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Immigration, Work, and Health: A Literature Review of Immigration Between Mexico and the United States

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Abstract

Understanding the influence someone's job or career has on their health goes beyond the physical, emotional and social hazards, risks and conditions that they face at work. One's job or career also exerts a significant influence over other aspects of life that contribute or detract from their health and that of their family. Work is the major incentive for Latin American migration to the United States. Latino immigrants experience increasingly poorer outcomes for physical health and chronic diseases the longer they remain in the U.S. The strong link between work and immigration suggests that, for many Latin Americans, immigration can be understood as a career path which puts them, and their family members, in situations that can change their physical, emotional, and social health as a condition of their employment. Given the large number of Latin Americans who emigrate for work, it is essential that the unique physical, mental and social impacts of emigration are accounted for when working with clients impacted by emigration at the individual, family and community level as well as those social workers practicing at the system level. This paper is a literature review that explores the impact that emigrating for work has on the health of those that emigrate and their family members that stay behind.

The World Health Organization (WHO) defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2014). The WHO recognizes there are many contextual factors that influence health, collectively known as *social determinants of health*. The WHO defines social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped on all levels, local, national and global, by the distribution of power, money and resources (World Health Organization, 2014). Latinos are the fastest growing ethnic population in the United States (U.S.) (Ortman & Guarneri, 2009). In particular, Latino immigrants experience increasingly poorer outcomes for physical health and chronic diseases the longer they remain in the U.S. (Acevedo-Garcia, Bates, Osypuk, & McArdle, 2010; Rogers, 2010). This paper is a literature review that explores the impact that emigrating for work has on the health of those that emigrate and their family members that stay behind.

Work is the major incentive for Latin American migration to the United States and has a tremendous impact on immigrant health (Cleaveland, 2012; Donald E. Eggerth, DeLaney,

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Flynn, & Jacobson, 2012; Ryo, 2013). Work is a central component in people's lives that directly and indirectly impacts the physical, psychological and social well-being of both the worker and their family (World Health Organization, 2014). Understanding the influence someone's job or career has on their health goes beyond the physical, emotional and social hazards, risks and conditions that they face at work (Commission on Social Determinants of Health, 2008). One's job or career also exerts a significant influence over other aspects of life that contribute or detract from their health and that of their family (Commission on Social Determinants of Health, 2008). Work often determines the type of health care you have, the kind of neighborhood you can afford to live in, how much money you have to meet the needs of your family, and the time you have to spend with your family (Braveman, Egerter, & Williams, 2011). Different careers offer different opportunities and challenges to health and therefore exert stronger influence over the physical, emotional and social elements of health. For example, long-haul truckers often make more money than local drivers and therefore may be better able to provide for the physical needs of their family, but their career requires that they spend significant amounts of time away from home which can be challenging to social aspects of health like family life and friendships. Social workers help individuals, families, and groups restore or enhance their capacity for social functioning (Barker, 2003). Therefore, the relationship between a career or job and the worker's ability to attain optimal health for themselves and their family is understood as an important consideration for social work.

Work is the principal driver of current international immigration (International Labor Organization, 2009). Over half of the 214 million international immigrants are labor migrants actively participating in the workforce; their families account for an additional 40% of the global immigrant population (International Labor Organization, 2009). Immigration from Latin America to the United States experienced tremendous growth over the past 20 years and there are currently about 19 million Latino immigrants living in the United States today (Motel & Patten, 2012). Mexican immigrants figure prominently in these numbers. In 2008, 12.7 million Mexican immigrants were living in the U.S. They accounted for 32% of the foreign-born population, up from just 8% (760,000) in 1970 (Pew Hispanic Center, 2009). Although most immigrants from Latin America are authorized to be in the United States, increasing numbers of recent Latino immigrants do not have legal status. For example, Passel and Cohn (2009) estimated that roughly 80% of Mexican immigrants coming to the United States in the last decade were undocumented. Increased emigration has led to significant demographic changes for Mexico as well. In 1970, only 1.7% of Mexican citizens lived in the U.S.; however, in 2008, 11% of the total Mexican population, and an even larger portion of the working-age population, lived in the U.S. (Pew Hispanic Center, 2009).

For many Mexicans, immigration can be understood as a career path which puts them in situations that can change their physical, emotional, and social health. The strong link between work and immigration (International Labor Organization, 2009) suggests that the health impacts of this change in lifestyle are, at some level, work-related even though they are often not the result of conditions at their place of employment (Davies, Basten, & Frattini, 2010; Ingleby, 2012) . The life course perspective is helpful in understanding how the decision to migrate for work can impact health and well-being over time (Leong,

Eggerth, & Flynn, 2014). While emigrating for work has the general goal of improving one's economic opportunities, Jones (1996) cautions against considering the benefits of a given career without also considering the negatives related to that profession. For example, becoming a physician provides one with high income and opportunities to assist needy individuals. However, it also involves long work hours, tremendous job demands, and a high divorce rate due to the failure to balance work and family. Similarly, migration, under the best circumstances, entails challenges for the individual and their family; such as long periods of separation (Grzywacz et al., 2006). Unauthorized migration has many additional risks ranging from exploitation by human smugglers to the stress of finding and keeping employment without documents (Flynn, 2010).

Social workers help people increase their capacities for problem solving and coping, and they help them obtain needed resources, facilitate interactions between individuals and between people and their environments, make organizations responsible to people, and influence social policies (Barker, 2003). Given the large number of Mexicans who emigrate for work, it is essential that the unique physical, mental and social impacts of emigration are accounted for when working with clients at the individual, family and community level as well as those social workers practicing at the system level.

Immigration and Health

The first section explores how immigration impacts the physical, emotional, and social health of the individual and his or her family. Specifically it looks at Mexican immigrants coming to the United States. The second section will then address the impact of immigration on the health of family members who stayed behind in Mexico. The final section addresses immigration and the health of immigrants returning to Mexico.

Impact on health of those that immigrate to the United States

Physical Health

The search for employment is central to Mexican migration to the U.S. (International Labor Organization, 2009). The jobs they typically work have an elevated risk of injury or illness (Hudson, 2007; Orrenius & Zavodny, 2009). Latino immigrant workers are fatally injured at a rate of 5.9 per 100,000 population, compared with 4.0 per 100,000 population for all workers in the U.S. (Centers for Disease Control and Prevention, 2008). Mexican immigrants figure prominently in these disparities. From 2003 to 2006, two-thirds of work-related deaths among Latinos were among immigrants, and 70% of those immigrants were Mexican. Lack of access to health care (Ku & Matani, 2001; Lashuay & Harrison, 2006), language barriers (Lashuay & Harrison, 2006; National Research Council, 2003), discrimination (Okechukwu, Souza, Davis, & de Castro, 2014), fear of retaliation (Smith-Nonini, 2003), temporary work arrangements (Landsbergis, Grzywacz, & LaMontagne, 2014), lack of knowledge about workplace safety procedures and regulatory protections (Pransky et al., 2002), and for some, lack of authorization to work (Flynn, 2010; Walter, Bourgois, Margarita Loinaz, & Schillinger, 2002) are some of the factors that can make it difficult for immigrant workers to address their occupational safety and health (OSH) concerns (Lashuay & Harrison, 2006).

According to data from the U. S. Census Bureau (Passel & Cohn, 2009), most undocumented migrants work in farming jobs (25%), followed by those employed in groundskeeping and building maintenance (19%), construction (17%), food preparation and serving (12%), and production (10%). Multiple studies across the U.S. have shown that immigrant farmworkers are vulnerable populations that experience high rates of injury and disease (Arcury, Rodriguez, Kearney, Arcury, & Quandt, 2014; Brock, Northcraft-Baxter, Escoffery, & Greene, 2012; Kelly, Glick, Kulbok, Clayton, & Rovnyak, 2012; McCurdy & Kwan, 2012; Shipp, Cooper, del Junco, Cooper, & Whitworth, 2013). The major occupational hazards experienced by these workers are pesticide and heavy metals exposures, sun exposure, musculoskeletal injuries, and poor field sanitation (Quandt et al., 2010; Sakala, 1987). Data on injury or illness rates among day laborers (construction, yard work, and maintenance) are sparse, but findings consistently indicate increased rates of occupational injuries. These workers also deal with problems related to the safety, security, hygiene, and privacy of migrant farmworker housing (Arcury et al., 2012). Latino immigrant workers in construction and roofing face higher risks of injury and death (Albers, Hudock, & Lowe, 2013; Arcury et al., 2014; Dong, Choi, Borchardt, Wang, & Largay, 2013; O'Connor, Loomis, Runyan, Abboud dal Santo, & Schulman, 2005). Immigrant workers in poultry processing plants in the U.S. face higher risks of exposure to parasites, musculoskeletal injuries and skin diseases (Grzywacz et al., 2012; Pichardo-Geisinger et al., 2014; Pichardo-Geisinger et al., 2013; Quandt et al., 2014), and cleaning workers are exposed to hazardous chemicals (Pechter, Azaroff, Lopez, & Goldstein-Gelb, 2009),

In addition to physical danger at work, the career choice to immigrate often entails work-induced lifestyle factors which impact physical health. Schedule demands, wage uncertainly, marginal benefits, overall stress, poor diet, and minimal free-time are some examples of factors which can negatively impact the physical health of immigrant workers and their families (Commission on Social Determinants of Health, 2008). Specifically, increased time in the United States results in an increased prevalence of chronic conditions and the adoption of poor health behaviors as immigrants assimilate to life in the United States (Singh & Siahpush, 2002). For example, recent Latino immigrants had better self-reported overall health, fewer daily activity limitations and fewer days spent in bed due to illness than U.S.-born individuals (Cho, Frisbie, Hummer, & Rogers, 2004). They also had a lower prevalence of negative health conditions (Antecol & Bedard, 2006). However these advantages diminish or disappear the longer immigrants spend in the United States.

Studies have also shown acculturation and time in the United States is positively associated with increased body mass index (Antecol & Bedard, 2006; Cho, et al., 2004) and adoption of less healthy diets due to work schedules and intensity that allow limited time or energy for food preparation at home (Arenas-Monreal, Ruiz-Rodriguez, Bonilla-Fernandez, Valdez Santiago, & Hernandez-Tezoquipa, 2013). Likewise increased rates of smoking (Abraido-Lanza, Chao, & Florez, 2005; Bethel & Schenker, 2005), alcohol use (Abraido-Lanza, et al., 2005), sedentary lifestyle and hypertension (Chakraborty et al., 2003), diabetes (Lopez & Golden, 2014; Schneiderman et al., 2014), poor sleep (Seicean, Neuhauser, Strohl, & Redline, 2011), and disabilities (Escobar Latapi, Lowell, & Martin, 2013) have all been shown to increase the longer immigrants remain in the United States. The lifestyle changes associated with low-wage, often temporary employment in the United States are often cited

as factors central to the deteriorating health of immigrant workers and their families. Escobar Latapi et al. (2013) concluded that improving migrant health is largely dependent on upgrading working conditions and education.

Mental Health

Working conditions and the ancillary effects of employment can have both positive and negative impacts on a worker's mental health. Blustein (2006) identified three core functions that work has the potential to fulfill: (a) work as a means for survival and power, (b) work as a means of social connection, and (c) work as a means of self-determination. To the degree that work can fulfill these needs, it likely has a positive impact on the mental health of the worker. However, the workplace is often one of the social spaces where people from different social, ethnic and racial backgrounds interact. Therefore it can be the site where larger social dynamics such as discrimination, xenophobia, racism and bullying play out (Okechukwu, et al., 2014). Latino immigrants are one group for whom this is especially true; they are often socially isolated within the larger community, with very limited employment opportunities and living with severe social constraints (Okechukwu, et al., 2014). This is even more significant for vulnerable groups of immigrants such as undocumented immigrants (Flynn, 2010) or immigrant women (Donald E. Eggerth, et al., 2012) who often face additional stressors at work. These dynamics can take a significant psychological toll on workers, as suggested by studies of discrimination and psychological and emotional distress at work (Krieger et al., 2006).

For immigrant workers, stress does not stop with workplace discrimination. Indeed, choosing to immigrate for work implies a total change in lifestyle that brings with it a series of social and economic stressors that reach well beyond one's place of employment and into all facets of life (Sandhu & Asrabadi, 1994). The challenges associated with the process of adapting to a new social environment are referred to as *acculturative stress* (Sandhu & Asrabadi, 1994). While Latino immigrants to the United States experience better mental health than the U.S. population upon arrival to the United States, as with physical health, these advantages tend to dissipate the longer they live in the United States (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Several studies have found higher rates of psychiatric challenges in immigrant groups when compared to the general population of their host country (Hutchinson & Haasen, 2004; Silveira & Ebrahim, 1998; Vega, et al., 2004). Time in the United States was associated with increased experiences of racial discrimination by Latino immigrants which negatively impacted both their mental and physical health (Gee, Ryan, Laflamme, & Holt, 2006). It also appears that immigrants may have worse mental health outcomes when compared with the population in their home countries. For example, Hovey and King (1997) found higher levels of suicide among Mexican immigrants to the United States as compared to Mexico.

Although journeying to a foreign land inspires hope for a better future, much acculturative stress surrounds the process (Suarez-Orozco & Suarez-Orozco, 2001). A longitudinal study assessing the impact of acculturative stress in immigrant adolescents found that as levels of acculturative stress increase, internalizing mental health symptoms increase as well (Sirin, Ryce, Gupta, & Rogers-Sirin, 2013) . These internalized mental health symptoms include

anxiety, depression, and somatic symptoms (Sirin, et al., 2013; Wei et al., 2007). Acculturative stress is closely associated with challenges to social health and is discussed in the next section.

Social Health

Labor migration plays a very large role in the social aspects of health. Employment is a key motivation for immigration and is central to the choice of a destination once the decision to emigrate has been made (International Labor Organization, 2009; Kochhar, Suro, & Tafoya, 2005). The destination sets the parameters for the social health of the immigrant. For example: is the destination a large metropolitan area or a small town?; does it have an established Latino community or is it a new settlement area with little to no bilingual infrastructure?; are the politics of the established population adversarial, friendly or ambivalent to new immigrants? Once employed the job will dictate the individual's daily schedule, the amount of free time they have, and their ability to work overtime or get a second job. As mentioned earlier, for immigrants, the workplace is one of the primary sites of interaction with members of the established community.

Isolation and a lack of social support is a significant challenge to social health for many immigrants. Immigrating for work often involves separation from one's social network – family and friends – for extended periods of time (Grzywacz, et al., 2006). This can be especially true when the cost of travel is prohibitive or the lack of immigration documents prevents routine passage between countries (D.E. Eggerth & Flynn, 2013). Moreover, developing social supports and accessing local resources among the established community can be very difficult.

Perhaps the most obvious barrier to integration with the established community is language. Not being able to receive assistance due to language barriers is frustrating (D.E. Eggerth & Flynn, 2013). Given their significant work and family obligations, immigrant workers often do not have the time or energy to dedicate to learning a new language. Likewise, many have limited formal education in their native language which increases the difficulty of learning a foreign language (Donald E. Eggerth, et al., 2012). In addition, the legal, socio-cultural and political condition of the host country can further complicate integration of immigrant workers into the community. For example immigrants are often prohibited from receiving means-tested benefits, gaining citizenship, or accessing resources such as health care (Castaneda, 2009). The most extreme example of social exclusion is the categorization of some immigrants as "illegal" (De Genova, 2002), as the constant fear of deportation contributes to both acute and low-grade levels of stress (Berk & Schur, 2001). Separation from family and friends together with language problems and social exclusionary policies in the host countries can all contribute to feelings of isolation for immigrant workers.

Alternately, even when entire families are able to immigrate together, there are significant stressors related to acculturation both as individuals and as a family group (Rogler, 1994). Often immigration confuses traditional family roles and power dynamics. For example children often acculturate and learn the language of the host country faster than their parents. This often places them in the role of interpreting social norms for their parents or translating at meetings with school officials, medical providers, etc. Similarly, immigration can

challenge traditional gender roles in the family. Immigrant women often work outside of the home in host countries whereas they typically would remain housewives in their home countries. Menjivar (1999) reported that Central American immigrant women found that the self-esteem they gained from working outside the home was often accompanied by demeaning or violent behavior from their husbands in an attempt to retain the traditional gender roles in the family.

Latino families are a part of social networks that exercise resource sharing such as transportation and financial support (Ayón & Naddy, 2013). Latino families rely on each family member for emotional, financial, and moral support; placing emphasis on the role of the father (Haxton & Harknett, 2009). However, in comparison to the African-American family, Hispanics are more likely to receive support from both parents (Haxton & Harknett, 2009). Thus, when one Latino spouse emigrates for work, it is presumed that heightened family conflict will occur (Donald E. Eggerth, et al., 2012), impacting those that stayed behind. The next section describes how labor migration impacts the health of family members who stayed behind.

Impact on Health of Family Members that Stay Behind

While immigration has been understood as a social determinant of health for the immigrant (Davies, et al., 2010; Ingleby, 2012), its role as a social determinant of health of family members left behind is by and large overlooked. According to Kanaiaupuni and Donato (1999) in its initial stages, migration is disruptive to communities and families; however, in the long term it is beneficial to household survival and eventually becomes part of local institutions and community life. In some cases, it helps families thrive. Families of immigrants in the U.S. have more economic resources that allow them better access to goods and services; these families are also larger, their members are younger, and have more years of education than families with no migrant relatives (Salgado de Snyder et al., 2010). For example, in 2013, an estimated $22 billion were sent by migrants to Mexico (Cohn, Gonzalez-Barrera, & Cuddington, 2013). The central question is to what degree the international labor migration determines the physical, mental and social health of those family members who are left behind.

Physical Health

Salgado de Snyder et al. (2010) conducted a survey among 702 families with and without migrant relatives in rural communities of three central states in Mexico. Compared to families without a migrant relative, women in migrant sending households reported having more sexually transmitted diseases and more chronic diseases such as hypertension and diabetes. They also reported having more infectious diseases such as tuberculosis and pneumonia. While the differences for each individual condition were not statistically significant, a consistent pattern of worse health outcomes in immigrant households emerged across all conditions that were studied.

Using data from the Mexican Migration Project, which surveyed Mexican communities during the winters of 1987-1988 through 1992-1993, Kanaiaupuni and Donato (1999) found that in communities going through the initial period of intense migration, infant survival

worsened considerably. However, infant mortality was reduced in half in communities with 20 years or more of migration. High annual remittances from migrant workers back to their families of at least $10,000 improved infant survival with the odds of death reduced by 27%, after controlling for other factors.

Using data from the 1997 National Survey of Demographic Dynamics (Encuesta Nacional de Dinámica Demográfica, ENADID), Hildebrandt and McKenzie (2005) found higher birth weights and lower infant mortality rates among children born in Mexico in a migrant-sending household. Conversely, they found that children in migrant households were less likely to be breastfed, vaccinated, or visit a doctor in their first year of life.

Baker et al. (2010) analyzed data from the Mexican Family Life Survey and found that children living in a migrant-sending household appear to have gained more weight (higher body mass index and risk for overweight) than those that did not have migrant relatives, even after controlling for past weight status. They also found that the levels and patterns of obesity in migrant-sending households more closely resemble those among resident Mexican-Americans than those of other Mexicans remaining in Mexico.

A nutrition transition has been occurring over the past two decades as a result of economic development and globalization, leading to increases in obesity. In less developed countries, obesity has tended to be relatively rare, but as economic development ensues (accompanied by rising incomes, urbanization, and increasing availability of inexpensive, high-caloric foods), obesity has increased. It has been suggested that migration networks may constitute one of the factors affecting nutrition transition in Mexico, a world-wide process that involves shifts in food consumption and physical activity patterns (Baker et al., 2010).

Elderly dependents that stay behind may have health effects associated with a child's migration. In a survey of rural communities in central Mexico, Salgado de Snyder et al. (2010) found that elderly residents of non-migrant sending households reported a lower number of "bone" diseases (osteoporosis, arthritis, rheumatism, uric acid), chronic diseases (diabetes, hypertension, heart disease), infectious diseases (pulmonary diseases, tuberculosis, urinary infection, intestinal infection, prostate infection), and eyesight conditions (blindness and visual impairment), compared to those in migrant sending households, although none of the differences were statistically significant. However, while differences for specific conditions were not statistically significant, a consistent pattern of poorer health for individuals from migrant households emerged.

Using data from the 2001 Mexican Health and Aging Study (MHAS), a nationally representative survey of Mexicans born before 1950, Antman (2010) found that elderly parents of migrants have a greater probability of being in poor physical health. This effect is independent of children's remittances, but the contributing factors could not be identified.

Mental Health

The mental effects of migration on women remaining in their countries of origin revolve around the issues of attachment, separation and loss. A study conducted in Mexico and reported by UNICEF (D'Emilio et al., 2007) found that 70% of women interviewed stated

that they had suffered periods of depression and 30% considered some of their health problems as related to the stress of having absent partners or family members.

It has been reported that 17 percent of Mexican children are expected to experience the migration of a father by the age of 14 (Nobles, 2007). Because female migration is becoming more common in Mexico, it is likely that the proportion of children experiencing household migration is actually even larger. Not much information is available on the mental health effects of children left behind by migrating parents from Mexico to the United States. Studies in Nicaragua and Mexico have found that children resented the absence of fathers; and mothers have reported increased parenting problems with their children (D'Emilio, et al., 2007). Furthermore, problems associated with drug and alcohol abuse were reported to be greater among adolescents of migrant fathers, and reduced attention to school and home tasks were also cited as result of parental migration (D'Emilio, et al., 2007).

Using longitudinal data from the Mexican Family Life Survey (MxFLS), Arenas and Yahirun (2011) found that parents whose children migrated to the US between 2002 and 2005 had higher levels of anxiety, sadness, loneliness and a wish to die compared to parents of children who did not migrate. In comparison, parents of children who migrated within Mexico only had outcomes related to sadness compared to parents whose children never left. Antman (2010) found a significant association between being separated from a child now living in the U.S. and poor mental health outcomes for elderly parents still living in Mexico.

Social Health

Mexican migration produces periods of spousal and parent-child separation that are often considerable in both frequency and duration (Kanaiaupuni, 2000). Separation contributes to a series of emotional, physical and health consequences among family members left behind. Those who remain in the communities of origin are mostly women, youth and children, who are left to face the new reality that migration imposes on their lives. These women maintain a strong relationship of dependency with their partners, not only because of their duty as wives, but also due to the economic control exercised by men, as it has been reported that they are not able to freely decide where the money their husbands' send will be spent (Garcia Oramas, Ruiz Pimentel, & Ruiz Vallejo, 2011).

Studying families of migrants in rural communities in the state of Veracruz, Mexico, Garcia Oramas et al. (2011) found that numerous migrants leave their spouses under the guardianship of their relatives, usually their parents or in-laws. This is intended to protect their families, but especially to maintain social control over their partners. Caballero et al. (2008) studied partners of migrants in two central Mexico communities, and found similar familiar dynamics. Moreover, they report that these women have little control over the type and timing of the use of contraceptive methods: the decision to stop or continue is almost always taken at the request of the male, with the expectation that the woman will become pregnant during the months that her partner is visiting.

Caballero et al. (2008) also found that when a woman is alone, she has less capacity to respond to health problems: in a moment of crisis, she has no one to discuss her doubts or concerns or seek advice, as typically her husband would fill that role. She also faces

difficulties such as childcare, access to healthcare and transportation. Thus, women of migrating men self-medicate and delay seeking professional healthcare. Alternately, having a spouse who emigrates can improve access to health care in certain circumstances. For example, in the case of sexual health, these women often have greater freedom of choice to attend health services and continue (or not) contraception (Caballero, et al., 2008). It has also been reported that families of migrants use private health services more often than families without a migrant relative (Salgado de Snyder, et al., 2010).

Impact on Health of Those that Return to Mexico

Mexican immigration to the United States over the past four decades has represented the largest migration from any one country in the history of the United States. However, the past five years have seen a marked decrease in the number of Mexicans emigrating to the United States as well as a doubling of the number of Mexican immigrants returning to Mexico, e.g. 1,390,000 returning migrants between 2005-2010 which is up from just 670,000 between 1995 – 2000),(Passel & Cohn, 2009). Indeed, in the 2010 Mexican Census almost a million people reported having worked in the United States, up from just 230,000 five years earlier (Escobar Latapi, et al., 2013). While future flows will fluctuate in response to changing economic and political conditions in Mexico and the United States, the 12 million Mexican immigrants living in the United States - many of whom came during the 1990's as undocumented immigrants – have the potential to significantly impact the flow of returning migrants as they age out of the labor pool (Passel & Cohn, 2009). Migrants return home for a variety of both positive (retirement after financial success, family reunification etc.) and negative (unemployment, illness, deportation, etc.) reasons.

The growing tide of returning migrants might present challenges related to social and economic reintegration for returning immigrants – especially those of working age. Alternately, those who are returning as a result of an injury or illness as well as those returning in their retirement might present challenges to the health care systems both in terms of service provision and cost. Gaining a better understanding of the physical, mental and social health issues that surround return migration is an important first step in developing policies and initiatives that will help address the needs of returning migrants today as well as anticipated needs in the future.

Physical Health

According to a binational report (Escobar Latapi, et al., 2013), retrospective studies of older adults who returned to Mexico either at a young or old age show that compared to immigrants that remain in the United States, the health of return migrants is poor in indicators such as self-rated health, height, hypertension, smoking and higher mortality rates. Mexican immigrants also have higher old-age disability rates than individuals born in the United States, perhaps due to the cumulative effects of repetitive manual work.

González-Block and Sierra-de la Vega (2011) conducted a cross-sectional study of Mexican migrants who returned specifically to Mexico from the U.S. for hospital care. They found that hospitals in high and very high migration areas, as well as those along the U.S.-Mexico border were being used by sick returning migrants, who were not able have their hospital

needs met in the United States. The treated conditions most commonly reported by the hospitals were: trauma (56%), diabetes complications (38%), elective surgery (36%), HIV-AIDS (20%), chronic renal failure (18%), cancer (18%), other chronic diseases (14%), respiratory diseases (13%), animal bites and dehydration (7%), and psychiatric disorders (4%).

Mental Health

The reason for return is likely an important factor in the mental health of returning migrants. It is not difficult to imagine that returning to Mexico as the result of deportation, unemployment, or medical care would entail a very different mindset than returning to retire in your home village after many productive working years in the United States. While both may face challenges reinserting themselves into Mexican society, those returning after some misfortune would likely be at greater risk for mental/emotional health problems. Therefore, an analysis of the 2008 National Addiction Survey (Encuesta Nacional de Adicciones) showed that, in general, U.S. migrants returned to Mexico showed a three-fold increase in the risk of planned suicide attempts (Borges, Orozco, & Medina Mora, 2012).

Social Health

Similar to mental health, the conditions under which the individual returns to Mexico are likely have a significant impact on their social health. For those who are returning with financial resources it is easy to imagine that the reinsertion would be easier.

On the other hand, for those who return not having met their financial goals, the return likely brings up feelings of frustration as well as stress related to economic needs. As mentioned above, work can both positively and negatively impact mental health. In the case of youth or working age returning migrants, probably one of the most important steps in the reinsertion process will be getting on the road to a job either through gainful employment or continuing their education. Moctezuma (2013) highlights the difficulties school aged returning immigrants have in matriculating into schools in Mexico due to a lack of certified documents (e.g. birth certificates, report cards, school records) as well as academic problems such as language barriers and non-aligned curriculum. He advocates for a process that takes into account the reality of the returning migrant and facilitates the documentation they need to continue their studies.

Another central component to social health and reinsertion of returning immigrants is family. As stated previously many parents often leave loved ones behind when they emigrate for work. While this strategy may have proved successful in providing materially for their loved ones it likely required them to spend many years apart, often during their children's formative years. It is not hard to imagine how reunification after many years apart may be difficult and even awkward. Moctezuma (2013) also points out that recently there has been a significant rise in the number of families with children returning to Mexico. Social health can be compromised if some of the family members were not in agreement with returning to Mexico. Likewise, if the children have never lived in Mexico or don't speak Spanish well, the transition to a different standard of living or limitations on social interactions due to language and cultural barriers can further threaten social health.

Conclusion

Eleven percent of the Mexican population lives in the United States and roughly 20% of all children in Mexico have, at one time or another, had a father working in the United States. If we add to these numbers the increased number of women emigrating to the United States as well as the increased flow of immigrants returning to Mexico after having worked in the United States, it is not hard to see that a large number of Mexican families are directly affected by migration in and out of country. Developing a better understanding of migration patterns and their impact, both positive and negative, on the health of migrants and on family members who stay behind is essential in understanding the individual and societal costs of immigration. This in turn will inform improvements in public health policies and interventions that may serve to improve the physical, mental, and social health of the Mexican population. Finally, this knowledge can provide a social context for therapeutic individual interventions and approaches to social work that attempt to understand and address the health challenges many Mexican children and adults face as a result of immigration.

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