% of the non-citizen population does (Pew Hispanic Center, 2011); both of these factors impact access to health services.

**Strengths and Needs of the Mexican Migrant Population**

Mexican migrants represent a hard-to-reach population. Unauthorized migrants in receiving communities typically stay hidden from authorities and are less likely to access health care and social services for fear of deportation. Meanwhile, the families of migrants in sending communities in Mexico are unlikely to seek help because the traumatic impact of migration on health goes widely unrecognized. Thus, one of the most salient needs of the unauthorized Mexican migrant population is for a consciousness-raising of the traumatic health impact of migration and for interventions that address the cultural context of health outcomes. A particular approach to collaborating with migrant populations that can be effectively applied to health interventions with unauthorized Mexican migrants: the strengths perspective. “The strengths perspective promotes attention to the assets and resources embodied by all individuals, particularly in expression and manifestation of resilience, wisdom and knowledge. As an empowerment-based perspective, a strengths approach intends to discover and expand resources” (Chang-Muy and Congress, 2009). The strengths perspective draws on the tools migrants utilize to overcome challenges and leverages culture beliefs to address needs, such as the vulnerability of this population to negative health outcomes.

The strengths perspective can be particularly applied to understanding a social phenomenon often described as the “Hispanic health paradox.” This term refers to the finding that many Latinos experience health outcomes that are equal to, or better than, non-Latino whites, despite higher poverty rates, less education, and worse access to health care; this has been found to be particularly the case among Mexicans (Morales, Lara, Kington, Valdez and Escarce, 2007). The health of Hispanics has been found to disproportionately favorable when measured by life expectancy, adult mortality and infant mortality. Morales et al. found adult mortality among Hispanics to be lower than non-Hispanic whites by 18%, and Mexicans represented the sub-group with the lowest overall age-adjusted mortality rate. Migration also factors into this data: mortality rate for foreign-born Mexicans was found to be 3.6 per 1,000 compared to a rate of 5.7 per 1,000 among native-born Mexican-Americans in the United States (Morales et al., 2007). These data point to three explanations that have been widely discussed: (1) healthier Mexicans are more likely to migrate – termed the healthy migrant effect – (2) migrants who become ill return to their country of origin and (3) acculturation among migrants erodes protective health behaviors – termed the acculturation hypothesis (Morales et al., 2007). The most salient outcome of these explanations is the notion that traditional Mexican culture compels protective health behaviors. It is important to avoid the trap of essentializing Mexican culture and assuming that all Mexicans engage in positive health behaviors. Instead, the more significant lesson is that culture and community hold a special power in the understanding and practice of healthy behavior. This implication
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dovetails with a strengths-based approach to health intervention and provides a strong foundation for leveraging the effect of migration to improve health outcomes.

Organization for Study

I propose collaborating with a public health organization on a project that examines the impact of migration on public health outcomes. My particular interest lies in health outcomes among members of sending communities in Mexico, and in examining the impact of migration on family members of migrants as well as on returning migrants. Although I have not yet secured a field placement, I have researched specific projects that would fit well with my interests as a way to clarify my objectives for this research proposal. The UNC School of Medicine, for example, sponsors a project in Guanajuato: Proyecto Puentes de Salud (PPS). PPS implements Mujeres en Solidaridad Apoyándose (MESA), a promotora-based women’s mental health and social support intervention (McKenney, 2011). This initiative employs individual migration narratives to help women in rural Mexico identify depression as a mental health concern and gain the tools to ameliorate the effects of depression through a supportive social network. I anticipate identifying a partner agency in Mexico that examines health outcomes through the lens of migration, and utilizes protective cultural factors to improve negative health outcomes.

Research Outline

The first and most crucial step in moving forward will be to determine a specific subgroup within the Mexican migrant community as the target population for this research proposal. My proposal to assess the needs of a population in Mexico poses challenges; this project will require a close collaboration with a partner agency during this semester, as I cannot be in the field until this summer. It will be challenging to work within a strict timeline – distance makes coordination with key informants difficult and my project will be only one of many competing priorities for a partner agency. Depending on the particular target population and agency with which I am able to negotiate a fieldwork placement, I may not be able to directly contact Mexican migrants. In this case, I will need to rely on email and long-distance interviews via Skype with public health professionals at my partner agency to complete a comprehensive needs assessment. I anticipate accessing previous research online for the purposes of a literature review. The Mexican National Institute of Public Health (INSP) has dedicated an expansive line of research to examining the impact of mobility and migration on health (Instituto Nacional de Salud Pública, 2011). I am currently reaching out to various public health professionals at the INSP, faculty members at UNC who have worked in sending communities in Mexico and non-profit organizations implementing health initiatives in communities with high rates of migrations. During October, I plan to secure a placement and negotiating the scope of my collaboration with a partner agency. During November, I will conduct a literature review, which will serve to inform long-distance interviews with key informants. This will allow me to synthesize my work for a final presentation by the first week of December. This timeline, together with a plan for remote collaboration with a partner agency, will guarantee the time and resources to identify and assess a target population as well as propose an evidence-based health intervention.
List of References


