ORIGINAL RESEARCH

Risk Behaviors among Undocumented Immigrants in Northern Mexico: 2006-2007

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Introduction

Migration is one of the key demographic, social, cultural, and economic phenomena of our times; it generates intense interest and concern both locally and globally. As populations move, the health of migrants emerges as a crucial issue. Displacement produces particular individual needs, vulnerabilities, and risks which demand complex and heterogeneous interventions (Salgado et al., 2007; Canales et al., 2010; Sáenz et al., 2010). Addressing these needs requires detailed knowledge and analysis. It is necessary to look both into the particular backgrounds of individual migrants as well as the entire migratory experience from the point of departure to the final destination (whether chosen or not) (Moya and Uribe, 2007).

The fact and the circumstances of migration generally increase risks faced by migrants, and these can have a negative effect on their state of physical and mental health (Salgado, 1998). The International Organization for Migration, IOM (2010) found that, during the process of migration, men and women face different risks and their health is impacted in distinct ways. This is due in part to specific roles and behaviors before, during and after migration.

Mexico is involved in all aspects of migration most of which is headed for the United States. Mexicans themselves emigrate to the US, many migrants to the US use Mexico as a place of transit, and thousands of people each year immigrate to Mexico in hopes of improving their lives, including their health. According to the 2009 Human Development Report (UNDP 2009), many migrants are seeking better access to social services, including medical care. Economics is clearly not the only important reason people leave their place of origin.

Most studies on the health of migrants have focused on describing changes in migrants' state of health between the time of their arrival in the receiving country and some later time. These studies generally involve populations with visas or official permits; this is a somewhat more privileged group than those who cross geographic borders illegally (Bronfman and Leyva, 2008).

The goal of our study was to analyze the health status of undocumented migrant populations[1] along the northern Mexican border (specifically Tijuana and Mexicali) in 2006 and 2007. We sought to measure changes in risk behaviors (smoking, drug-taking and/or drinking, sexual practices and violence) that were associated with migration.

The context for Mexico-United States migration

According to the National Statistics and Geography Institute, INEGI (2006), the Mexican population residing in the US during 2006 was just over 11 million people; this means that 10% of the Mexican population is living north of the border. The National Population Council, CONAPO (2009), reports that around 6.2 million cross over and stay illegally; this figure is, based on information from the Survey on Migration across the Northern Border (EMIF).

The land border between Mexico and the United States is 3,200 km long. The US has erected a metal wall along 1/3 of this distance. Tijuana and Mexicali have historically been strategic locations for migration. Due to recent regulatory and security restrictions, border crossing points have moved and

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[1] By 'migrant' we mean a person who changes residence (whether temporarily or permanently) regardless of distance. The migrant has a place of origin and a final destination.

diversified to other more rural, sparsely populated and dangerous areas (Anguiano and Trejo, 2007).

Health programs for migrants in Mexico

Migration is a recurring political topic in both countries. However, the focus and framework differs between Mexico and the US.

As yet there are no joint efforts to address migrant health. Mexico has created the Health Program for Migrants, 2007-2012, based on four strategies: 1) strengthening institutional cooperation on migrant health, 2) promoting self-care and migrant health care programs (within the country and abroad), 3) providing support services to the Mexican migrant population and their families, and 4) promoting research on migrant healthcare (Ministry of Health, 2009).

Materials and Methods

This is a descriptive study. Information was derived from a survey conducted at migrant hostels in Tijuana and Mexicali by Doctors of the World (DOW). The surveys were conducted between January 1, 2006 and December 31, 2007. The interviewees fell into one of the following categories: deportees, repatriates, in transit (Mexicans), voluntary departure from the US, transmigrants (non-Mexicans) or intending to cross.[2] The main objective of DOW was to provide free health services to individuals passing through the hostels,[3] as part of a three-year project along the northern border of Mexico. These hostels – seven in total – allowed DOW staff to set up a unit where they could work.

During the study period 6,234 consultations were carried out. Only 24.6% of patients took part in the survey; this resulted in 1,535 interviews (Table 1). The sample was a not random one. Those surveyed were migrants who went voluntarily to the migrant shelters or hostels and also decided to make use of the medical services offered by DOW. Therefore, the results of this survey cannot be generalized to the entire population of migrants. To the contrary, this study is a specific limited exercise which sought to explore and highlight habits and practices related to health among those interviewed. Nevertheless, this small sample can be seen to reflect a larger migrant population with similar features to those of the migrants described herein.

The questionnaire had three parts: 1) socio-demographic profile, 2) access to health care, 3) social status and migration route. Most questions were closed-ended. Survey respondents provided informed consent and received no monetary reward for their participation in the study.

Results

Socio-demographic characteristics of migrants

The sample was predominantly male (90%) with an average age of 34.2 years. Remarkably, only 5% were illiterate; 47.6% had been educated to primary level, 45.6% to secondary or pre-university level and 2.1% had a university or advanced degree. Most were single (58%) and 29.3% spoke both English and Spanish. Approximately 70% were from urban areas, 5.3% spoke an indigenous language, and 17.7% were foreigners. The most frequent origin countries were Guatemala, Honduras and El Salvador, Internally, 55% of participants were from states such as Jalisco, Michoacán, Mexico City, Guanajuato, Guerrero and Sinaloa. Migration status was as follows: 33.2% deportees, 25.3% in transit, 22.6% repatriates, 16.4% transmigrants, 1.4% intending to cross into the US and 1.2% having returned from there. It should be noted that the socio-demographic characteristics of individuals showed differences depending on their migration status (Table 2).

Migration Experience

One third of migrants had never been in the US, while 18% had been in the US for 1 to 5 years and 24.5% had remained there for 5 to 10 years. Among those crossing the border, 29.1% did so only once, 24.2% twice, and the rest three times or more. The most frequent crossing point was Tijuana (57.8%). The last migration attempt was often undertaken either alone or with relatives and friends. An important strategy was hiring the services of *'polleros'* or *'coyotes'*.[4] At the time of the interview, the vast majority (58.7%) still planned on entering

[2] It was not always possible to establish the criterion used to classify the interviewees from the survey form.

[3] Hostels are places where migrants receive free, or very low cost, services such as showers, meals, a place to sleep, clothes, telephone, among others. Most of them belong to religious missions.

[4] *Coyotes* or *polleros* are defined as social actors on the Mexico-US border who offer their services as 'experts' in the clandestine transfer of migrants from Mexico to the US. Authorities consider them to be people traffickers (Alonso, 2010).

the US (58.7%). A fifth (20.2%) had desisted from this idea and expressed their intention of returning home, 13.4% considered settling in Tijuana or Mexicali, and 7.6% had no definite plans.

Eight out ten interviewees were migrating for economic reasons; 18.5% were motivated by family reunification. It is noteworthy that only a very small proportion, 0.5% decided to migrate in order to seek medical care. Eighty percent had worked in their home towns and 30% had worked during the course of their migration..

The interviewees were engaged in illegal migration. 36.8% of those who had managed to cross the border into the U.S. were arrested on the other side. Within this group, 26.2% reported their imprisonment and subsequent deportation were occasioned by traffic offenses or unpaid fines, 22.8% had been arrested for drug and/or alcohol consumption, 17.2% for other offences or crimes, 14.2% for being without papers, and 12.7% for selling drugs and the rest for other reasons.

Changes in Risk Behaviors and Violence Due to Migration

We examined changes in risk behaviors (alcohol, tobacco and drug addiction, sexual practices, such as condom use), which arose after crossing the border or during the attempt to do so. We also looked at acts of violence faced by the migrants (both in the US and in Mexico) which put the health of this population in a situation of constant social vulnerability.

At the time of interview, 38% of migrants drank alcohol; this was ten percentage points less than the total number of people who reported drinking before migration. On the other hand, tobacco usage increased considerably: 53% of those surveyed smoked at the time of interview; prior to migration 37.3% were smokers. The prevalence of alcohol and tobacco consumption among men (97%) was far greater than among women.

Additionally, 4.9% reported using other types of illegal drugs; 52.9% had acquired the habit in their town of origin, 21.4% during migration and 25.7% in the US. Exactly half of those who used drugs said they had altered their drug habits during migration. This meant either changing (increasing or decreasing) the dose or combining/changing the type of drug consumed. The most common pattern (45.1%) was the daily use of drugs. The most common drugs, in order, were: tetrahydrocannabinol (marijuana, 56.3%), methamphetamine (28.1%), cocaine hydrochloride (7%), cocaine hydrochlorate (6.7%), and others (1.9%). Only six respondents admitted to injection drug user (IDU) and five of these began injecting either during the border crossing or once they were settled in the US.

The majority of migrants stated that they were heterosexual (89%); 9.3% reported being bisexual and 1.7% were homosexual. When asked about the use of condoms at some point in their journey, 67.3% reported unprotected sex; 69.4% of males had done so and 48.1% of women. 8.9% of interviewees found themselves needing to exchange sexual services for drugs and/or money, a situation more recurrent among men (9.4%) than women (4.5%). Another important finding is that 43% combined sex with drugs.

Risk behaviors varied depending upon migratory status. The group that lowered their alcohol intake the most was the deportees. Among the transmigrants smoking increased the most of any group. In-transit migrants had the highest level of drug consumption compared to other migrants. Deportees and those in transit were the groups which most frequently combined sex with alcohol and drugs, with a high percentage of the latter exchanging sex for money and/or drugs (Table 3).

A third of migrants were involved in incidents of violence. A large proportion of these incidents occurred in Mexico (85.6%). Of all those subjected to violence, 4.6% required medical assistance but only half of these were able to obtain it. Over 80% of cases involved physical violence (aggression, insults) and theft. The perpetrators were mainly police on either side of the border.

Discussion and Conclusions

The health of migrants has become an important topic of general interest; it should be included on the cross-border agendas of both México and the United States (Doctors of the World 2008; Sáenz et al., 2010). Furthermore, special attention should be paid to the most socially vulnerable groups such as the migrants included in this study. For various reasons our subjects had to leave their homes in search of better socio-economic opportunities; this involved great risks since they are without papers, money, social protection, etc.

The very fact of illegal migration makes it highly unlikely that there are any records of these migrants reporting their true situation, outlining their characteristics, the routes and processes of their journey, let alone the factors associated with their

health and well-being (Revista Panamericana de Salud Pública, 2005; Salgado et al., 2007; Bronfman and Leyva, 2008). This study provides valuable insight into their condition. While our data are only the tip of the iceberg, they provide a general idea of who the migrants are, the circumstances of their migration, and some of the elements associated with their health.

We identified, for instance, that although our subjects share certain characteristics with legal migrants (such as being young, from urban areas, and literate), the nature of the interactions they face during the migration process sets them apart. Our study also examined undocumented migrants who were still en route. Unlike most studies which examine migrants once established in their receiving country, our subjects had either already attempted to or were intending to cross the border. They were still itinerant, hoping to achieve their final aim of reaching the United States.

Despite the small sample size (particularly when compared to the huge numbers of people in similar circumstances), our data may well be illustrative of a situation commonly experienced by a much broader conglomeration of migrants. We noticed a reduction in alcohol consumption in our subjects which contrasted with an increase in the use of tobacco and other psychoactive substances. Some took to injecting drugs and a significant proportion exchanged sex for money or other items. A recent study of injecting drug users in the frontier town of Tijuana, found that those who had been deported from the US were four times more likely to be infected with HIV/AIDS as those who had not (Strathdee, 2009).

It is generally thought that undocumented migrants consume more alcohol than they normally do in their places of origin; alcohol consumption is thought to increase during the migration and in the final destination (Revista Panamericana de Salud Pública, 2005; Sánchez et al., 2006; Tortajada et al., 2008; Arellanez and Sánchez, 2010). Our findings, however, disagree with these studies, suggesting the need for further research to better establish possible causes of this phenomenon.

A major finding is that migrants who are 'passing through' have unprotected sex (i.e. without using condoms); this being more prevalent among males. Other migrant studies support this finding. People generally know about condoms, but their actual use is restricted. This reflects the limited possibilities available to undocumented migrants for negotiation in sexual relations and the lack of resources enabling them to use safe methods of self-care (Ríos et al., 2009; Médicos Sin Fronteras, 2010). There is cause for even greater concern if we consider that almost 10% had to exchange sex for money or another reason. Although women are generally considered more vulnerable to these circumstances (Kaplan et al., 2002; Bronfman and Leyva, 2008), the data on which this article is based show that it is more often men who take part in this activity, making them social agents deserving of attention. Too often, concern for the female group means male problems go unnoticed and keeps them invisible.

Violence is a constant in the lives of those we interviewed. This reinforces the need to address migration from a human rights perspective. This means the defence of social equality within an up-to-date legal framework enforced by regulatory agencies and public advocates, and through the creation of mechanisms and spaces where these individuals can be presented within civil society (Comisión Económica para América Latina y el Caribe, 2006; CONAPO, 2008).

Lastly, we note the urgent need to generate and analyze better information on health conditions among the undocumented population near the Mexico-US border. One way of doing this would be by including questions on health in the EMIF survey which has been carried out since 1993 (El Colegio de la Frontera Norte, 2010). It should be borne in mind that the population to be included in these surveys is heterogeneous, from diverse cultural backgrounds, and characterized by belonging to various socio-economic and demographic contexts. We would venture to suggest that, for future research on the subject, it would be useful to consider the implications of gender by examining the differences between men and women in terms of the routes and processes of migration and how their health is affected.

Limitations

Given the nature of the recruitment process and the final sample obtained, our study is not representative of all undocumented migrants. Given this, it is not possible to use more refined statistical techniques to measure and explain the phenomenon we examined. Findings such as a change in drinking, smoking and drug habits should be treated with care, since altered patterns might not be

directly related to migration, a situation we were unable to determine in this study.

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Table 1: Medical consultations held and number interviewed Stratified by hostel. Northern border of Mexico, 2006–2007

Hostel	Consultations held		Persons interviewed	
	Total	%	Total	%
Casa del Migrante Scalabrini Scalabrini Migrant Shelter	3441	55.2	608	39.6
Casa del Migrante Betania Bethany Migrant Shelter	1354	21.7	521	33.9
Albergue Maná Maná Refuge	640	10.3	239	15.6
Instituto Madre Assunta Mother Assunta Institute	400	6.4	145	9.4
Albergue Juvenil del Desierto Desert Youth Hostel	333	5.3	20	1.3
Guadalupe Cathedral	66	1.1	2	0.1
Total	*6234*	*100*	*1535*	*100*

Source: Doctors of the World survey. Mexico, 2006–2007.

Table 2: Socio-demographic characteristics according to type of migrant. Northern border of Mexico, 2006–2007

Socio-demographic characteristics		Type of migrant (Percentage distribution)					
		Repatriates	Deportees	Departed voluntarily	In transit	Trans-migrants	Intending to cross
Average age		34.2	35.9	32.8	34.2	31.1	32.5
Gender	Male	79.8	96.5	94.4	89.7	94.0	54.5
	Female	20.2	3.5	5.6	10.3	6.0	45.5
Partnership status	Single	51.3	60.9	44.4	61.1	57.0	63.6
	Partnered	48.7	39.1	55.6	38.9	43.0	36.4
Level of schooling attained	Primary	45.8	47.5	50.0	58.2	64.1	45.5
	Secondary or higher	54.2	52.5	50.0	41.8	35.9	54.5
Languages spoken	One (English or Spanish)	70.6	54.2	66.7	84.5	82.5	81.8
	English and Spanish	29.4	45.8	33.3	15.5	17.5	18.2
Indigenous language	Yes	5.2	5.5	5.6	6.7	2.0	13.6
	No	94.8	94.5	94.4	93.3	98.0	86.4
Country of origin	Mexico	96.3	100.0	83.3	98.7	0.8	95.5
	Abroad	3.7	0.0	16.7	1.3	99.2	4.5
Nature of place of origin	Urban	69.2	69.9	72.2	64.7	54.2	72.7
	Rural	30.8	30.1	27.8	35.3	45.8	27.3

Source: Doctors of the World survey. Mexico, 2006–2007.

Table 3: Risk behaviors according to migrant status. Northern border of Mexico, 2006–2007

Habits and behaviors		Type of migrant (Percentage distribution)					
		Repatriates	Deportees	Departed voluntarily	In transit	Trans-migrants	Intending to cross
Drinking	Currently	30.3	42.0	22.2	43.3	36.7	22.7
	Before migration	38.3	60.1	27.8	50.0	39.8	22.7
Smoking	Currently	43.8	59.9	27.8	51.9	57.4	27.3
	Before migration	34.3	47.0	33.3	34.8	27.1	27.3
Current drug use		4.0	4.9	0.0	6.2	4.4	4.5
Unprotected sex		64.3	64.4	38.9	72.2	72.5	59.1
Combining sex with alcohol and/or drugs		37.2	49.7	16.7	48.3	31.9	22.7
Exchanging sex for money and/or drugs		6.6	9.8	0.0	10.6	8.4	9.1

Source: Doctors of the World survey. Mexico, 2006–2007.