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Autonomy in Health and Health Seeking Behavior among Older Mexican Immigrant Men in California's Central Valley

by

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DISSERTATION

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Autonomy in Health and Health Seeking Behavior among Older Mexican Immigrant Men in California's Central Valley
Tania L. Pacheco

Abstract

This dissertation expands the understanding of how gender, immigration, and aging impact health behaviors in older Mexican immigrant men. Along with other Latino elders, these men are poor and plagued with chronic or disabling conditions, however, they live longer and have higher self-reported health than their white male counterparts. This research aims to 1) explain their conceptualization of health, illness, risk and prevention and 2) map the health seeking process. Data gathered includes 20 in-person interviews of older Mexican immigrant men in four Central Valley counties using a semi-structured interview guide and ethnographic data. Analysis of written, audio, and visual data was coded using grounded theory methods. Participants had clear conceptualizations of health, illness, and risk. While active in their own self-defined health regimens, participants rely on women to help them navigate the United States healthcare system. Participants saw themselves as adhering patients, did not have overarching negative sentiment about the healthcare system, and yet did not adhere to screenings, lab work, and avoided seeking healthcare. Abstaining from health care or modifying prescribed health regimes was due to distrust of biomedical risk, and the labeling of sick as being an overall impediment to their autonomy. They identified systemic barriers that were the sum of their lives as agribusiness farmworkers. Older Mexican immigrant men are using their agency to make decisions about seeking healthcare. Their desire for autonomy is conceptualized within the constraints to health care and as a consequence of systemic barriers. A discussion is needed on other marginalized groups and their movements in and out of the US healthcare system, its belief system, and technologies.

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Chapter 1: Introduction

Over the next few decades, the United States will see one of the most dramatic demographic changes in its history. It is estimated that people over the age of 65 years old will be the only age group to see an increase in population over the next 40 years (US Census 2011). Older populations in the United States have historically faced challenges that put them at risk for health related issues. Poverty of older Americans is prevalent today, and many of things related to their lifestyle, such as illness or family disengagement, make them much more likely to be poor or vulnerable to fall into poverty than other age groups (Fisher et al., 2009; Shinn et al. 2007).

In the United States, there is also an increasing population of Latinos, most of which are Mexican. They are also expected to comprise a large part of the estimated increase in the United States aging population (Arias 2010). When focusing on Latinos, it is important to look at the largest group among them, which are Mexican Americans and immigrants. Of the 50 million people classified as being of Hispanic origin, Mexicans make up about 12 million people, or about 29% of immigrants in the country (Passel, Cohn, and Gonzalez-Barrera 2012; Wallace and Gutierrez 2005).

In spite of having a lower socioeconomic status in the United States, Latinos who have been in the United States less than two decades enjoy similar health status to non-Hispanic whites (Markides and Eschbach 2005; Antecol and Bedard 2006). This phenomenon is known as the Latino or Hispanic Paradox. For many years, sociologists have attempted to explain how social factors drive individual choices and outcomes (Bourdieu 1984; Shim 2010; Pacheco, Ramirez, Capitman 2012). For Latinos, particularly Mexicans, the focus has been on figuring out how a

marginalized group can be just as healthy or live longer than their white counterparts (Arias 2010).

While this "Latino Paradox" has been widely criticized, an extensive study in 2010 by the Center for Disease and Control and Prevention has found the trend remains amongst Mexican immigrants in particular (Arias 2010). The paradox is said to fade after years of living in the United States due to adaptation of cultural behaviors that lead to an unhealthy lifestyle (Wallace and Castañeda 2008). While immigration may lead to better health care access, it also can introduce unhealthy lifestyles and new factors that impede the achievement of better health (Smith et al. 2002). For my dissertation, I am focusing on the sub-group of elder Mexican immigrants who have at least one decade living in the United States. Therefore, while this group may seem healthier, time spent in the United States may also negatively affect their health outcomes, but the specific reasons for this unhealthy lifestyle change are still widely unknown (Arias 2010).

For the older Mexican immigrant population, this complex picture of migration, labor, legal status, and aging and gender identities leaves them at a particular crossroad. Their health status and behavior as elders now and in 20 years will be largely shaped by their work and legal status in the decades prior to them joining the older population category. This population has worked in high-risk environments throughout their lives, and their limited access to a healthy lifestyle has left them plagued with chronic conditions such as Type II diabetes (Angel and Whitefield 2007). Many of these conditions stem from hard lives in their home countries like Mexico, as well as from migration (Montoya 2011: 186).

The initial questions of this project centered on how attempting to answer a part of this "Latino Paradox" in a place that is also paradoxical as a space: the California Central Valley.

The participants in this study grew up in Mexico, migrated as children into and settled in the place that is surrounded by food, where they worked on a daily basis in the food system, but where access to affordable fresh fruits and vegetables for many is at least a 15 minute drive away (Getz and Brown 2009). While poor in the socioeconomic ladder, the participants belong to the Hispanic group in the Central Valley which does not have a higher likelihood of premature mortality than their white counterparts (Joint Center for Political and Economic Studies 2012). While this dissertation does not engage in the causal factors of the Latino Paradox, it provides a snapshot into a subpopulation that contributes to this data anomaly.

Older Mexican immigrant participants revealed how geopolitical, economic, and health care circumstances affected their conceptualizations about health, illness, healthcare, and their own behaviors pertaining to these topics. Elders having informed conceptualizations of illness and disease, and whether their decisions to not seek care are driven by more than just lack of literacy. Their identity-driven agency of provider and worker within systemic barriers of being immigrant and in poverty drives their decisions about when to go to a doctor, take medications or follow a diet, and do follow-up or preventive tests. Their healthcare behavior therefore, is a consequence of their individual experiences and the way social structures prevent or help them attain healthcare.

The literature recognizes that Mexican elders have enabling and impeding factors that affect health seeking behaviors, which are primarily linked to socioeconomic status (Blewett et al. 2004). Factors such as level of education, transportation to health centers, and lack of specialty services in their locality impede them from accessing care (Guo and Phillips 2006). When this subpopulation does seek care, studies have shown that the narrative of that process often does not portray a linear process of feeling ill or needing prevention, then getting care.

Rather, it is a complex spectrum, where systems of care can include the biomedical system, like hospitals or clinics, almost exclusively or exclude it completely (Chang, Wallis, and Tiralongo, 2007; Loera 2007).

Mexican-Americans are the largest subcategory within the Latino community, yet studies about conceptualization of health and health seeking have missed the subtleties that exist intra-culturally by gender or not focused on men (Rich and Ro 2002; Sobralske 2004; McNaughton 2007). What researchers do know about Latino men who migrate is that they are healthier than women upon arriving to the United States and retain a healthy status longer than women who migrate (Antecol and Bedard 2006). In addition, they report a healthier status than women even as they engage in the same occupational classification (Salinas and Peek 2008). In addition, it is widely known that they will utilize healthcare less than women (Rich and Ro 2002; Kellog 2003; Courtenay 2000b). Rather than a result of biological sex characteristics, differences in health status between men and women are often about gender within healthcare system as a social institution (Courtenay 2000a: Courtenay 2000b).

Latino health is studied without an emphasis on gender roles of the older population, so little is known as to what accounts for gender differences in health status and health seeking behavior, even though research shows gender differences across many racial and ethnic groups (Arias 2010). When thinking about older populations in the US, we know there are vast cultural and systemic gender differences amongst the older population, such as the way men are portrayed and the poverty of women. When the health-seeking behavior of the older Latino segment of the population has been studied, the most widely cited articles discuss the lack of access by researchers to Latino men (Wong, Espinoza, and Palloni 2007; Brown 2007; Markides and Eschbach 2005).

We can gain much knowledge about the healthcare utilization and status of this population from studies focusing on systemic barriers. However, these give us an incomplete picture when it comes to older Mexican immigrant men who tend to have protective health status factors even within their own subpopulation and socioeconomic status (Rich and Ro 2002). Previous studies focusing on health seeking behavior have dealt with predictors to seeking care in a variety of lenses which either overemphasize the role of the person or their social capital, or emphasize systemic barriers as overarching explanations for health seeking behaviors. However, there is a gap in the literature, which ideally would map the points of convergence between personal decisions based on internal factors and their health experiences as shaped by systemic barriers.

There has been much research on how migration and the systemic barriers Mexican men face upon arrival to the United States affect their masculine identity (Broughton 2008; Coltrane, Parke and Adams 2004), but not nearly enough on how their identity shapes their behavior when it comes to health care decisions. Research shows that family and community networks are important to Latino and in particular Mexican immigrant communities and that use of these networks can influence healthcare decisions (Kao and Kyungeh, 2012; Weisman, Duarte and Koneru et al. 2006). However, little is known about how the influence of networks on behavior within the healthcare system is mediated by the identity of the person, and men in particular.

Research points to a disconnect between how the systemic level systems and meso-level networks think they interact with the older Mexican immigrant population and how this subpopulation believe it is interacting with those levels of healthcare. For example, numerous programs targeting Mexican Americans and Mexican immigrants have found short term success in lowering HbA1c levels among diabetics, gotten them to seek preventive screenings, and even

enrolled in nutrition programs. However, long term effects of these programs have not been widely studied and those that have researched these on a long term period have women grossly overrepresented or found that the effect decreases over time (Carbajal et al. 2013; Armour et al. 2005). Something at the individual level is happening that the systemic level systems are not being able to capture to ensure participation of men and long-term success of health care interventions.

Now more than ever, it is imperative to understand the complexities of elder Mexican immigrant health status, health care and health seeking behavior, and the social and structural conditions that shape health status and health related behavior. While enabling and impeding factors which affect health care seeking behavior are known for specific portions of Mexican elders living in the United States, much of this research has relied on key informants or studies where women were overrepresented. An analysis of how issues of gender, immigration, and aging frame the concepts of health and illness and drive the help-seeking process for older Mexican immigrant men is needed.

Problem Statement

The lack of knowledge about Mexican elderly men's perceptions about healthcare and their conceptualization of health, which can be described as how they define health as a status or way of being, is evident in the lack of available research that focuses on vulnerable subpopulations of men seeking healthcare in the United States. This research will add to the broader understanding of how gender, immigration, and aging shape policies and health services in an increasingly Hispanic and aging population. I propose in this project to focus on the conceptualization of health and health seeking behavior among older Mexican immigrant men. I ask two basic research questions:

1) How do older Mexican immigrant men perceive health and illness?

a.) How are their perceptions shaped by their notions of what it means to be a man?

b.) How have their perceptions on how to stay healthy, deal with illness, and when it is appropriate or necessary to seek care been shaped by their migration from Mexico to the United States?

c.) How are their perceptions shaped by their notions of what it means to be elderly?

2) What are the driving factors in their decision-making process about seeking or abstaining from any type of medical care?

My goal for this and future research is to extend the dialogue on the re-framing of health and illness conceptualization that would inform health promotion interventions geared towards Mexican immigrant elderly men and women, with the hope of re-shaping behavioral intervention models. My initial hypothesis, based on pilot study data, is that elders have very informed conceptualizations of illness and disease, and that their decisions to not seek care can be due to more than just lack of literacy. While empowerment literature talks about the use of health literacy by marginalized groups to access allopathic care, I believe that older Mexican immigrant men may be using their agency by enacting their aging, masculine, and immigrant identities to refrain from using health care.

It is possible that when allopathic care is being used, it is used not only within the traditionally studied frameworks of social space and systemic barriers, but also through using their own conceptualizations, resources, and networks. In other words, the decision-making process to seek care may go beyond external factors that have been widely studied, such as socioeconomic status and access to care. Rather, seeking and using healthcare services may be related to internal factors that have more to do with acquiring a particular health or social status, which may result in engaging in the United States allopathic healthcare system, or making a

conscious decision to abstain from this type of care. This research can open up a conversation about the re-framing of conceptualization of health among marginalized populations as lack of literacy and fatalism to a conceptualization that takes into account agency.

Health Seeking Process among Latinos

In order to understand the health seeking process of Latinos, it is important to understand their medical and migration history. Mexican immigrant elders, along with other Latino elders, are disproportionably poor and plagued with chronic and other disabling conditions (Wallace and Villa 2003). The immigrant labor force is robust and elder Mexican immigrants tend to experience work conditions that are physically demanding before and during their old age (Salinas and Peek 2008). In a study of elders living along the southwest border of the United States, Salinas and Peek sought to find the health status of the Mexican immigrant population residing in the area compared to their white counterparts. The research found that the Mexican American population tended to engage in physically demanding jobs such as those in agriculture, construction, and tourism (Salinas and Peek 2008). Those who had worked in more physically demanded jobs were more likely to have disabling conditions like arthritis.

While utilization of allopathic medicine by older Mexican immigrant men as a subpopulation is unknown, much research studying factors significantly predicting seeking care have been used as evidence that points to when they are willing to seek care. Health care seeking can be described as any action done towards the achievement of a self-defined healthy status. This can include anything from taking Tylenol, being able to work, to getting colorectal cancer screening as a prevention measure. Al Snih et al. (2006) found that women tend to seek more allopathic healthcare than men and having insurance and more than one diagnosed condition will make people more likely to seek care. What is seemingly contradicting about the health status of Latino men is that while Latinos are less likely to see a physician on a regular

basis than any other group and enjoy the benefits of preventive medicine, they have high self-reported health, even higher than other groups (National Institutes on Aging 2009).

Research about Mexican-Americans and health is incomplete without taking into account how religion shapes numerous health outcomes. The narrative around religion and Latinos has traditionally been one where fatalism explained their lack of engagement within the healthcare system. However, fatalism may not account for other social factors that may affect decisions to abstain from seeking care (Abraido-Lanza et al. 2007). Krause and Bastida (2009) analyzed how notions of pain and suffering in relation to self-reported health status and help-seeking behavior are related to level of religiosity. They find that there is no clear pattern of how Mexican elders use prayer and religion; some use religion, specifically God's will, to justify not seeking care. Others actually use religion as a motivating factor to get better. Religion has also been found to be used as an accompanying factor to social barriers to care. Praying for health by older adults in the United States has been correlated with lower income, and women are more likely to use prayer than men (Tait et al. 2011). However, the actual decision-making process for seeking both allopathic and alternative methods of care, one over the other, or neither remains unknown.

For Mexican elders, their community is a strong influence in the decision making processes for seeking health care, however, the dynamics of community change once migration happens as migration can be an isolating process (Finch and Vega 2003). The definition of community shifts for different people; it can include friends and neighbors or be limited to immediate family. The role of migration and its long-term deleterious effect on the sense of community has been studied on a large scale through survey data, but further inquiry on the

implications of this phenomenon for help-seeking behavior is needed (Finch and Vega 2003; Markides and Eschbach 2005).

The experiences of Mexican immigrant elders in the United States healthcare system include other factors related to their experience of migration, acculturation, and beliefs about alternative medicine. Acculturation can be described as process by which an individual or group modify their lifestyle and cultural behaviors to fit with the new cultural norms and behaviors (Marín and Gamba 1996:297). Medical, public health, and gerontology researchers grapple with the questions of what are the health needs/outcomes of this group, how do they receive messages about health, and what are the social structures that lead to health risks (Trevino and Coustasse 2007).

Decision Making around Health Seeking Behavior for Men

Research about the conceptualization of health seeking among men is needed (Wenger 2011). Part of the journey towards a better understanding of this phenomena is identifying factors that influence the decision making process. Research has shown a number of factors may be at play, that different decisions and levels of engagement depend on the context, and that there may be a disconnect between decisions and actions. For example, Schapira et al. (2011) found that medical numbers, like statistics, or counts related to blood glucose or pressure, are important factors in how Mexican Americans conceptualize health and illness. To illustrate the disconnect between decisions and actions, research among older Latinos found that patients will confide in one person in their family, or will have informal conversations with their doctors about end-of-life care, but there is a disconnect between that and getting them to write it on paper into an advanced directive (Kelley, Wenger, and Sarkisian 2010). While end-of-life care is not the focus of this dissertation, this research points to the importance of learning about

both conceptualization and process, since people can be literate about health-related decisions, yet may choose not to act.

The engagement of others within the decision making process provides the most complex and fascinating findings in this body of research. Crist (2002) found that decisions about whether to go into a skilled home nursing among Mexican Americans are made as a family rather than individually. Furthermore, when care is needed, the expectation is that a female daughter will help the family with services a skilled home nurse could perform. However, Donlan (2011) found that this trend may change with acculturation. The narratives of frail older Mexican immigrants reveal a trend that as families stay longer in the United States, they are more likely to send the older generations to nursing homes rather than care for them at home (Donlan 2011).

Some research reveals that the decision making process of health services related decisions also varies not just by gender, but by type of services. When it comes to mental health service treatment, a survey research study on ethnically diverse populations found men to have a more passive approach to decision making than women, letting the doctor take most of the treatment related decisions (Patel and Bakken 2010). The sample in the Patel and Bakken study was limited to those patients who had already decided to seek treatment for anxiety and depression in an outpatient facility. In my pilot study, one of the participants was being treated for an acute problem, and he left the entire decision making process up to his doctors. His wife, while participating in the management of his illness, was herself completely withdrawn and opposed to the medical system for her own health care. Even in one household, mindsets and health seeking processes look different.

Perkins Cortez, and Hazuda (2003) also found that Mexican American men felt that the medical system controls their medical decisions. This handing over of medical decisions to the medical care team is defined by the authors as an example of a population feeling disempowered, as they do not feel their input is valid. More about the role of masculine or male identity in the decision making process is revealed when research about male-specific diseases is studied. Getrich et al. (2012) studied men who self-identify as Hispanic or Mexican men in New Mexico and asked them about their ideas regarding colorectal cancer screening. They found that self-identified Mexican men protected their masculinity through waiting to receive medical care when deciding on when and whether to seek this type of cancer screening, while self-identified Hispanic men viewed this as a purely medical practice. Mexican men perceived the procedure should be a last resort as the risk for loss of manhood exists since one of the procedures for screening is a colonoscopy.

This body of research is developing, as is evident by the number of articles found published recently that focus on gender, aging, and ethnicity. This may point to a larger gap in our understanding of the costs that a female-centered public health has had for marginalized or underserved men's health, a phenomenon which is yet to be studied within a Latino health framework. A lack of inclusion of men in public health interventions is troubling for both genders. From a feminist point of view, this further medicalizes women's bodies and focuses on them as the source for bodily intervention, as have other marginalized populations (poor, ethnic groups) in medical history. The difference is that this becomes a "lose-lose" situation for all, because Mexican immigrant men do not enjoy better health forever, while they may self-report as being healthier, they still die sooner than women (Antecol and Bedard 2006; Arias 2010).

Chapter 2: Theoretical Perspectives

Theorizing and Defining Concepts

This dissertation places an emphasis on behavior within the health care system, which requires further explanation. The name of the dissertation includes terms that are very intentional and speak to the type of analysis that is constantly zooming in and out, from the individual decisions to the systemic situations. In my analysis, both identity and migration are important to know about, and as mentioned in chapter 1, I hypothesize that both are playing an essential role for the behavior and health status of older Mexican immigrant men.

I have chosen to interweave the definitions of the essential terms I am using in the theories in which I am grounding them, also noting where I am problematizing said theories. First, I will define older Mexican immigrant men from the ethnographic perspective where I take into account their background and the journeys, both physical and chronological, they have traveled up until their point of interview. I also define masculine identity within the context of migration, this results in specific masculine behavior that is adjusted for the systemic constraints to being a breadwinner and an immigrant at the same time. These classifications matter because they influence how they will interact with social structures such as the education, health, and the legal systems (Walter, Bourgois, and Loinaz 2004). However, I also think they matter because identity formation is an important aspect of understanding power relations between people, their identities, and the systemic frameworks where they enact these identities. In addition, they matter because identity construction has at the core of its framework, the idea of co-construction, which is part of the underlying thesis of this dissertation: situations and behavior are co-created by systems and individuals and both must be examined.

Next, I will define the medical system that older Mexican immigrant men seek health care within our outside the US healthcare system. I use the theoretical framework of biomedicalization to describe the processes involved when someone navigates the system of modern US healthcare of biomedicine. It is not just the doctor-patient relationship that is implicated or is the focus of this dissertation, although that is a complex relationship itself. Rather, I seek to understand how people navigate within constructs of health, the technologies to diagnosis, cure or treat disease in biomedicine. In addition, I want to see how they navigate public health constructs of wellness and bodies thriving, particularly in old age.

Within this chapter I will also define medical care, as I will differentiate medical care from the biomedicine system. An older Mexican immigrant man may indeed participate in the US medical care system. However, he may also define medical care as something outside of its purview. This may include, but is not limited to, the Mexican healthcare system, traditional home remedies, alternative medicine practitioners and medications, and religion.

As I define medical care further, I have two goals. The first is to have a working understanding that there are health care systems operating which this population may engage in for personal reasons. They may also engage in these healthcare systems because of the systemic barriers they face within the US biomedical system. The second is that I want to speculate based on some previous research what this population may define as medical care, but I also want to leave the possibilities open so that each may define and explain in his own words, his reasons for viewing any venue as a source of "medical care." This relates to health seeking behavior among the population, what it means to seek care, and the interplays between individual choices, definitions, and the systemic constraints to US biomedical care.

This dissertation is grounded in the idea that people as patients are acting within the confines of systemic barriers, but navigating them in such ways that they are not simply reactions to a system. It is under this assumption that I will define the health seeking process. In order to better understand this process as I am posing it, agency must also be defined. This dissertation is also focused on investigating the driving factors in moments within the help seeking process that do not include participation in the US medical system. Finally, the dissertation attempts to have a beginning understanding of what it means for a marginalized subpopulation to resist the aforementioned system vis-à-vis the enacting of their identities and networks.

Mexican immigrant men and identity

The term older Mexican immigrant men, is an intentional term, whereas each pronoun means and signifies something to the participants. Being old carries marginalization consequences in the United States, as does being a Mexican immigrant, as this involves being male coming from a country that emphasizes the role of the strong male as the head of household. Each of these also signifies what others perceive them as and how their lives are organized, situated, and adapt to change within society.

The men are in a stage in their lives where aging is at the forefront of how society sees them and they see themselves. These two views are not always in sync. As the Pew Research Center points out, most Latinos will identify with their country of origin first, then as part of the Hispanic/Latino group (Lopez 2013). The immigrant male experience is unique in this case, as men of this generation, the 65 and older group migrated as teenagers or young adults. Rather than move their entire families to the United States as a unit, they gradually built their lives around their situations in this country. Their masculinity is also changing as it is shaped by all the descriptors of Mexican immigrant, older, and their work.

Postcolonial identity theory stems from literary studies based on works from cultures which were colonized. Postcolonial theorists refute colonial hierarchies and instead place people who were colonized at the forefront to highlight their lives and struggles. Sociological identity theory too has moved from the traditional anthropological notions of self and culture to how race and class relations, among others, influence small groups of individuals, such as those within a particular group or organization, and the effect of identities on larger social structures like education and the economy.

I chose include both sociological and postcolonial identity theories because I am studying elder Mexican immigrant men living the United States. The cultural component that postcolonial theories provide is a deeper view into what Mexican immigrants may experience as they migrate into the United States. Identity theory provides the perspective of how postcolonial theory came to be situated, but also how identity was formed uniquely in the United States. Some of the literature included in this review provides some of the early arguments in the sociological study of identity, as these are the works in which the more recent empirical work on identity is grounded.

Postcolonial Identity

The Postcolonial Case for the Study of Identities

To understand men as they see themselves through their gendered identities, it is important to use analytical tools that most reflect the experience of these men. They have migrated into a country that has exposed them to a different culture, and where expectations about how they should be identified as men is different than the wealthy American male natural citizen. Postcolonial studies provide the analysis of identity most suited to understand men who, through migration and poverty, straddle at the margins of power in the household and marginalization in society. They also give insight into how through the process of identification

of an individual by systems results in creation of new identities that result in something that neither the systems of power nor the marginalized individual predicted.

Postcolonial studies grew as a response to the numerous scholarly works that described the experiences of Third World countries and their people from a Western perspective. Within this framework of new scholarly work written from a Third World perspective came redefinitions of who the people were as they defined themselves and a critique of how they were viewed by the Western world and scholarship. Stuart Hall finds that identity, as a method of critical analysis is critical to postcolonial studies because processes of identification are central to understanding the politics through which humans become subjects (1996/2002:1; Butler 1995:439). These subjects do not exist in as stable subjects with fixed identities, rather, as subjects who are constantly being represented by powerful social structures and are redefining themselves (Hall1996/2002:3-4).

Hall defines identity as a process and, like all processes, it can occur alongside another, making possible multiple identifications. "Identities are about the process of what we might become, how we have been represented, and how that bears on how we might represent ourselves" (Hall 1996/2001:4). Gilroy illustrates this point further, asserting that identification is about "coming to terms with our routes." These 'routes,' however, are not always laid out by the person being identified (Gilroy 1994 in Hall1996/2002:4).

Identities are marked and categorized vis-à-vis power and exclusion. Hall points to this process using Althusser's concept of interpellation (Althusser 1971 in Hall 1996/2002). Althusser attempted to bring together the social structures ideology and the symbols of ideology as experienced by the subjects. Interpellation is the process that occurs when a person accepts being subject by identifying with the preconceived ideologies that come with being that subject.

Interpellation acknowledges the ideas of social structures dictating subjects, while also recognizing the complicity of subjects in their own identification. Both of these levels, the personal and the structural, are struggling because they are not equal in power.

Hall argues that because identity is socially constructed and not a totality, it is never stable nor does it offer a center point of reference by which it can be analyzed. He reconciles this concern by stating that while identity does not have a center; it is itself the point of 'suture.' Thus, what is essential to study are the processes and effects leading up to the point of suture vis-à-vis discourse of interpellation. When individuals articulate identity, or the process of articulation of identity, they describe identity through its social and psychic, or psychological, fields.

Hall further advances the argument for the necessity of identity by drawing on Foucault's treatise on the subject as an illustration. While Foucault was well attuned to the play of discourse on the subject, he fought against the inescapable component of the psychic. Foucault's later works are evidence of an attempt to deal with the role of agency, and in doing so avoids dealing with the unconscious and controversial (to him) psychic components of a subject. Judith Butler moves the work of 'suturing' the discursive and the psychic subject forward in her analysis of the process by which a subject assumes a sexual identification. Butler argues that this happens while simultaneously being shaped under the "heterosexual imperative" that regulates the inclusion of certain sexualities.

Identities are necessities according to Hall, and it is impossible to deny their existence. Critics of the essentialism of identity, such as a cultural or racial identity, have portrayed identities in "their most grounded forms" ((1996/2002:1), allowing them to exist only in the manner in which they can be observed and self-identified by the subject who is identifying.

While Judith Butler makes a valid point about identities being taken up under grounded imperatives, Hall argues that postcolonial identities analyses must push back through the exploration of the process of interrogation and the social structures at work in the interrogation process.

For Mexican immigrants as patients, their predetermined status has to do with how everyone is set up to experience the healthcare system. Their identities as patients are taken up under grounded imperatives like how their visit to the doctor is structured, or the unidirectional medical gaze upon the patient. Mexican immigrant men think about their role of patients as an ill person, and that identity is compared, along with how biomedicine sees them as patients. As one participant reflects about the doctor-patient experience with chemotherapy, "It's very difficult to understand. Why? Because the doctors, the majority of them know it by theory by studying and the patient." Instead, he sees the process as a loss of self, "I couldn't tell you which is more difficult-- the physical or the mental. With the physical, you lose yourself." The patient identity is compared and contrasted with identities in which they have more power, such as their role of father, lover of the outdoors, or husband. While the roles of each of these identities may seem too fluid and convoluted as to prove nonconsequential, their identities are important when analyzed through the layers of structural inequalities that lie within the healthcare system and other systems at large like the economy and the family.

Homi K. Bahba, like Hall, responded to the postmodern movement placing identity in a simplified "architectonic" outdated box, arguing that theorists had stopped problematizing the identity issues dealing with structural inequalities which they had undertook in the 1960's and 1970's by simply saying identities were too fluid to matter (1996/2002:53). This was a theoretical crisis because modern cultures were being cognizant of the effect of migration on

their formation of self. Academics needed then and still do need to learn to theorize/problematize/articulate the inevitability of convergent and divergent boundaries between new and old cultural practices to keep up with the realities of modern migration movements. The United States and in particular Californian patterns of migration are dramatically changing so that immigrant and minority populations like Mexican immigrants, South Asian Indians, and their families now make up the population majority.

As a result of migration, culture is not plural choice. One cannot, as an immigrant in a new place, choose to completely retain the culture of origin or wholly abandon it to assimilate. Likewise, others cannot successfully impose such absolute demands. By recognizing that culture is constituted through hybrid or meshed discourses, we do not presuppose unequal outcomes when there is struggle for rights and power. Bahba says there may still be differences in power, but we do not know the outcome for sure. Solidarity will only be used as a strategic method in a particular situation and relevant only to the present and future times because these interests groups cannot claim a common history due to the hybrid composition.

Bahba's work was included here because minorities in the United States, particularly the Mexican immigrant population in the Central Valley, have been here for many decades. While others have written about the need to return to a critical analysis of the effect of identity on specific migrant communities, Bahba delineated theory that could be applied to understand different groups and across time. Moreover, they are multi-lingual and interact with people of many different backgrounds. They do not have what could be perceived as an "untouched" Mexican culture, a fantasy of a homogenous way of life. In fact indigenous cultures, Mexicans, and immigrants living in Mexico as well as transnational cultural carriers from elsewhere in the world converge in Mexico as well. Bahba's paper captures the predicament of advocating for or

claiming the identity of a particular migrant culture. Advocating for equality becomes problematic when these previous images of 'what the group represents' are permeable and not homogeneous, and the images presuppose an inevitable notion of inequality.

I agree with Bahba that new interest groups should be at the forefront of the culture/social justice discourse (1996). However, I do not believe Bahba sufficiently problematizes what he refers to as the 'anxious age of identity' in the 21st century, where people are striving to reclaim some type of pure culture that existed in another time, such as Mexicans attempting to reclaim the Aztec way of life. I believe in this instance, solidarity may be only situational and strategic. Those in power will often claim the solidarity of particular groups so that they may be used as scapegoats for societal problems. For example, the perceived lack of assimilation among Mexican Americans can be seen as reason to not push immigration reform forward.

Minority cultures are caught in a predicament where cultural identity may be claimed for them without consent but where disassociating themselves from the group may deny them benefits generated when cultures use their identity as a political strategy to gain privileges or alleviate inequalities. When Mexican immigrants first arrive to the United States, they must make the decision to either attempt to assimilate or not, these decisions are impacted by systemic frameworks that will aid or hinder that decision. The situations of Native Americans who live outside of the reservations illustrates this point. Many who leave are faced with claiming their heritage, such as their language, religion, and child-rearing customs, while assimilating to a new lifestyle. Meanwhile, the social systems in the United States have already put them at a disadvantage for educational and economic success. However, Bahba does take

this issue up in his paper written in the year 2000, "Interrogating Identity: The Postcolonial Prerogative" addressed below.

The question of negotiating culture for an immigrant, addressed by Bahba in his 1996 piece, left open the follow up questions regarding who or what determines the culture the minority individual plays out and why this matters. To address these questions, Bahba begins by asserting the importance of a postcolonial analysis for immigrant identity inquiries (Bahba 2000). First, postcolonial identity theories broke from the traditional philosophical reflection of the mirror, where one was thought to recognize oneself for the first time as a child. Hall discusses this in depth in "Who Needs Identity" (Hall 1996/2002: 1; Butler 1995: 439). Next, postcolonial theorists broke from the traditional "naturalistic" anthropological view that identity lies within the realms of what can be found in the social environment of people (Hall 1996/2002: 2).

Older Mexican immigrants change the perceptions of who they are throughout time as they interact with governments, social structures and new networks. They are changing as new laws are put into place that criminalizes or decriminalizes their action of migrating, but they also change as they have networks that protect them from criminalization once they are established. In addition, they grow in their identities as new concepts to their lives are introduced, such as aging. Aging identity is formed both as a personal response to physiological changes and as within the realm of what it means to be an aging person in the United States, what that gives access to, and the marginalization that comes from this status. These changes in identity can be visible or invisible.

Bahba (2000) moves his explanation of postcolonial identity theories forward by arguing that the postcolonial calls for a break from notions that identity is a fixed concept throughout

time and that identity can represent an all-encompassing representation of knowledge through the observable. Bahba praises Roland Barthes for being able to take the sign into a vertical dimensional space where symbolism can exist alongside predetermined aspects of words like immigrant or old. What Bahba adds to Barthes is that the depth of the linguistic sign works in the visibility of identity, where an individual is simultaneously between, prior to, and outside of how that individual is being signified. This vertical dimension in identity theory allows the person to be something other than what it is being signified or constructed by others. When a person takes the immigrant to mean something that is a variant of what it has been set out to mean, immigrant becomes something else altogether. In Chapter 7 of this dissertation, older Mexican immigrant men reveal how their own agency brings a whole new meaning to what it means to be a patient who does not seek healthcare.

Bahba (2000) then takes the sign into a third postcolonial dimension that does not fit into the symbolic sign. Rather, writing about identity in the postcolonial manner goes beyond the ontology of the self and the other, the conceptualization of what it is to "be" and "to be an 'other,'" to also highlight the interrogation between the two. Who does the naming and how does the other resist by making him or herself known? Identification then becomes a doubling of what is there and what is absent, and what was once absent at the point of identification now is present. The 'other', Bahba points out, must be seen as the necessary negation of a primordial identity, thus resisting the sign under which it has been placed. Finally, Bahba reiterates that the metaphoric access to this entire process is variable. For the other to self-identify at will is contradictory to our greater infatuation with the ability to exist and perform in contrast to an 'other'.

Bahba's argument of other in the process of the third dimension of identification as a form of resistance is the crux of postcolonial narratives. The 'other' usually observed or named should have a voice in the process of identification wherein each time it is known, it defeats the image of an 'other' more and more. I agree with this argument, because on much simpler terms, it is like defeating the stereotype. For example, when Associate Justice Sonia Sotomayor was speaking to a group of law students, and she identified herself as a wise Latina who could reach a decision on a legal matter based on her experience as an "other." While controversial, she used this identification to serve not in a non-stereotypical way of looking at Latinas as uneducated, but as someone who could provide valid highly educated decisions within the legal system.

What is most captivating and useful as a person wishing to write under this tradition of postcolonial identity theory is the acknowledgement about the need for an 'other.' What Bahba is pointing to, building on Fanon's *Black Skin/White Masks* (1967), is how the 'other' will look at the rest of the people with whom he or she identifies. This person may then feel compelled to build a new 'other' as a reference point, the same label the person was just liberated from, hence the prerogative of the possibility of eliminating the 'other' completely. In addition, Bahba (2000) and Hall (1996/2000) speak of all identities as representations, whether they are viewed as self or "other," although Bahba takes it a point further by arguing the need necessity for us to classify ourselves by using others.

Bahba (2000) is writing about the need for privilege of one identity over another, which follows the emancipation of one's own 'otherness.' However, the recent wave of anti-immigrant sentiment is a time when the 'other' was clearly labeled and where many are unwillingly included. Agency through the writing of policy and use of media outlets can seem inaccessible

at times. Mexican immigrants can be reduced to the anthropological view of an 'other' culture, lacking voice in the major discourses about them. Groups such as elder Mexican immigrant men must continue to rely on a smaller scale of re-writing their selves and their identification as an "other."

When studying Mexican immigrants, it is not only relevant to view them as individuals from a third world once colonized country, but also as people immigrating into a neighboring country that has many roots in Mexican history. This fact, combined with the unique development of American culture, places Mexican immigrants in a particular space. On the one hand, they are encouraged to assimilate, while on the other they are diffusing and influencing so much of the American culture. This phenomenon is exacerbated by the long history that Mexicans and Mexican Americans have had in the entire history of the United States (Gonzalez 2011).

Meso-level Analytical Perspectives

Concerns about what can be distinguished as cultural and what is the historical experience of a group leads me to another analysis of identity from the wider theoretical perspective of meso-analytical identity theory. Here I refer to Pierre Bourdieu's "The Biographical Illusion" because, as a field researcher inquiring about identity, it is important to retain a sociological perspective even when dealing with personal histories. Bourdieu writes about the failure of biographies, autobiographies, and even résumés to capture the situations in which we are living in our habitus, our social conditions, milieus, situations both historically and contemporarily.

Habitus is the imagined space where each person has inherent traits which shape interactions with other people who have different or similar traits, forming a set of specified interactions based by and influenced by social structures. Habitus is important because

biographies or narratives tend to focus on linking a series of events occurring through a long trajectory, without taking into account the "social surface," or social space which is driven by interactions rather than time, in which the implicated individuals were living (Bourdieu 1987/2000). This lack of awareness about the social surface hides other narratives that would depict a richer biography. Another reason why the social surface must be added to the context of identity formation vis-à-vis biographical inquiry is because it may make us more keenly aware of other social agents acting upon that individual. These social agents may elude the first-person account.

In studying the identity of elder Mexican immigrant men, it also makes methodological sense to look at the social surface accompanying their biographies. Although this may be viewed as a "given" in the methodology of medical sociology and public health through the inclusion of socioeconomic status and other demographics, its importance must not be taken for granted. We still live in a society where behavioral modifications triumph any social surface means of improving health and wellbeing. Behavioral modifications are often targeted at the ill individual, ignoring the social structures and how others within the medical system interact with patients. Interventions that include both behavioral and medical treatments to treat many diseases do so through the individual and not the social surface, including many diseases that Mexican immigrants are diagnosed with and die from every day. Demonstrating this in identity-related research, such as this dissertation attempts to do, follows Bourdieu's (1987/2000) call for praxis, theory demonstrated through empirical research.

Finally, a new type identity theory has emerged, one that goes beyond identity, or identities, to argue that all such labels are a social production under a societal hierarchy. Judith Butler reviews both notions of culture and identities and how these are resisted (Butler

1995:439). Ideas about resisting identity and identities became increasingly popular as Judith Butler's questioning the utility of gender identities sparked a large academic movement towards postmodern intellectualism (Butler 1990; 1995). This movement occupied itself with writing about differences rather than identities as a way of rejecting the inferiority assumed with certain labels such as "gay."

When it comes to talking about racial and cultural identities, Butler says that "culture" should not be constrained to its racial histories. She disagrees with literary theorist Walter Benn Michaels who says it is critical to view the role of history as the overarching factor that shaped how cultural identities were created in the United States (Michaels 1992). However, she does say that Michaels acknowledges that the way in which culture is being redefined and undone, does not and should not feel obligated to keep the notion of culture frozen in time. Her critique of another identity theorist, Kwame Anthony Appiah, however, brings her to a new theoretical lens for inquiring about identities.

Butler's critique of Appiah's notion of identities states that by acknowledging the space for identities, one is also confirming the assumption that labels exist in some true form. For example, a white feminist must define what her whiteness and her gender mean individually. Both of these labels have different value-added definitions in American society. These identities are simultaneously having an effect on the individual, so they never truly exist in a "pure form." However, my perspective on what Appiah and Bahba mean by identity is that when a person has multiple identities simultaneously, their original meanings fade, and reflect instead something new and undetermined. For example a white lesbian may be seen by whites and lesbians as two different people, and yet she may reject both of those identities and view herself first and foremost as a single mother.

Butler's last point is that perhaps identities should just be left as collected and fractured and we should just use them as the tool of translation to analyze the state of the subject. I agree to an extent with this point when it comes to studying elder Mexican immigrants. Many of them may feel they are at a point in their lives where they do not want, nor feel the need, to be defined or identified. However, what they would like more is for their situation and that in which their children may find themselves when they reach that age, to be better situations. Indeed, the social surface that Bourdieu's speaks of is part of who people are and who they aspire to be for themselves and their future generations.

These aspirations for redefinitions of identities or the process of leaving identities as fractured are put into practice as people engage with systems like the healthcare system. It is important to note that systems, like medicine, have shifted the ways they identify patients. At one point they were just the point of inspection for science vis-à-vis the visible physiological being, but now they are inspected at the genetic, molecular, and even theoretical level through risk assessment. Furthermore, immigrants are in a tenuous identification process as debates about the worthiness of their bodies for treatment reach the highest levels of our government. No longer is a patient just a patient interacting with a doctor, and how much attention and resources immigrant populations should be given in order for them to understand and comply with health regimens is debatable. The isolation of them as a group is an important way to identify their needs, but also serves to further place them as a different or "other" group.

Identity Analysis: Considering the Implications of an "Other"

The analysis of identity is complex. This is particularly true because identity has been framed as always also referencing an "other." The process of naming that other, resisting the other, and excluding or including is one plagued with issues of power, history, and constant change. The literature brings a better understanding of how the authorities can reinforce or

impose identities, as the Benn Michaels piece exposed. While all of these pieces contribute to a theoretical framework for the understanding of elder Mexican immigrant identities, they lack a complete account of how people actually resist or push back against unwanted identities conferred upon them. The role of Latinos in the mass media juxtaposed with Latinos in alternative media is an example of how people have created a space to fight stereotypes about Latinos. They have slowly immersed themselves in mass media while to a greater extent built new realities through making their own films, radio, and television shows in which they portray themselves different than comical or violent stereotypes of traditional mass media. Changes in identities can transform the systems and organizations they engage with on a daily basis. However, organizations can morph into new structures that continue the otherness of certain individuals in new forms.

Paul du Gay provides a nice illustration of how identification changes happen for organizations (du Gay 1996/2002:151). He studies how organizational structure has shifted, and how these changes have been met with resistance through the very processes of exclusion and inclusion that the previous theorists mentioned. Schildkraut (2005) studied the role of identity in political engagement among Latinos, arguing that the less they feel identified with their ethnic group the less likely they are to be politically engaged. This attests to Bahba's (2000) point that identity can be used as a political strategy. Except for DuGay's research on organizations, which attests to the possibilities of studying people within an organization such as the complex healthcare system, the pieces of the puzzle seem to present themselves separately, and it is only through a combination of inquiry and theory that we can come to a better understanding of identification.

The transition into understanding how male identity is linked to health, and why this is a feminist theoretical concern is best described by Will Courtenay's (2000a) seminal piece on theorizing the effects of masculinity on men's health, health risks, and well-being. Courtenay is a pioneer in bringing together a variety of theoretical perspectives, including feminist and constructivist theories to address the disparities in health outcomes amongst men and in relation to women. The author does this through relational theory using the feminist theory, which argues that the rejection of femininity contributes to oppression, and the social constructionist perspective, which argues that culture shapes identity. Analyzing the health of men using these two perspectives points to the social structures and daily living as the sphere under which men construct views about themselves and act them out.

Courtenay first identifies and challenges traditional views of gender as psychological or strictly physiological traits. Rather, he adheres to the constructivist perspective that society imposes and reinforces behavioral stereotypes of men and women. Albeit, men also act as agents in reinforcing and enacting said stereotypes. In relation to health, Courtenay argues that enacting gender stereotypes produces distinct male behaviors. When a man is ill or faces a disability, his masculinity is threatened in the sense that pain and illness constructs do not include concepts of power that are prevalent in masculinities. These include a power struggle with pain and illness, such that they refuse to acknowledge pain in fear that it will interfere with their daily performance of male actions (2000a:1389). This may have detrimental effects physiologically. For example, Emslie and Hunt (2009) have found that men, as a way of enacting out masculinities, delay seeking help when they experience cardiac symptoms.

Rejecting healthy behavior, according to Courtenay, is also done in relation to rejecting the feminine, an inferior position in the construct of masculinity. A man engaging in healthy

behaviors, therefore, is potentially risking his place in social hierarchies. However, the level of superiority of the masculine status is already stratified depending on the social location of the male in accordance with age, ethnicity, social class, and sexuality. Courtenay states that overcoming pain and rejecting the feminine are key factors in the performance of unhealthy behaviors as a way to exert power over women and over other men. For example, an upper class man may display his masculinity through sky-diving while the urban male of color may resort to physical violence. However, Courtenay does not leave out an analysis of the interplay between unhealthy risky behaviors and the social structures.

According to Courtenay, engaging in physical behavior that is unhealthy is a "readily accessible means of enacting masculinities (2000a:1391)." The lack of other available means of enhancing social status makes these unhealthy behaviors most appealing to those men who are marginalized. The result, Courtenay outlines, is poorer health outcomes for men in general and even worse outcomes for men of disadvantaged social locations. This is what Courtenay refers to as the situation or interpersonal hegemony. This type of hegemony leads to "different levels and categories of health risks" for differently positioned men (Courtenay 2000a: 1393).

One strength of Courtenay's analysis of men's masculinities in relation to health is that it accounts for the complexities that ethnicity, social class, and sexuality bring to theorizing men and masculinities in the United States. In a later section that outlines the health inequities of men of color in relation to white men in this country, it is evident that Courtenay makes a clear argument around differentiated risk across ethnicities. The only weakness in this article that others studying specific men of color have addressed is the fact that not all men engage in the risky behaviors associated with their ethnic/racial/class group. For example, not all men of lower social class will engage in physical violence to perform masculinities. Many variations of

masculinities may be disproportionately accepted more or less within a specific social sphere. Courtenay asserts what others find about disadvantaged groups of men: if they are trying to attain the ideals of hegemonic masculinity, they confront contradictions because many of these are unattainable to men of this social location.

The identities of elder Mexican immigrant men within the healthcare system are combining identities of the patient, the elder patient, and the immigrant, and the man. The combining of these within this biomedical structure reveals their expectations to be empowered patients, to consent to being gazed upon, at the same time as being an invisible entity. The exclusion of undocumented immigrants in the largest healthcare overhaul in decades speaks to the expectation of an invisibility of this marginalized population. Likewise, the male identity of Mexican immigrant men is still an "other" type of male, not the empowered male patient.

There are programs such as the Emergency Medical Treatment and Labor Act (EMTALA) which cater to patients who are undocumented immigrants to provide stabilizing treatment in an emergency situation (Pacheco et al 2012). In addition, there are local resources available such as the indigent medical care programs in California. These pieces of legislation and their respective programs help people get care, and yet they also serve to further identify immigrants as an "other" draining the system while at the same time also expecting them to adhere to healthy citizenship. This tension of identification is revealed as older Mexican immigrant take upon their own notions of what levels of involvement with the health care system are appropriate and which are not plausible. While the decisions are made on an individual level, they are done so because of the tensions presented to them by conflicting messages within the systemic structure: be healthy, be invisible, be responsible, you do not belong.

Mexican immigrant men are actors within a medical care structure to which they bring their own definitions of identity. Under the analytical lens of du Gay, I believe they change the organizations themselves. The medical structure has responded to their needs through language and culture appropriate materials. However, the cultural appropriateness of materials still has one end goal, the induction of patients into a medical care philosophy that places has risk at its center, places a high value on individual prevention, and promotes enhancement of the self through wellness regimens that define what older people should be able to do and what illnesses they should be able to avoid. These pushes and pulls by the medical care structures ignores the histories and structural pathways of the patients, which are not inconsequential for any marginalized populations, but especially not men who have migrated to the United States for the sole purpose of engaging in work that takes a massive toll on their health for decades to come.

Masculinities and Migration

In the early 2000s, Mara Viveros Vigoya (2001) undertook a literature review project attempting to examine the literature about men in Latin America that had emerged during the prior decade. Vigoya found several trends in social theory, which brought forth issues that, she argued, should be considered when studying Latin American men. Each of these trends focused on a different part of the systemic, interpersonal, and identity issues. The social context of the lives of men in Latin America at each of these levels is useful in understanding men who migrated to the United States.

The first theoretical trend Vigoya attends to is how ethnographic and life histories research has placed emphasis on the socioeconomic conditions that shape masculinities. For example, Gutmann (1996/2006) noted that the economic catastrophes in Mexico during the 1980's shaped the economic conditions of men, and women were forced to enter the workforce while men became more engaged in the home. Social class was also found to be vital in the

creation of moral codes and expectations of men throughout Latin America. These codes and expectations were often contradictory and potentially produced tensions. Ethnicity within a country (indigenous versus mestizo) can also be critical in the construction and performance of masculinities. However, class within itself is an important determinant in how men shape their perception of what is required for them to be considered masculine.

Theorizing about men and the concept of fatherhood was has also been evolving throughout Latin America. This concept carries many variants depending on place. One author noted the division of labor as a major influence on fatherhood. Another argued that men are no longer just the authoritarian father figure; rather, they involve themselves, particularly in the father-son relationship, with a form of satisfaction in the act of fathering, many times serving as accomplices for their children. History too, has played a role in the evolving of this identity; events like war and political and economic shifts influenced how fathers could be present for their children. Mexican men who were shifting towards egalitarian styles of fatherhood could potentially face ridicule. The notions of fatherhood are changing, not just with time, but through treaties and policies like NAFTA, as men were forced into massive migrations to find work and thus become fathers across borders.

Recent studies exploring this topic found that Mexican men who migrated tended to have more progressive views about fatherhood than those who stayed in Mexico (Behnke, Taylor, Parra-Cardona 2008; Taylor and Behnke 2005). Fatherhood is a complex issue that must be studied further on its own in relation to the social contexts of masculinities for men who migrate. In my pilot study, I found that interactions with the health care system where at times mediated by the stance a man took as a father—he would either interject in the help

seeking behavior of his children or take a certain health care decision based on his role as a father and provider.

The review concluded that Latin America is not at all homogenous, nor are the men in this region. Vigoya notes that these differences produce masculinities with different power structures, where some men have access and others do not have power in a variety of social structures. Even elder Mexican immigrant men are not homogenous. Their history and social class in Mexico, along with ethnic relations may have strong influence on their identities as immigrant men living in the United States and even on their behaviors related to health seeking.

The "Latino male" construct needs to be further teased out, especially when it comes to how *machismo* is conceptualized and theorized about in any context, but especially health seeking. While providing evidence for particular frameworks related to Mexican American males. Torres, Solberg, and Carlstrom (2002), argue that the literature has many contradictions when it comes to definitions of machismo, the common way to describe Latino male identity. Furthermore, the characteristics associated with machismo are often contradictory to definitions of dominant masculinity or hegemonic masculinity of American society. This dissonance in the literature is also reflected in men themselves as they struggle between notions of what it meant to be masculine before and after migration (Behnke, Taylor, and Parra-Cardona 2008).

Researchers have been unable to describe and classify the variations of masculinity across the Latino male spectrum. To illustrate examples of Latino male identity, Taylor et al. (2002) performed a survey analysis of 148 men. They administered surveys with scales relating to machismo, gender role, compassion, masculinity, and gender equality. Demographic analysis revealed that Puerto Rican men tended to be less educated, had less children, and had not

resided in the United States as long as their Mexican American counterparts. No other groups showed significant intergroup differences.

Analysis of the scales revealed that, among all men, their scores on five scales tended to cluster around certain characteristics. These ranged from "Traditional Machismo," with authoritarian and emotionally stoic characteristics to "Contemporary Masculinity," which tended to be men with more flexible and collaborative gender roles and emotional expression. Within these five groups, there were no significant differences attributed to the level of acculturation.

The authors suggest that the generalizability of machismo identity to the entire Latino male population in the United States is simplifying at best and harmful at worst.
Along these same lines, they pose the argument that machismo is a variant of Latino male characteristics and should not be viewed as a "less than" or deviant characterization. Rather, Latino males have different masculinities, while vacillating in terms of integrating themselves into dominant masculinities of United States society.

Chad Broughton's study on migration goes further in explaining the male types of identities involved with men who migrate to the United States (Broughton 2008). The self-identified male stances are that of breadwinner, traditionalist, and adventurer. Broughton warns that stances that are always combined together to different degrees. Depending on the situation, one might dominate over the other. The men who migrate describe their decisions through these lenses. Through ethnographic research, Broughton finds that aside from the cultural and structural conditions driving migration, coming to grips with the reality of migration involves drawing on their own expectations as men.

Broughton's (2008) study on migration and masculinity is a clear illustration of the role of gender in aspects of personal life. There is a push and pull in social relations, wherein gender plays a role. The gendered aspects of migration, such as fatherhood, motherhood, care giving and risk-taking roles influence poverty, education, and foreign trade agreements. People who migrate are influenced by their social conditions. American agribusiness benefits from having men who would rather die in peril in poor working conditions than be blamed for the misfortunes of his family if he does not provide for them. However, not all men who migrate can put that kind of pressure upon themselves, for their masculinities may be driving them to work in different fields. This can lead to a state of pushback where men imagine and enact different possibilities in their masculinities. When it comes to healthcare, while many men once sought a "good enough to work" condition, they may now be seeking much more, including a better doctor-patient relationship. My potential work may begin at the point where men may be initially seeking different types of goals from the biomedical complex.

Trying to define a masculine identity framework for Mexican immigrant men within the healthcare context includes looking at the massive systemic issues of the immigration, the social spaces in which most of their daily interactions take place, as well as the cultural psychologies they are bringing with them to the United States. Research about day laborers illustrates how this process of having a masculine identity for immigrants shapes their behavior when it comes to seeking health care. In addition, this research illustrates how their decisions are made within a system that is constraining them in terms of time and resources. Walter, Bourgois, and Loinaz (2004) conducted an ethnographic study of day laborers living in San Francisco who had been injured. Researchers noted that the work these men were engaging in was directly linked to a combination of economic and identity factors, which resulted in taking high risks to work

injured as undocumented immigrants in order to fulfill their masculine identities of father and provider.

These immigrant laborers decided to work in the United States because of their home countries' failing economies. This impeded them from fulfilling their societal, familial, and personal expectations as breadwinners, often providing for a specific need assigned by their family members to them solely based on their construction of them as the male provider. One man describes his journey as a man who was already severely injured in a previous migration experience, but again risked crossing the border and working illegally because of his promise to his daughter to throw her an elaborate coming of age party known as a *quinceañeara*. His inability to get enough work as a day laborer and provide sufficient funds for his daughter's party left him defeated as a man and a provider when in fact the entire global economic system had contributed to his situation.

Walter et al.'s (2004) ethnography on day laborers is a great example of the marriage of the complexities of social structures, social relations, personal psychology, and the distinctive features of the broader social context when studying masculinities and their effects on health. Ethnographic research is a great tool to provide such insight, but other methods such as policy research, clinical studies, and survey research can also help paint pictures of said complexities. However, what this study, and will be shown here, along with my dissertation produce is an in-depth look at how men are reflecting on their lives. This reflection reveals their self-defined roles as members of a household, members of a community, workers, and patients. This type of identity research is key in order to inform discussions about factors contributing to health seeking behavior.

Defining and Problematizing Health Concepts

Medical care will be defined as a body of scientific knowledge practiced by a professional body that is regulated by government and corporate entities to deliver cost-efficient biomedical care (Hafferty and Light 1995). For the purpose of this study, medical care will be limited to Mexican immigrants living in the United States. Mexican immigrants deal with particular issues about labor and politics of legalization that reflect on their personal decisions about medical care and their interaction with this system. Medical care is linked with health-related behavior of the individual and under scrutiny by medical institutions and their actors, as well as by government entities, health insurance providers, public health, and the public at large (Wheatly 2005; Rose 1999).

The different actors within the medical system do not share equal power. Individual actors such as older Mexican immigrant men are entering this system as consumers, patients, and every other identity that has been created by others and themselves throughout time. As Mexican immigrants interact with structures, technologies, and actors, the power relations displayed are reflections of power structures that put them in a position of less privilege in society (Collins 2009). Power relations within the medical system are leveraged upon the control over what defines healthy (Foucault 1997).

Foucault refers to our modern medical system as a collective consciousness that made disease infinite in an open space wherein doctors have exclusive insight (Foucault 1975: p.196-199). Rather than a strict top-down approach of power, individuals must discipline themselves into adhering with health regimens (Foucault 1975; 1979). People may change their behaviors to fit within the specified social order, which in the case of American society, means achieving the status of a healthy and productive individuals that can perform their roles in the capitalist system. Under this Foucauldian governmentality lens, seeking allopathic medical care, adhering

to medical guidelines on self-care and preventive car, and striving to achieve wellness all become part of achieving a disciplined body through medical care (Foucault 1979: 215; Quesada, Hart, and Bourgeois 2011).

Medical care, in the context of my research, occurs as a form of disciplinary power specifically within the politicized body of a Mexican immigrant in the United States. This body is constructed in recent healthcare debates as "freeloading" whilst being exploited for cheap labor due to their citizenship status when first arriving to the United States (Quesada et al. 2011). The Mexican immigrant man is not just a patient, but a patient whose full integration into the American citizenry is contingent on legal status and his ability to conform to its regimens and social order, which includes health regimens as delineated by our healthcare system (Ong 1998). Older men in the United States must work within their personal lives to achieve health by visiting the doctor, getting screenings and taking medications to reduce the risk of aneurysm, colorectal cancer, depression, diabetes, high blood pressure, high cholesterol, sexually transmitted diseases, and obesity (AHRQ 2011).

It is important to note that within this context of body as an object of discipline, resistance to become a disciplined subject is widely present (McGillivray 2005; Vander Schee 2009). A crucial component to the disciplined body in the United States is maintaining a healthy weight and body mass index. These have been problematized as producing social hierarchies that should be resisted (Vander Schee 2009). In addition, while people may ascribe to these ideals and are knowledgeable about the benefits of fitness, many resist the practices in their daily lives (McGillivray 2005).

Similarly, Mexican immigrants, and particularly elder men, may not seek medical care, even when resources are available for them to receive care and when they understand the

concept of prevention (Pacheco, Ramirez, and Capitman 2012). Agency in this study is observed when participants understood their health regimes, the benefits that the doctors explained to them if they adhered to said regimes and preventive measures, the measures of biomedicine that marked "wellness" like cholesterol and HbA1c levels, but did not employ them as prescribed. However, studies that focus on the underlying motivations to not seek care have not been done with older Mexican immigrant men that use the lens of agency, rather than fatalism.

Understanding Medical Care through Biomedicalization

Biomedicine is more than dealing with anatomical body parts; rather, it is the treatment of disease within the purview of a body, wherein genetics, public health and risk drive the definitions and regimens of treatment and the origin of disease lies in the body (Estes et al 1989). Biomedicine is used as a term that is drawn from the larger theoretical framework of biomedicalization (Clarke, Shim, Mamo, Fosket, and Fishman 2003). Under this purview, biomedicine is a discipline which is highly dependent on how scientific technologies affect and are affected by culture and discourses of the body. Biomedicine becomes a way in which we think about and interact in society around illness, health, productivity and wellbeing (Riska 2010).

This dissertation seeks to understand the experiences of participants within the healthcare system that goes beyond the doctor-patient relationship. While this was an original purpose of the dissertation, the crafting of the questions emerged as participants themselves drew connections between labor and health, risk and genetics, and the economic and biomedical complex reasons for testing and public health interventions. While other research has focused on the health of older minority populations from a medical, public health, educational, and even

migration perspective, this dissertation seeks to understand this subpopulation from a biomedicalization perspective.

Biomedicalization, as described in this paper, is the theoretical framework used to analyze how biomedicine as a discipline is highly dependent on how scientific technologies affect and are affected by culture and discourses of the body (Clarke et al. 2010). These discourses are ways we think about and interact in society in regard to issues pertaining to our body such as illness, health, productivity and wellbeing. While in medicalization, the incorporation of women's health into the analysis came later, feminist theories have been an integral part of biomedicalization. Biomedicalization is heavily rooted within the larger scope of poststructuralist theories.

The postructuralist roots of biomedicalization are manifested in Foucault's theories of biopower as a form of social control. This biopower is exercised through the use of technologies, such as screening and medication, approved by experts, that governments use to regulate and individuals use to self-discipline. However, agency constantly marks this power. The poststructuralist emphasize that social systems are not solely controlled as a top-down approach. Therefore "role of experts" and technologies in biomedicine for the purpose of "body enhancement" within a hierarchical biomedical context are foci of biomedicalization theory analytics (Riska, 2010:156).

Biomedicalization has focused on men's health as it had been largely unproblematized by medicine- a large relatively untapped market. Riska explains that while masculinity had been studied under this purview since the 1950's through the Type A personality thesis, the current era can be better analyzed through biomedicalization theory. By looking at men's health over the past decades, a large emphasis has been placed on the role of male hormones.

Specifically, male hormone deficiency has placed gender at the forefront of medicine as an example of how it clearly transcends into other institutions such as the family.

What Riska and others have referred to as the "Viagra man" is the discourse on men's health that puts the focus on self-enhancement rather than disease. Furthermore, this life-enhancement tends to be focused on sexual pleasure. A large body of research explaining this phenomenon of men's bodies is conceptualized and analyzed in biomedicine. Through this analysis, three major themes emerge.

First, the male body is conceptualized solely as biological, and the sexuality of this male can also be explained solely within this realm. As a result, masculinity is reduced to sexual biological processes that can be restored or enhanced through biomedicine. Assuming that this sexual processes can be enhanced leads to a second research agenda that tracks the construction of the "normative discourse" that makes up men's health. This research analyzes processes by which construction occurs, which are driven by experts using sexuality as a social control mechanisms and their respective resistant groups, a la Foucault biopower. Normative constructions of men's health may be a way for men to "reaffirm social hierarchies" (Riska 2010:162). Finally, other research focuses on a bigger question about the effects of sexual health as the focus for men's health, which leaves the rest of the body excluded from regulation and surveillance (163).

Riska also reviews what has been done in within the realms of neurology and psychological stress and gender. Research on the brain has either completely ignored gender or used the research purposefully to define what the "standard brain" is by studying only male rats and male monkeys (2010:165). Other research claims the brain has standard reactions that date back to prehistoric days, thus allotting gendered behavior as innate. The result is a

reinforcement of discourses of naturally occurring gender differences, which further result in gendered hierarchies.

Riska provides an invaluable analysis of how technologies and molecular biology have shaped the discourses on health and illness as they relates to the gendered body. Her review of the literature in this arena reveals the plethora of questions that are left unanswered. For example, how have biomedical technologies help to perpetuate or propagate ideologies that feed into social stratification of class, gender, migration, sexuality, and age? Many more issues around biomedicine have yet to be problematized when it comes to the effects of gender and gendered social hierarchies. As Riska notes, intersectional identities are influenced by biomedicine, while other discourses on biomedicalization may still be lacking intersectional analysis.

Intersectionality as a Theoretical and Analytical Tool

When studying Mexican immigrants, it is not only relevant to view them as individuals from a third world, once colonized country, but also as people immigrating into a neighboring country that has many roots in Mexican history. This fact, combined with the unique development of American culture, places Mexican immigrants in a particular space. On the one hand, they are encouraged to assimilate, while on the other they are diffusing and influencing so much of the American culture. The two countries have become mutually dependent on each other, where Mexico provides a reserve labor force for the United States and Mexicans benefit from remittances sent by Mexican immigrants in the United States (Massey 2002). At the core of the large influx of Mexican immigrants in the United States is their inextricable ties to Mexican society, and within it, their social institutions such as the healthcare system. In

addition, the shared border of a developing nation like Mexico with a superpower like the United States is unique in the world (Massey 2002).

Mexican immigrants, as other immigrants in this country have a lower socioeconomic status than their white counterparts, partly as a result of discrimination (Aguirre and Turner 2004: 13). One of the ways to appease or diffuse the effects of discrimination for many ethnic groups has been assimilation. Mexican immigrants have become so numerous that this process of assimilation has occurred alongside an interjection of their cultural customs on mainstream society (Aguirre and Turner 2004). The bidirectional influences of culture and economy are only some of the many different aspects that provoke a multilevel analysis of factors that affect the health seeking behaviors of older Mexican immigrant men.

I will be using intersectionality theory both as a way to conceptualize questions concerning a traditionally marginalized population and as an analysis tool. Intersectionality theory claims that race, ethnicity, social class, sexuality and gender are not just demographics, but ways in which to organize and stratify society (Thornton-Dill and Zambrana 2009). In addition, it posits that when looking at an individual, researchers must think about how all of these come together to form the person's social situation compared to others around them and others outside of their social groups. In studying any phenomenon that deals with inequality in any structure, it is imperative to have a clear understanding of how race, ethnicity, class, gender, and sexuality are simultaneously and exponentially affecting the social outcomes of marginalized groups.

Intersectionality is also important as a lens to look through experiences of health-seeking behavior to see how agency is formed. Older Mexican immigrant men have masculine, immigrant, and aging identities that shape their decisions and behavior. At the same time, those

identities are also producing systemic barriers that will prevent them for carrying out their desired courses of action. Intersectionality is important because it really allows for both looking at how people behave based on who they define themselves as and also who they are as a consequence of social institutions. It does this without the need to identify which of the identities is most consequential, as all are interacting with each other.

The Social Systems Sustaining Inequalities

Margaret L. Andersen and Patricia Hill Collins (2007) posit four common themes across each race, class, gender, sexuality, ethnicity, and migration. The authors define intersectionality as an analytical tool for how systems of power operate to privilege some within the aforementioned socially constructed categories referred to as intersectional points. These are coordinates used to place groups of people within a particular social location, allotting benefits, privileges, or stigma accordingly.[1] The four common themes then place intersectional points as systems of power operating within larger social structures.

The first theme is that all points of intersection are socially constructed categories, existing within historical contexts. Next, the categories are defined within a binary perspective, which helps privilege one over the other. Third, the categories have far reaching effects beyond self-identification, as they intersect with other intersectional points to form into structures defined by "power and inequality" (63). Finally, a common theme across all categories is that due to the social processes within a historical context used to define the categories, these are dynamic, changing over time. According to Andersen and Collins, these themes are useful tools to use with the analytics of intersectionality as a social structure.

[1] Sana Loue also goes through an in-depth exercise to define intersectional constructs, particularly as they relate to health. See Loue (2006) "Defining Race, Ethnicity and Related Constructs." For the purpose of this paper, it is more useful to look at Andersen and Hill Collin's analyses of these categories as systems of power since their implications on health will be discussed in a biomedicalization theoretical context. See Audre Lorde's (2007) "Age, Race, Class, and Sex: Women Redefining Difference."

The authors illustrate their point through the lived experience of the professional basketball world. Here, the players, concession workers, and the proprietors are all products and agents within a system that privileges some over others when using an intersectional framework. Sexuality among players, for example, is constructed in such a way inside the court that doing acts like touching other men leaves masculinities unchallenged. Yet these patterns are not the same for their male team proprietors (Andersen and Collins 2007:65). Furthermore, the economics involved in basketball largely reflect our class system, where white men own the wealth and immigrant labor is left doing the invisible janitorial work.

To understand how the four themes are at play in race and racial stratification, the authors first distinguish between prejudice and bigoted attitudes or reactions and racism as a "system of privilege" (Andersen and Collins 2007:68). Along these same lines, they posit that race as a system discounts the notion that race is something that can be "over," as it is now embedded in our social institutions.[2] This type of racism plays out through discrimination, for example, in hiring/promotion practice. Keeping in mind the themes, institutional racism has fluctuated and has resulted in oppressions of different peoples across time. Finally, race is deeply explored on the biological level, such as using disease proxies to identify race groups. However, no identifiable race gene can be determined for all peoples. Therefore, race definitions are in flux as power relations within our institutions. A significant aspect to the way power relations evolve is through class.

Mexican immigrant men have shaped their sexuality and privilege within the phenomenon of migration. Mexico is a predominantly catholic country where homosexuality until recently was not approved of and is still not approved of as a religious maxim. Their providership was tied to achieving the role of provider or breadwinner. Yet attaining this role

[2] Cornel West (2005) makes a similar plea in his "Introduction" to *Race Matters*.

meant something completely different to those who migrated and worked in the fields alongside their female spouses than it did for men who earned enough to have a family structure where the wife could stay home.

Andersen and Collins (2007) study class in-depth to provide evidence towards the point that intersection points are systems of power, viewing class as a "series of relations depending on access to economic, political, cultural, and social resources," is another intersection point that shares the common themes (71). Class is more than just a form of rank, and as such cannot be seen as a simple measure of income. Although, disparities in income are evident, as people of color work longer and are paid less than their white counterparts, doing so to meet the basics. Wealth, in fact, illustrates the picture of privilege and disadvantage. Wealth disparities persist in spite of income or social mobility, and a few people control most wealth. As such, cumulative wealth allows people to be in similar income brackets but different class situations.

Poverty, similarly, is looked at in a complex way to analyze the role it plays in class. Andersen and Collins, keeping in mind the theme of class being its own structure of power and inequality, argue that in the United States, the number of poor is underestimated and they are given few resources for permanent class improvement. For one, aggregate data used to analyze poverty often ignores the intersections of race, gender, sexuality, and migration, thus painting a deceiving picture. For example, the notion that Asian Americans are well off discounts the experiences of large sections of this population, such as many Southeast Asians groups who live in poverty. The policies around poverty further contribute to painting an elusive picture about the poor, particularly ignoring that a large section of the working population lives in poverty, ineligible for programs targeted for the poor because of their employment.

The effects of class, which are also largely the effects of class as an intersection point, are profound in terms of how this leaves its historical imprint on certain groups. Wealth and income translate into power that can be exercised across institutions. As this occurs, ideology around the class system is sustained through the illusion of merit as the basis for class status. Thus, value is added to the concept of class as a good and bad binary.

Studies about Mexican immigrants are incomplete without looking at how economic policies have discriminated them and the infatuation that the United States has had over the past century with cheap agricultural labor coming from Latin American countries. Mexican immigrants have been allowed to work in this country, legally or illegally, in agriculture. Meanwhile, this subsection of labor has time and again been exempted from labor laws about overtime and minimum wage and now migrants who are not legal are not included the Affordable Care Act. While many immigrants have been able to achieve upward social mobility, those that have not are blamed for their lack of work ethic rather than seeking blame at the economic system which has created this subsection of poverty in agriculture and now the service sector like hotels and restaurants.

Gender, similarly, can be viewed through the four themes to identify how this intersection point is more than a demographic, a system at play within other systems of power and inequality. First, Andersen and Collins (2007) argue that gender is a binary system at large, which affects other institutions, as is evident in wage disparities and violence against women. However, experiences of gender are not the same across all men and women. For example, African-American men and women are both viewed as more sexual than other groups. However, African-American men will experience their interactions with the other institutions differently than women of the same ethnicity. Gender, while a stand-alone system of power

relations, is also a system of power and inequality that interacts with other institutions such as the economy and education. The culmination of these interactions eventually produces inequality for some men and all women.

Ethnicity also has evolved as a system of power and inequality (Andersen and Collins 2007). This is accomplished first by the construction of pan-ethnic categories, designating large numbers of people and groups whose lived experiences vary greatly from one another. Their definitions are in constant flux, as has been the case with Latinos and Asians who have grown in numbers in the United States. However, new waves of immigrants are rapidly changing what these groups actually look like. The country as a whole is changing in its ethnic make-up due to migration and differential reproduction.

The ubiquitous nature of globalization has significant implications for the "cultural representations" of US institutions (Andersen and Collins 2007: 84). For example, post 9/11 ethnicity ideologies reflect a system of ethnicity and migration that goes beyond the melting pot narrative. A binary system of the American and the "other" has been further highlighted, distinguishing between the "deserving Americans" and the rest (85). This new ideology is reminiscent of the history is the privileging of whites over other "minorities" in the United States. This plays out in forms of mistreatment by the social institutions. However, due to the ever-changing nature of the system, the roles of the personal agent and groups as agents are strong. Minorities have become agents in their racialized experiences. Through various outlets such as education, the media, and the economy, they are negotiating the commonly held definitions of who they are and resisting oppressive ideologies of their ethnic people groups.

Finally, sexuality is a system of power and inequality as evident in the four themes of this concept. This intersection is crucial to analyze within the general intersectionality

framework. Black women, for example have been largely affected in an oppressive manner regarding their sexuality and gender. This oppression feeds the systems that allow for the oppression of a group of people, producing inequalities that many times put people in physical danger. While the biological pleasure interactions within this intersection that are deemed appropriate have changed throughout history, a system where heterosexism is privileged has persisted in many institutions.

All of these systems of power and inequality have different historical contexts and biological ideologies used to justify them, yet this does not discredit the argument that all are linked. The labor force is a strong indication of this, where sexuality, race, gender, ethnicity, and migration together produce unequal results in opportunities and rewards. Within each intersection point is the motivation to gain and stratify power, which results in inequalities. However, the force of agency is also present within each of these systems, allowing for new knowledge formation about marginalized groups.

This analysis offers a complex yet thorough explanation of where intersection points relate to larger systems of power. Yet intersectionality power dynamics are difficult to discern in daily interactions. It is even more difficult to discern how they may affect health seeking behavior and health outcomes. In this dissertation, I attempt through observation, empirical research, and critical analysis to discern how factors of aging, gender, social class and migration play out in the health-seeking behaviors of older Mexican immigrant men. Behavior is important to learn about both to know how each identity is playing out in people's lives and how systemic structures affect behaviors in a cross-section of the population that shares marginalized and empowered statuses such as immigrant and male.

Chapter 3: Research Methods

Ethnography

In order to analyze conceptualizations about health and the decision-making process during engagement with the health care system, I find it suitable to use a quasi-ethnographic and grounded theory data collection strategy. John Johnson (1971: 1-12 in Heyl 2001) describes several things about social scientist that cannot escape influence into his/her own research. He says that the language the researcher uses can influence what the reader understands. He therefore urges researchers to show in their work the lens through which they are interpreting the accounts given by the interviewees. In choosing the title for my dissertation, I wanted to make sure I would capture the group identity as much as possible. There are many words that would capture what this group is, their history, and even their etiology, but I chose to classify them as elder Mexican immigrants. In the current sociopolitical context the word "immigrant" is charged with negative political, economic, and sociocultural content. However, the consequences of ignoring this term would be to ignore the implications of this label in men's life experiences and specifically within the medical conceptualization of health and health seeking.

The complete term to classify my study sample, elder Mexican immigrant men, is important, because I am making a direct statement, as mentioned in the problem statement, that men are largely understudied as a subgroup and underrepresented in public health intervention samples. Because my recruitment materials will include these labels, it is assumed that the participants also identify themselves as elder Mexican immigrants when taking part in the study. What I have presupposed through the ethnographic lens is that this aspect of their identity

means more than a governmental status to them, and I intended to seek out how the label plays out within their migrant, aging and masculine identities.

Ethnography as a method of inquiry has moved from what Denzen, Lincoln and Rosaldo describe as the Malinowski and Mead "lone ethnographer" period, which sought to produce "timeless truths," to one where the researcher questions his/her objectivity and role in imperialism (Denzin and Lincoln 2005:15; Rosaldo1989 in Denzin and Lincoln 2005). I intended to rely on my existing rapport and familiarity with the people frequenting the planned recruitment sites to gain confidence among the participants. I emphasized that I am Mexican and was raised in the Central Valley, which aids to my rapport as a researcher approaching a population which may not be familiar with research.

While my ethnographic approach of collecting observational and interview data is not intended to be accomplished through full immersion, rather as interviews in a place of convenience, I relied on my rapport to allow for a positive entry with the participants recruited through specific sites and through snowball sampling. The study attempts to capture those who are not at medically related sites so as to capture those who are not currently engaging with the biomedical system as part of the health seeking process. This is why recruitment from places such as flea markets and outside of churches was also necessary.

Capturing accurate cultural meanings is important to any ethnographic study. While conducting interviews, Kvale's (1996 in Heyl 2001) words of advice about things to be cognizant of during the interviews are also relevant. He notes the importance of actively listening and simultaneously being aware of one's role in the construction of meaning. Furthermore, when the researcher is describing an event in his or her notes or when they are listening to something the interviewee is saying, this person must also be aware of the social

contexts surrounding the events or language, as they are all crucial to the meaning construction process (Kvale in Heyl 2001; & Emerson 2001).

Study Design

Sample

The research project consisted of conducting in depth interviews of 20 who responded to a flier looking for elder Mexican immigrant men. Inclusion criteria was defined as men, who are 65 years or older, were born in the Mexico, and have lived in the United States for at least 10 years. People residing in the United States for less than 15 years are considered to be less acculturated compared to those who have lived in the US longer than that period or those who were born in the United States (Abraido-Lanza, Chao, and Florez 2005). Length of time was not used as the sole acculturation measure, rather as the research shows; it was also an entry into understanding changes that have occurred in socioeconomic position, networks, and health promoting behaviors *within* this allotted time (Carter-Pokras, Zambrana, Yankelvich, et al 2008). Acculturation, in this dissertation, was used as a recruitment tool to identify those who might have legal status, know some English, and be familiar with the US healthcare system, and thus be somewhat to very acculturated. Analysis of the differences of acculturation, while important for many Latino health studies, was not in the scope of the questionnaire or the analysis, as I had selected those that were already in one group of acculturation, those somewhat acculturated to very acculturated. Over a 6-month recruitment period, 20 participants were chosen based meeting the inclusion criteria, although all of the participants had been in the United States for over 15 years. Recruitment materials and interviews were offered in both Spanish and English, given the preference of the participant.

Interviews

Data collection consisted of in-depth interviews and ethnographic observations about surroundings and participant behavior. Across all of the questions, the interviews sought to measure acculturation by how much participants were tied to heath practices and beliefs from their place of origin in addition to their connection with the Mexican health care system. There were four general aims to the interview questions. The first was to grasp the concepts of health and illness. I drew upon questions from an interview guide used for a pilot study with both older Mexican immigrant men and women conducted in 2008. Next, the interview process made an attempt at grasping the process by which the sample engages the US healthcare system and whatever other health care mechanisms they utilize. This process has been mapped elsewhere for Mexican immigrants living in the Central Valley, but with an underrepresentation of men in the sample (Pacheco et al 2012). The interview questions then turned to uncover what motivates people to seek health advice, engage in health practices in non-acute situations, specifically for prevention or management of disease. Lastly, I gathered narratives of times when the interview sample chose purposefully to disengage from the US healthcare system in order to gather information about the conceptualization of agency in health and risk discourses, and identify other factors about their identities that may drive this behavior.

Throughout the interview, questions from the semi-structured interview guide encouraged the participants to engage gender, age, and migration related identities. Follow up questions focused on migration, age, gender, or class. My aim here was to understand how men's conceptualizations, processes, and narratives about health are uniquely based on these different identities. If they do not see them unique to one aspect, for example gender, is this because they perceive class as ultimately defining their situations? In addition, several questions encouraged the participants to employ a specific identity. Singling out specific

identities was also a way in which I could further understand the points of convergence and divergence in research that has studied my research questions with the other populations, or in samples where men were underrepresented.

Recruitment

Those who are deemed eligible because they were over the age of 65, had been in the United States at least 10 years, and spoke Spanish or English learned about the study in one of five ways: 1) looked at a Committee on Human Research (CHR) approved flyer posted in community billboards, 2) looked at CHR approved flyer at Spanish speaking church in Fresno, CA, 3) given a flier at a local community health clinic by a provider or health educator 4) Flyer given to them by past participants in the study, 5) or told about the study by an adult who has seen the flier. The purpose of recruitment at non-health care settings is an attempt to capture a part of the sample that may not be engaging, or engaging sporadically with the healthcare system in the United States. Recruitment of a sample population that is not engaged at all with the United States health care system is not central to my research questions, but would aid for comparison purposes during the analysis.

Analysis

Grounded Theory

The interviews and observational data were analyzed using grounded theory. Anselm Strauss, co-founder of the grounded theory method, recognizes that there are many things one can do with the qualitative data within the social science disciplines (Strauss 1987: 3). For example, we can test a theory by providing narrative accounts or through coding and then converting them into a frequency chart. However, he proposed a method that takes induction, deduction, and verification seriously at all points of the research process. A method where data

collection and analysis occur simultaneously, resulting in a different research process altogether. Strauss delineates this process.

First, a research problem is proposed, but there are no hypotheses at first, only questions about a phenomenon. Next, "provisional distinctions" emerge from the first observations in the field (Strauss 1987: 14) by coding the data. The researcher must then return to the field to verify the codes through gathering more data, which leads him/her to code again. However, throughout the whole process, the researcher must keep making sure that the codes are directly tied to the real world that the data represents. A purging process must happen where the importance of each code is assessed, and the codes that appear most often must be kept and tested for parsimony.

Throughout each stage of the data collection and analysis, the researcher is making memos about the theories that are emerging in the data through the codes. Memos are structured free-writes focused on one particular topic; they are discussed in depth below (Charmaz 2006). The last step is quite distinctive about the non-linear grounded theory process because the data is never lost, and the researcher can always return to the original interviews for new codes. According to Strauss, this process, while broken down here in steps for clarity, involves constantly re-engaging with the data, forcing these steps to be repeated many times throughout the analysis.

Developing codes may seem difficult or may be over-simplified as a process where one is looking for similar words. However, the point of coding is so that codes eventually become empirical indicators of a concept (Strauss 1987: 25). The researcher is able to fact check by looking at each code to see if each ties in with the larger concept. Throughout this process, the researcher is going back to the data to ensure that the concepts and each code are reflective to

the data, refining the codes if necessary. Strauss points out that this process keeps happening until nothing new is coming out of the data (25). Memos allow the researcher to write about emerging theoretical concepts that are prepared in the data. For Strauss, this was a point where the researcher could step back from the immediate data at hand and look at how it could possibly fit into the broader scope of the research problem, finding holes that need to be filled and future directions (1987: 111). These writing exercises are semi-structured, but also written without much attention to editing so that thoughts about new comparisons, issues, and conjectures can arise, always stating where these are grounded in the data (Charmaz 2006: 84).

The idea of memo-writing as part of the analysis is the best way for me to understand the break from traditional or positivist empirical research methods and postmodern grounded theory (Clarke 2005: 32). Postmodern grounded theorists recognize that the researcher is not a foreign entity in the process, much like a robot analyzing the data. Rather, they acknowledge that the role of a researcher is not neutral, and this has an effect on what researchers may see as codes, how theories are employed or developed, how memos are written, and the process by which concepts or theories are compared (Charmaz 2006: 9). Interviews were transcribed by me and a private consulting group. I used NVivo software for parts of the data analysis related to how participants defined health and instances in which they mentioned tortillas.

Postmodern grounded theory takes two main points of departure from traditional grounded theory. On the one hand, Kathy Charmaz (2006) invites the analytic researcher to construct theories by using the seemingly "mundane" in the data (146-147). This motivates researchers to avoid taking for granted something that they may view as well-established but that taken in context with other pieces of data can reveal something new. Adele Clarke brings back the actors and asks researchers to see the data through a lens that views data as discourses

happening within meso-level social worlds at macro level arenas (Clarke 2005: xxxiii).Within the postmodern world, there are major implications for realities being portrayed through data.

For Charmaz, data collection and analysis is a process that is jointly constructed by the researcher and the interviewee within the boundaries of the relationship they have developed during the interviews (Charmaz 2006: 130). Therefore, the reality represented cannot be portrayed as objective, rather, a reality contingent on the spatial and temporal factors under which the construction of such took place (131). For Clarke, the spatial factors are of prime importance, where space is an actor within the research. She uses tools like social worlds and arenas maps to examine the discourses that are evident in the data and to place them and the individual/group within larger social places, concrete or abstract (Clarke 2005: xxxiii).

Grounded theory connects many of the aspects of the research, which I believe are imperative to provide a clear analysis about the processes of conceptualization about health and illness and help seeking behaviors. Ethnography allows me to collect data while being sensitive to what I bring to the table, the social contexts of the people I am interviewing, and the meaning of people constructing concepts using their own lens. These methods provide me with a broader understanding of how the data and my interpretation of the data both will be part of the constructs and themes that may emerge.

Themes are presented both for ethnographic purposes, telling the stories of participants. In addition, they are presented in order in which they were most salient. Themes were included in the dissertation only if they appeared in at least 1/4 of all participants, unless otherwise indicated. Following is a key for additional context: 1) “some” or “others” =1/4 to 1/2 of participants 2) “majority” or “many” =more than 1/2, and 3) “most”=more than 2/3 of participants.

Chapter 4: Older Mexican Immigrants Living in the United States

Ethnographic Landscape

The California Central Valley can be described as a vast land that is best traveled through wide paved roads and highways that are shared by 18-wheelers spewing out carbon dioxide and particulate matter into the lungs of its residents day and night. It is emblematic of two things: food and transportation. What adorns the night in the Central Valley cities are not massive high rise buildings or bridges. Rather, the system of ever-expanding highways carrying the hundreds of thousands of passengers traveling either from one working place to their designated bedroom town, or driving straight through carrying truckloads of goods and services that drive the State of California. The highways are the bridges and the skylights are the lights of cars as they go up, down, and through curvy parts of endless quiet roads.

The California Central Valley is a nature paradox, as it is rich in food; it is also lacking it for many of those who live there. It is difficult to understand this concept until one has stepped foot into a place so rural yet with a scarcity of resources such as food and drinkable water that rival developing countries. Traveling up and down the roads of the Central Valley, this fact becomes even more incredulous, when the eyes meet rows and rows of trees, plants, and shrubs of fruits and vegetables that seem to end at the horizon. There is one main problem for the residents who live here: they do not own the food they labor over.

The life of the farmworker in the Central Valley is emblematic of the textbook vulnerable subject of health research. They do repetitive labor from dusk until dawn, are usually of a racial or ethnic minority, almost always from an immigrant background, and are in the low socioeconomic echelon. While the poster image for a farmworker may be a young man, driving by the any field between the hours of 3am and 3pm reveals that farmworkers include

women, and middle age and older men and women. Those who are not visible are working in other sectors of the food chain in packing houses and processing factories. When they are not working, they and their children often mingle with the rest of society in some similar activities related to the landscape of Central California.

There are many places where people can enjoy the outdoors as a range of topographic environments bring mountains, hills, lakes, and rivers all within a driving range. In Fresno County for example, there are 18 different large recreation areas apart from city parks (Fresno County 2014). On holidays and long weekends, these places are filled with people outside enjoying carne asada, their bbq grills, or cooking another sort of ethnic food. Those spaces, however, are not immune to poor air quality.

Of all of the languages that are spoken in the Central Valley, like Spanish, Punjabi, Hmong, and Portuguese, people have ways to describe the bad air and their allergies, even if they do not classify it as something medical. During my interviews, I heard "moquera" (snot), "la alergia," "allergies," and "sinusitis," all attempting to describe how pollen, pollution, and other allergens that loom in the air affect the residents of the different towns. However, just as many other indicators of health and illness, even the effects of the air are stratified. The latest research has shown that people most likely to have asthma complications in Fresno are Latinos who live near freeways and living in poverty (Joint Center for Political and Economic Studies 2012).

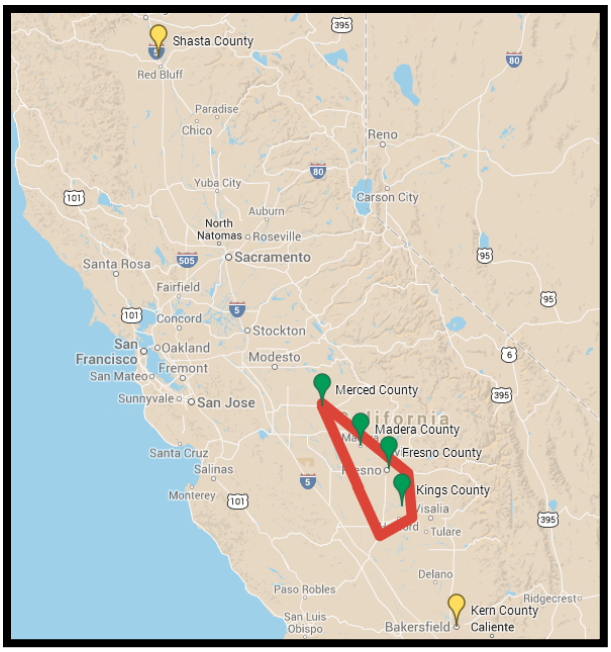

Figure 1.
Geographic Area of Interviews. The area of the interviews is outlined by the red line. Each of the green points shows the counties that are represented in this study, which covers approximately 100 miles of highway. The entire Central Valley is composed of 18 counties, from Kern County to Shasta County, which is approximately. The San Joaquin Valley, within the Central Valley, is comprised of 8 counties, from San Joaquin County to Kern County.

In the San Joaquin Valley, the middle counties of the Central Valley (Figure 1), grass filled lawns kept neatly, swimming pools and freeways mark the line of poverty and wealth. Growing up as a child, I remember on a fall afternoon being on the school bus looking out the window as we passed through one of the historic neighborhoods of central Fresno to get dropped off to our less affluent neighborhoods. We were all quiet as we looked outside into what seemed like a magical array of warm colors and leaves coming down on enormous lawns that were neatly kept. One girl who had a reputation for being tough and mean said, "Look at that fancy ass house, well, my house also has trees with leaves falling on the front yard looking all pretty and shit." We all laughed. It was the first time that I noticed she was not just the tough mean girl in the school, that she was a human being who yearned for more, and tried to reconcile in her head how the world of the residents of Huntington Park and her own had

something in common, even though in our neighborhoods we dealt with the never-ending noise and chaos of our urban impoverished neighborhoods.

Rust adorns the buildings that once housed the little non-agriculture related industrial economy that Fresno that emerged in the early 1900's and boomed during the post WWII era (Figure 2). After the war, many buildings started to spring up as people invested and the money they had made from the crops necessary for the functions of war such as cotton for uniforms (California Council for the Humanities 2003). Many of the towns where I conducted the interviews had older buildings that while beautiful and historic, could not be maintained once the decline of those buildings began and the golden era had run out for most small farmers and industry workers.

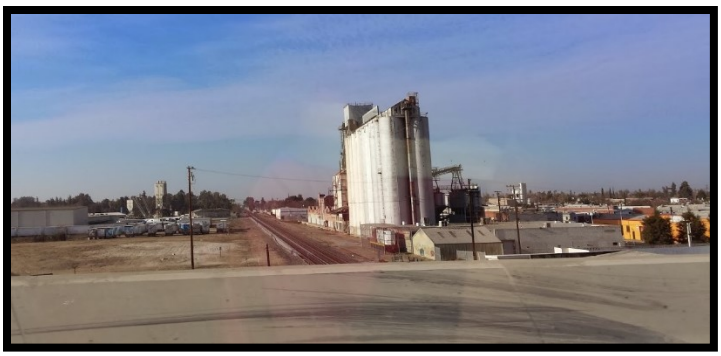

Figure 2. Photograph of Downtown Fresno Industrial Landscape

As mechanization improved and irrigation was vastly modernized after the war, agriculture had its boom as other industries declined their production (Olmstead and Rhode 2004). However, with waves of immigrants coming in to work these lands, an economy has been sustained. One of my earliest memories of Fresno's busiest commerce street, Shaw Avenue, included visiting the massive orchards of fig trees all along the avenue. These have now been replaced with rows and rows of commercial buildings that include national chain stores and small niche stores and restaurants catering to the Mexican-American and Southeast

Indian middle-class population. This was part of the larger trend of small farms being bought out to make room for new housing tracts and their respective commercial developments.

In the larger rural surroundings, this type of commercial growth has not happened as the land has been used for the expansion of agribusiness. Driving through the different spaces where the people that work these lands live, it seems as though these were created as an afterthought. The Central Valley evolved over the past 100 years to the landscape that is now visible- enormous plots of land owned by few agribusinesses, small pockets of housing and commercial interests, and a plethora of deteriorating neighborhoods and towns in deep poverty (Figure 3 and Figure 4).

Figure 3. Rural Town in the Central Valley

Figure 4. Edge of Rural Town

Like other places in the United States, it is at a juxtaposition of a hold on the "traditional" values and American way of life, at the same time its economic development has made it so that an influx of immigrants and the cultural changes they bring, are slowly blended into its mainstream way of life. "Big Hat Days" and rodeos are big events, as are Cinco de Mayo and 16th of September (Mexican Independence Day) celebrations. While Mexican immigrants are the highest proportion of immigrants in the Central Valley, it is a land that became home to some of the largest Indian Punjabi and Hmong refugee communities in the country. While from an outsider perspective the Central Valley can seem as homogenous as its

agricultural landscape, walking into any city high school will reveal the plethora of languages that are spoken and the variety of ethnicities that have settled here over hundreds of years.

There are clear racial and ethnic lines drawn by housing communities and religious institutions, yet they are continuously smudged as economic mobility of the second and third generation immigrants move into the wealthier neighborhoods of the suburban areas. While there is constancy in towns like Stratford, California, where the majority of its residents are Mexican immigrants who migrated in the 1970s and are now retired, there is also a constant flux as their children go off to college and settle in other parts of the Central Valley and the Portuguese controlled town becomes a point of a post-colonialism struggle sequel.

In spite of all the economic hardships of its local governments and residents, it also has a strong barrier of protection, which is evident, not in its crime or asthma rates, but in the stories of the people growing up here and choosing to stay. It is a place where family is not just a warm and fuzzy idea, but an expected way of life. Unity in these communities can be seen Friday nights as people gather in high school stadiums to see their children or their neighbor's children play football, or on Saturday and Sunday and when droves of people gather at the various religious celebrations, from weekly worship to *quinceañeras*, Hmong New Year, and Ramadan. In each of these celebrations, one can see a white young man being the escort for his Latina friend who is celebrating her quinceañera, a Mexican family from southeast Fresno walking on to the fairgrounds to taste and take in the Hmong New Year Celebrations, and college friends wishing each other happy Eid, Merry Christmas, and happy Chinese New Year.

As the Central Valley became a place where farming unnaturally evolved into agribusiness, and other economic sources ended or moved out, the environmental effects of poverty, urban flight, and pesticides made for a booming health care sector. Health care is a

growing business in the Central Valley, with a wide range of specialties, but no doubt allergies and diabetes are subsectors of healthcare where people can expect to find jobs. However, everyone in the Central Valley is involved in health, and this is probably why it makes it such an interesting landscape for health research. Educators, politicians and pundits, business owners, farmworker activists, and farmers are all involved in the healthcare debates, because everyone feels to have a stake in how conversations about food, water, and pollution are shaped. The places of care therefore, are impacted by all of these debates as the level of access to their facilities, and the opinions of those going to these facilities are being shaped outside of their physical perimeters.

Places of Care

One of the principal providers for immigrant populations of all ages are community health clinics, which are often also referred to as Federally Qualified Health Centers (FQHCs). FQHC's target a medically underserved areas, have accessible service hours to its service population, and have sliding scale fees for services (HRSA, 2012). The network acknowledges that this is a hard to reach population, and that often through their own constraints of time and resources, they are limited in finding out why they do not visit their clinics as patients. They noted that while they do visit the clinic, they often do so for two reasons: 1) they are there accompanying their spouse, adult child, or grandchild, or 2) they have an acute illness or advanced chronic illnesses.

There are stories that are told as folk stories throughout the community clinic network about this subpopulation, illustrating the extreme instances in which the men will reach out for healthcare. Two stories that were told to me speak to the level of hesitance a person will have before seeing a doctor, the family dynamics involved in health seeking care within this

subpopulation, and the complexities of working in older age. One was of an older Mexican immigrant man having heart attack in the parking lot as his adult daughter had forcibly taken her father in to see the doctor after a long period of resisting care. Another story was of an older man that came in with a dangling toe. The man had sustained a work injury, but left it untreated to the point that the toe was unsalvageable. Practitioners are left puzzled, and yet constrained in resources to find out why these stories define health-seeking behavior for older Mexican immigrant men.

Understanding how these stories became the reality of older men living in the Central Valley reveals many layers of sociopolitical, historical, and personal issues. I believe that the stories of where this subpopulation came from and how they became agricultural laborers are necessary to an understanding of their health-seeking behaviors. These experiences shaped who they became, where they lived, what they had access to, and what they were exposed to, so they affect their health stories as well. The next section highlights these stories as told by participants.

Migration Stories

In this subsection, I focus on the motivations in which people migrated. I also focus on their circumstances once they arrived and how their lives have shifted from their first experiences of migration. I should note here that participants also discussed their migration experiences within the context of transnational politics, biomedical knowledge in relation to health care services and food, as well as their own conceptualization of health. These experiences will be discussed in Chapter 5.

Countless stories of migration have been narrated, and while many Mexican families can trace a continuum of members of their family migrating back and forth from the US to Mexico, all struggle with the same identity of migrant (Gonzalez 2011). This immigrant identity

transcends the legality of their circumstance today, although the importance of their legality in access to resources in the United States is not to be overlooked. In addition, when thinking about health, it is crucial to understand how the lives of those who migrated were shaped in ways that impacted their beliefs, behaviors, and physical and psychological wellbeing at all points of their lives. When analyzing the migration stories, three major themes arose:

1) many ended up in agriculture jobs who had done agriculture work with their families since they were children.

2) The context of migration led them to come in silos or with established networks, but this did not influence how financially well off they ended up in old age, or their occupations.

3) Most men had legal status by old age, although not all came legally in the beginning, and while many expressed love for their home country, there was no overwhelming sentiment that these men looked forward to returning home, in a way that could be determined by health or financial status.

Again, in each of these three major themes lay the groundwork for understanding their health seeking behavior, and how they conceptualized their own health and illness. The migration and health seeking narratives are inextricable, and the stories have both theoretical implications on social barriers to health as well as clinical implications to that these men have always and still see themselves primarily as working immigrant men. Their networks, their financial status, and their ability to migrate back and forth to Mexico all have implications on their health-seeking behavior.

I remember hearing about the stories of my own grandparents working since they were children, before their teenage years, either helping their parents in their business or working outside the home to try to help their families. I see now that while there are laws in place in the

United States and Mexico that deem this as no longer acceptable, it is still the reality of many immigrant families. A summer in the Central Valley can give great testament to this. As I drove by the many crop fields going to my interviews, I saw children working alongside parents. This type of labor is not just limited to Hispanic families, as I also ate at an unnamed Asian ethnic restaurant and saw their children, as young as 14, helping their parents during the summer. The legality of this work is not the point of discussion in this dissertation, rather, the highlighting of child labor helps paint the story of who these men are, how their identities have been shaped, and the motivations for work that they have held since childhood.

Growing up in Agriculture

While agriculture has been around 10,000 years, it has now become for many Americans a distant memory of something their grandparents or great grandparents engaged in decades ago. However, there are still places in the country, such as the California Central Valley, where agriculture is the center of the economy, and most everyone knows someone involved in agriculture one way or another. Within the Central Valley is the San Joaquin Valley, which is where we can find the core of California's agribusiness (Umbach 1997). Perhaps it is this microcosm that makes it ripe for people like the participants in this study, it is a world that not only is financially designed to attract people who have agricultural skills, but also those who do not wish, or who lack the opportunity to engage in something else.

Many people that are over 65 may have had work or life experience in farming and agriculture at one point in their youth, and then transitioned out over time, education, and class out of that ethos into a metropolitan or suburban lifestyle. However, most of the participants of this study had a farming background since their early childhood into their age of retirement and

beyond. Their stories of hard labor in youth reminded me of stories like those of some of the people in my life who farmed as children or young adults.

When I think of the image of a seven year old, I think of my nephew, who likes building anything with toy construction blocks, and plays outside with his younger brother racing, climbing trees, and reading. This is a very different image than that of the seven, ten, and twelve year olds in the narratives of my participants. Many of them began work at that very young age, and while some of these stories are shared by many families in the United States whose parents worked in the farms at that age, these stories set the stage for how the men eventually ended up in rural and suburban towns in the Central Valley, still tied to the land economically, culturally, and emotionally.

> *There where I was raised, I grew up there right? Well there I worked in nothing but fields.* (Fernando, 66, Married)

Most participants did not grow up in big cities, rather, in rural areas, and had constant interaction with their own food system, the fruits and vegetables along with the livestock.

> *Well, yes it was a small town. (un rancho) I worked in the in the fields, in agriculture… in that time we worked with animals.* (Josue, 67, Married)

I found that the fact that they grew up in rural towns is important, because it helped shape their early concepts of work, the land, and the way people make a living, organize their family life, eat, and their value system. I think about my own upbringing in a mostly metropolitan to suburban lifestyle, and how that shapes my own thoughts about how people make a living, that it is not always connected to the land, rather, can be in very abstract sectors such as the stock market, and that food can come in cans, out of a drive-thru, and that education is not an option, but the only thing my social life revolved around as a child.

It was evident that the majority of participants were woven into the workforce of their households, and that education was not the primary thing that dictated their lives as children.

> *I lived as a farmer, working, I helped my father in his tasks, we had livestock, and I took care of the livestock, I also helped my dad sow the fields.* (Moses, 65, Married)

While agriculture work is perceived as unskilled labor, participants recalled learning the trades of their parents with great detail. As I interviewed the participants, I couldn't help but think of the type of skills I learned as a child. I grew up in the 1990's in California, a time where the massive standardized testing took its experimentation and emphasis to new levels with the CLAS (California Learning Assessment System) and then the STAR (tests (McDonnell 2004:108; Boaler 2003). I remember the teachers and administration engraining into us how these tests were the ways in which our value would be measured, and even we as students influenced one another in that matter. I remember thinking that being in the top 10% of my school in the STAR test was just the basic measurement that I was part of the smarter kids, and to not have made it to that top tier would have been devastating. These test taking skills are far detached from the skills that participants recalled learning in their youth.

> *Yes, well my father had a ranch, he had his parcel, twenty hectares…this is where we began to learn, where he began to teach us to use the shovel, the plow, and other instruments to prepare the land, to water and everything else.* (Humberto, 68, Married)

The labor that the majority of participants engaged in as children had to be done around school time or instead of school time. One participant recalls, "At the age of seven I began to work in the field with my parents. I went to school and I worked." None of the participants reflected on this experience as particularly painful or neglectful. However, it is important to note that most of the participants had adult children who had at least received an undergraduate degree. Throughout my conversations with participants after the interviews and by looking at

the degrees displayed proudly in their living room walls, I learned that many of their children were working as professionals, working on their master's degrees, and some even their PhDs.

While their children may endure the work life balance of many college students of their age, these participants were working out this balance at a much younger age.

> *Picking cotton, cleaning, taking out the leaves-these are the things I did most, even at a very young age because one is also going to school, and there in those days we were used to working a month before classes started we would start picking cotton.* (Erasmo, 68, Married)

Another participant noted that sometimes this balance was too difficult to achieve, and eventually most left school before finishing any degree.

> *Yes, because we always started, and I had to leave school because since the morning to noon we were working and then go [home] and quickly change and go to school. There was no way to study for anything. Then I said no more, I said: "No, well, school or work" Oh well! I left school.* (Humberto, 68, Married)

When I asked Mr. Fernando if he had worked in Mexico, he responded *"Hard!"* However, he, similar to every other participant, eventually moved on from his homeland. He says, "Yes I worked in just in the fields, but then at a certain age I got out of that area and I came to another."

Perhaps the most fascinating aspect of this theme is that while their lives were difficult and consisted of negotiating helping their parents and going to school, most of the participants had stable economic lives. Fernando states, "I worked for my family. My family was somewhat comfortable." In the next section, I highlight the way in which participants slowly migrated out of their homes and stability into other parts of Mexico and eventually the United States, where they endured much economic instability. While life was full of physical labor, the history of this life, before economic instability and migration, is not one where they were born into deep strife and poverty.

The stability in the early lives of the majority of participants was largely due to dependence on their own land for most of what they needed.

> *He [Father] lived off of the livestock. Well in that region there wasn't anything else, just agriculture. The people lived off of the agriculture, everybody! Over there, if you can't produce, you can't live.* (Marciano, 65, Married)

Migration within Mexico was very common among the participants. Many participants knew migration long before they reached their final destinations in California. This phenomenon has been studied, and the conclusion remains: Mexicans will travel north before making the official migration across the United States border.

> *[At] age thirteen ...I went first to Reynosa, then to Sinaloa, then to Mexicali. Then when I was seventeen, I came over here.* (Matias, 66, Married)

It was unabashedly clear among participants that for those that lived in Southern Mexico, there was a northward trend among most of them to better economies and job opportunities.

> *I came to Sinaloa because there was work there, there was agriculture. From there we came little by little until we arrived here. [laughs]* (Marciano, 65, Married)

For those who migrated from Northern Mexico to the United States, their narratives included multiple trips to the United States before settling here permanently.

> *For a while I did do the same type of ranch-hand work in the small ranches of Ensenada. From there we worked in the mountains [cerro] and then I left for Tijuana. I got work in a restaurant but the family stayed back. Not until I had work did they all come to Tijuana.* (Tomas, 80, Divorced)

During these migration journeys, many of the participants began to build their families. Their life stories, from their spouses to their grandchildren, are marked by their internal and international migration patterns. Some met their spouses in a metropolitan Mexican city and

had their children in Mexico, while others in the United States. As Antonio, a 73-year old widower notes, sometimes that meant that their spouses were not from their hometowns, but from somewhere along their migration journey. He says of his own marriage, "I am from Jalisco, but my wife is from Michoacan…We met in Mexico City."

Through these stories, I learned that mixed legal status families are not a new phenomenon, but have existed for decades, and that the varying legal statuses mark their lives deep into aging, and for their children as well. Some of the participants had some of their children begin their education in Mexico and the majority had children who were born and fully educated in the United States. This is more than just a differing legal status, but a differing in opportunities as well. Antonio, who recalls his trajectory with his wife that was experienced by the majority, but his legalization process being unique:

> *I got married and I came here afterwards. We made a life here, but we kept going back and forth to Mexico, because her [wife] parents there…My mom arranged for us to get legalized…three of us siblings automatically received citizenship…I was 21.*

Apart from just migrating north, many first migrated to more metropolitan cities, to try their hand at jobs that were of a different nature, and stayed there until eventually migrating to the United States.

> *From the age of twelve years old I came from a small town ….to Guadalajara, Jalisco. There I stayed well practically all of my youth until I was married around '72…seventy-one or seventy-two…and from there, well, we came.* (Moses, 65, Married)

These types of stories resonated with me as my own mother had a similar migration story. However, she did not have the pressure to earn a living to provide for those who were left behind, and this is a marked difference that during the interviews I hypothesized may have had to do more with gender. She was willing to take a risk to move to a metropolitan area because

she had established networks and wanted to see new worlds, these men migrated strictly to work, and many did so alone.

I found that of those who acknowledged they had migrated here legally, most had come from the North, which is in tandem with the experience of Southern Mexicans who saw wealth and opportunity in Northern Mexico. However, even those that migrated from Northern Mexico acknowledged that extreme hardships ultimately had them permanently settle in the United States.

> *In my life I've had, as the saying goes, highs and lows. I came once when I was 18 years old and I stayed three months in [town]… I didn't come back…Then my son said, "Dad I think I'm going back (he was born in the US) because the cows aren't giving us anything in returns anymore…then little by little we all migrated back legally.* (Adan, 77, Married)

The reasons for migration to the United States were second to their reasons for migration from their rural towns into to other regions of Mexico. The idea of the American dream was only a rationalization tool for making the jump to come to the United States, not the main driver. Like many other Latin American immigrants of the 21st century to the United States, older Mexican immigrant men reached the conclusion to come to another country out of extreme necessity, not just needing or wanting more money (Gonzalez 2011; Ryo 2013).

> *When I came here I came to work. I worked in the fields cleaning cotton. All of that… I was about 16 years old… I worked in the fields until I was 30 years old.* (Ramon, 72, Separated)

The geopolitical and environmental circumstances of the hometowns, then the wish to be reunited with family are more prevalent reasons for migration.

> *We left there because the drought started to hit very hard. There wasn't any more production, and well we had to move, because if not we couldn't have survived.* (Marciano, 65, Married)

Participants were not ashamed to say that their economic necessity drove them to migrate to the United States. Whether they came with visas, green cards, or crossed the border

illegally, most of the participants acknowledged a necessity that was worded as "survival" or "living" not just better living.

> *I was 22 when I first came to the United States…We came to see what kind of luck we would have…yes, sometimes necessity makes it so that one has to find a way to live one way or another.* (Samuel, 65, Divorced)

I did not expect to hear of such large intervals or lots of trips back and forth to the United States. While the risk was high to cross the border, the necessity to work and then leave when the work was over was greater.

> *When I started to come here, the first time was in '72, then in 80'. Then I lasted longer and longer here. Sometimes I would work here and then well, the work would end, because I worked in the fields.* (Moses, 65, Married)

The type of work evolved as migration occurred, some continued to do agriculture work, while others recurred to industrial work as they moved to more metropolitan places.

> *Since the age of 12 I came from my town, when I came, I was working six years in construction.* (Carlos, 70, Married)

For those that started work very early on, their work evolved as well. Many started in the agriculture and as they migrated or simply grew older, the types of work they performed shifted.

> *We always worked in our youth, I mean since childhood, because we were kids, but we did go to school…then once we left school, when we were older, well we had jobs like anyone else, in the fields, doing construction and things like that, selling fruit…those are the jobs we learned to do.* (Erasmo, 68, Married)

These narratives of the differing type of work as they grew older and migrated to different places speaks to the variability in the labor skills of immigrants living the United States. Many never learned to speak English, but learned a variety of trades before retiring, although not all have stopped working.

The paths that participants took that led them to the Central Valley varied in geographic location, but all had similar trajectories in terms of their economic disparities, and

the way in which their roots have been planted in different parts of Mexico and the United States before settling permanently. Their upbringing in agriculture was a useful piece of knowledge to begin to understand why they would eventually settle in such an agricultural center that is the Central Valley. In addition, their mixed legal status and the transitions that their families went through began to give a clue into which members of their family, if any, they relied on as health networks later on. This aspect was further illuminated by learning about the networks which they relied upon to first migrate to the United States.

Arriving Alone: Migrating with Few Established Networks

The stories of the big migration to the United States are tied to the larger understanding of why networks are so important to the Mexican immigrant population. Even though the continuum of Mexicans living in the California Central Valley has its origins hundreds of years back, for these participants, it was a new experience, a jump into an unknown (Gonzalez 2011). I reflect on my own set of friendships in other parts of the United States, and even the world, and cannot imagine how, while they would help me navigate some of the ins and outs of a new city, would make leaving everything I know any less difficult. However, I must note that for most of the participants, this was just another migration, the big one, but nonetheless not the first time they had to leave everything behind to explore a new area for work.

During analysis of the interviews 2 groups of people that arrived emerged, the ones that traveled with friends or met up with friends here, and those that had family already here. As these two different groups emerged, I saw that within them, there were patterns in terms of what their work life looked like later on. For those that came with some established networks, they found stability in the workforce much sooner in life than those who traveled with friends or acquaintances.

I will begin this section with what each of the networks people had or the ones they traveled with looked like. I was interested to know if the friends were neighbors from Mexico, or more detached acquaintances that they had very little personal connections with back home. For family, I wanted to know if it was extended family which they relied upon for networking once they arrived, their parents or even their own children. I also found that because the majority of them traveled back and forth, their initial networks ended up looking very different from their first to their second or third trip into the United States.

Those that came to the United States with acquaintances or knowing very few people, which were only some of the participants, came to do immediate field work.

> *I did not know anyone. I came because of acquaintances, and because of friends of acquaintances that were in Mexico. They called over here and they contacted people and said well if you go over there you will [know someone]…that was the second time, because the first I didn't know anyone. I came through Tijuana by night. I walked by night…we hid in high shrubbery during the day…the first house we would see we would go to supposedly buy a taco or something right? So yea, they gave us a taco and we would continue, about three nights, then they caught us and sent us back to Mexico.* (Fernando, 66, Married)

This story highlights the aspects of traveling illegally and not having relatives to help cross the border. The interviews showed that for all, this was not an easy decision, but the necessity overrode the need to stay close to their own family.

> *I came alone! Well my parents stayed over there, but there wasn't much of a life because we could afford to live with what we produced.* (Marciano, 65, Married)

While some arrived alone, the soon began to build networks within those that they worked. The purpose of these networks was mostly for the purpose of finding more work.

> *I arrived in [small town]. In [town] I knew someone and from there I began to get to know more people from work and everything and that was why I started working. That's where we stayed. In the country. In the fields. There were grapes, plums things like that.* (Tomas, 72, Divorced)

For those that arrived to the United States having family, many were isolated to just knowing their family members and relied on each other for housing and work. One of the participants came when he was so young he relied on his brother finding him clandestine work, not only because of his legal status, but because of his age. Indeed, while many were used to working as children in agriculture back home, here it was a different matter altogether, even more serious than being undocumented.

> *When I got here my brother and father were already here; at that time they were here already. Once I arrived my dad left and I stayed here with my older brother. I started to work… the thing was they didn't want to give me work because of my age.* (Matias, 66, Married)

Before the interviews, I hypothesized that the participants moved as entire family units from town to town until finally settling and building a life in the central valley. I did not expect the role of siblings to be so powerful. One participant notes, "I had my sister here, only my sister, both of us were here alone." However, not all were fortunate enough to have siblings around and those that did not have them felt like they struggled to find a community.

> *Well, yes, I had a brother but he was far away...I struggled and suffered a lot but then I began to make more friends and I worked in a ranch for 20 years and all that.* (Luis, 66, Married)

It was clear that for those that migrated, their networks and building of networks centered on work situations. This is different from other immigrant groups, both from the past and present, who have established networks based on ethnicity, from coming from a similar foreign town as those already established in the United States, and those based on religious affiliation or a particular church group.

Once here, many continued to migrate during their adulthood to continue to seek work in different areas until eventually settling in the Central Valley.

> *Well I worked pretty much everywhere…I spent some time in [town]. Then I went to work in the fields in Oregon, Washington, Texas and even Colorado…people would tell me of work there and I would just go.* (Samuel, 65, Divorced)

The precarious status of immigration reform may seem like news today, but the majority of the participants in the study knew what it was like to encounter immigration officials.

> *One of my mom's sisters was a friend of a man who helped people get legal, and with one that was from immigration [Homeland Security, then INS]. Well we came and then they gave us a permit to be here, and we stayed. They [immigration agents] would grab us every now and then, but we went to him and then they wouldn't kick us out.* (Antonio, 73, Widower)

The key points about networks that were revealed in the interviews were that networks either consisted of acquaintances or immediate relatives. However, this shifted over time as they settled. These developing networks are imperative to understanding their available networks for health information, health seeking behavior. The insight on the history of their networks also reveals connections to their level of confidence for seeking health services alone in old age.

Not Leaving: Documented Men Staying in the US during Old Age

Understanding the life course of groups is a research topic that has long baffled historians, anthropologists, and sociologists alike. Some sociologists attempt to understand where a group will end up in the life course given certain factors throughout their lifetime. Medical sociologists have written extensively about the life course of Mexican immigrants as a cursory to understanding why they as a group will die later than their white, wealthier counterparts (Markides and Eschbach 2005; Arias 2010). One of the most noted theories that speak to this healthier outcome is that sicker Mexican immigrants return to their homeland, thus leaving the healthier ones here. Throughout the interviews I saw the stories of their end of life course filled with more complexities than just poor or good health, however, their interactions

with the health care systems did indeed factor in on whether they would return or stay in the US.

Approaching this subject form a self-reflective perspective was difficult for me. As a child of immigrant parents who are close to reaching old age, conversations of migrating back to Mexico have been at the center of our family life for many years now. There is an extensive list of pros and cons that happen in the process, and while no action is taken in either direction, the idea of planning my own family is done so without the certainty that my own parents will be here to be a part of the childrearing networks that many Latino families rely upon (Cauce and Domenech-Rodriguez 2002).

> *I struggled and struggled a lot…like four years, those four years the 'migra' took me out many times, until my brother told me, "You know what, why are you struggling? Let's go look for someone to fix your status. In finally in 72' I fixed my status.* (Matias, 66, Married)

There are many push and pull factors that influenced a final settlement in the United States during old age. While most of their participants built their families piece by piece around the United States, for others, it was their grown children that ultimately had them make the permanent move.

> *I remained several years in Mexico until my son told me, "I think that it's my chance to go to the United States," because he was born here. We eventually became legalized through my daughters who were also born here. We go to Mexico, but the maximum time we spend there is a month, and we stay here all the time.* (Adan, 77, Married)

For others it is the shear pull of time and geographic reorganization of their extended family that has made it so that the United States has become a permanent home.

> *Well now my whole family lives here. All my brothers and sisters live here in California around Los Angeles.* (Josue, 67, Married)

Over the years, a conceptualization of "home" is changed for many participants so that they see this country as the logical place for them to live out their days.

> *I came here when I was 21 years old…We have taken here in California as if it were our native land, like our land.* (Antonio, 73, Widower)

Even for those who still yearn for Mexico as home, they find it difficult to leave because of their established networks in the United States, mainly their own adult children. I leave this section with part of the migration story of Marciano, a man who migrated alone, then with his wife, and eventually brought his children to live in the United States, where there are all adults and have families of their own. His story captures the fractioned story of migration, where necessity overrides desires for a conceptualized "American Dream," and where circumstances shape the outcome of their future, rather than a chosen life path, but one nevertheless, a destiny that is met with joy rather than bitterness.

> *I then brought my sons because over there the school got closed down, because the parents go into fights with the teachers. They killed a teacher and the state got angry, so they closed down the school. And I thought well instead of them being there, I went to get them. That was how I brought them, and now I can't take them back! [Laughs]*

For some participants, the flux of migration has changed their ways so much that there is no illusion of a homogenous way of life and the Mexicanness of their home country. They have made the United States home within their Mexican identity. One participant in particular, Matias, illustrated the dangers of what Bahba called the predicament of claiming a uniform identity when the images of what the group represents are not homogenonus. This man due to first internal migration to the northern states and then the death of his relatives, does not have affinity towards his home town.

> *I'm from Guanajuato…I can't tell you much about that place because I migrated when I was thirteen or fourteen years old. I went first to the border, to Sinaloa and then Mexicali, then when I was seventeen I came*

here, and so I'm going to tell you that I can't tell you anything about where I'm from.

When I asked Matias if he went back to the Mexico, even if just the northern states and not his southern state childhood home, he responded that he only went several years back, when he met his wife. He instead had done much more internal US migration in his working age years, and then traveled to Mexico for leisure. Not going back to Mexico was evident among the majority of participants, whether willing or unwilling. Some theoretically would like to go back but felt like most of their lives had been constructed geographically in the United States. Others did not want to go back because they did not identify as Mexicans, rather Mexican immigrants, and rejoining the Mexican citizenship did not seem plausible. Their identity was not unified, and it speaks to the negotiating of culture that they had to do throughout their lives that left them either assimilated, unassimilated but with a new citizenship, or unassimilated and wanting to return to their land of original citizenship.

Work Life

"The logical answer to the question as to how conditions similar to those that have unfolded before our eyes in Upper Silesia can be prevented in the future is, therefore, very easy and simple: education, with its daughters, liberty and prosperity... what is necessary and desirable is above all the association of the unpropertied, so that through these associations they can join the ranks of those citizens who are enjoying the bounties of life and thereby at last cease being mere machines for others… People only count as hands!...Man should work only as much as…needed for the comfortable existence of the whole race…These are the radical methods I am suggesting as a remedy against the recurrence of famine and of great typhus epidemics in Upper Silesia. Let those who are unable to rise to the more elevated standpoint of cultural history smile; serious and clear thinking persons capable of appraising the times in which they live will agree with me."
Rudolf Virchow- Report on Typhus Epidemic in Upper Silesia, 1848.

Work life, capitalism, and health have been a point of research since the beginnings of the Industrial Revolution. As I thought about studying this population and then through the interview sections, it was evident that work life would be crucial in understanding not only the

health status of participants at old age, but the systemic barriers that could influence health seeking behavior. The first theme that arose characterized the physical labor that participants did for long periods of time. The second theme revealed that once their immigrant status was legal or they were in a job that did not require them to have a legal status, they remained in the same company for decades. The third theme of their work life really links the other two together. They began to reflect on how their difficult physical labor and the conditions in which they worked for long periods of time had affected their health. Like Virchow, participants knew that something about working that hard and that long produced deleterious health effects in the long run.

Working with the Hands

Working with the hands, what does that actually mean? When we type on the computer we work with our hands, when we write or do office things like write e-mails on our smartphones we also work with our hands. This type of working with the hands is different, it is what my mind reveals as I tried to visualize their work while analyzing the transcripts, and when I looked at the endless rows of fields and large processing centers as I traveled on highway 99 and 41. I knew that working with the hands was the only way, even when using large mechanized technology, that the fruits and vegetables would get picked and processed before someone across the world would be able to pick them up at their grocery store.

During the interviews I found that there were many ways in which Mexican immigrant men had been inserted into the food production systems of the United States. The first was those "on the ground," are literally in charge of picking, watering, and working the dirt with a variety of hand tools.

> *Well here, picking, picking, well, I haven't done. I've just done the cleaning [of the fruit and cotton], and irrigation….Yes, with pipes and the*

> *water seeped out, so we piled on dirt with a shovel.* (Roberto, 69, Married)

Most of these older Mexican immigrant men have seen first-hand the evolution of agriculture into agribusiness over the past several decades. As they stayed in companies for long periods of time, some also moved up in responsibilities and went from picking to working with the machinery.

> *Yes, here I then dedicated myself to working just in agriculture. From the time we came, we worked in agriculture by hand, by foot and that type of thing, right? That's what is used most, but then with machines, but also in agriculture, machinery, all types of machinery. We worked in a very big company that was here and that had all types of machinery. We drove machinery, we drove trucks, even diesel ones we drove there.* (Erasmo, 68, Married)

Whether they ended up working in machinery or not, most participants worked physical labor jobs and did so for long periods of time. Some even then graduated into other parts of the food system, but still doing heavy labor jobs into most of their adult working life. Roman, 65 and separated, tells of his journey going from picking cotton to packing tacos.

> *I worked in the fields until I was 30 years old… And then I began to work in the factory. I began to work in the cheese factory, where they make cheese. And then in the butcher shop-- rastro. From there I began to work in the--my other job was where they make tacos. Frozen tacos. My principal job was as a packer. I packaged the tacos. And I did different jobs. I worked there for seven years…I was in the cold. Well, the word says it: frozen tacos.*

Some that managed to avoid outside agriculture work altogether once they migrated to the United States also worked in other parts sectors of the food system.

> *I arrived when I was about 30 years old. I came in '70.*
> *Over there I worked selling corn; selling tamales; selling churros; what I could, right? But thank God I never knew jail, not even here. And my profession was putting glass in windows; I learned that. I was a driver for [a soft drink company].* (Ramon, 72, Divorced)

The question the public, pundits, and researchers have asked about this particular generation of Mexican migrants and the ones that came after is why they have had a slower rate of acculturation than other immigrants in the US history. One explanation has been that Spanish has been spoken in this country for many generations, so the possibility of encountering those that would speak the same language is high (Gonzalez 2011). In the interviews this high probability of knowing someone of the same language is revealed for those who came alone and with family, because the type of work they had to engage in involved other Spanish-speaking farm workers. However, another theme arose which has relevance to health seeking behavior. Those participants that came here, as stated in an earlier section, came here with one focus: work. There was no foresight that they would settle in the U.S. or that they would build a family, rather their unilateral focus of work drove their decision making about learning English along with other non-physiological needs, such as health (Kenrick, Griskevicius, Neuber and Shaller 2010). Therefore, their entire life decisions and constraints, including health ones, were centered on work. Many participants experienced having low wages most of their working age, especially as recent immigrants.

> *When I came here -- the first time I came here to the United States they paid me $2.50 an hour, 2.50. Yes, I spent a lot of time working in the fields but I never-- it never stuck and it's not that I didn't want to-- I dedicated myself to work. And learning English was important, I would've been promoted. But all the time I worked in the country or in the ranch. Never in 20 years did I make more than five dollars.* (Luis, 66, Married)

The decision to learn English and the intent to assume that assimilated identity of a Mexican American is also revealed in this narrative. As Bahba points out, new interest groups and new networks can make it acceptable to form a new identity such as being an English speaker (1996). As is explained in this narrative, the economic system played a role in determining what the minority status would confine this particular participant to, he could be a

worker, but not a full citizen. We see that the unilateral focus of being a worker was driven not just by the participant, but by the confines of the economic system that did not allow him to earn enough to take time off of work to learn English.

Company Loyalty

In trying to understand health seeking behavior, it is important to understand the relationships that participants have with other systemic structures. Undoubtedly, the men in this study do not live in the upper middle class echelon, and nearly all of them lived in poverty at one point in their lives, especially during their early migration periods. Their own conceptualizations of their work establish the need for permanence, which is what separates these participants living in the Central Valley from others who still migrate from California up to the fields of Washington and Oregon (Holmes 2007; 2012).

The older Mexican immigrant men that settled in the Central Valley but worked elsewhere in the California before settling were also contributed to industries that boomed decades ago, such as canneries and fisheries.

> *Well, if they ask me what other jobs I've worked, well, I also worked in a cannery.* (Matias, 66, Married)

Many moved laterally in the same place, but stayed working. I soon found that they prided themselves in how long they had worked in the same place. They underplayed the places where they had worked temporarily, and instead focused on the places where they worked for decades.

> *Right now I have worked in the same company since 1982. I have 31 years in that company…I worked in the fields before I started working in the ranch where I am now…but I've spent nearly half of my life working in the same place.* (Matias, 66, Married)

As participants described the places they had worked at for decades, they talked about some of the hardships of their work, which I will describe in the next section. However, they did not resent the economic system, even as many spoke of the long hours they worked during

their life and the hazards they were exposed to while working. From my own outsider perspective, I would think that they would complain of the poor working conditions and even perhaps the neglectful management. However, they did not. They simply talked about the work and the struggles as matter of fact, not complaining. There are certainly masculine identity issues at play here, as Broughton (2008) points out, the identity of breadwinner carries implications to how they will make decisions within any social structure, including economic and health.

Work and Health: Making Early Connections

Work life can be viewed through many theoretical lenses, such as that of the worker's connection to the economic system and how gender hierarchies distinguish between work and home tasks. As Walter, Bourgeois, and Loinaz (2004) point out, men are constituting their masculinities by exerting their bodies in labor, and this has specific consequences for those who are doing physical labor. All of the participants engaged in this type of physical labor, and similar to the day laborers in the Walter et al. ethnography, their health took a toll as the longer they worked. A participant that helps illustrate this point is Fernando.

Like many others, most of Fernando's early childhood in Mexico consisted of working in agriculture alongside his family. He then decided to migrate internally to northern Mexico. As I sat in his kitchen table with him and his wife, he shuffled around before we began, he was nervous about the interview, but enclosed in his home of comfort and yet rural, he does not talk to many people other than his wife on a regular basis. He mentions his grandchildren come by every now and then, and mentions the mess they make kicking dirt in the house. The house is very neatly kept, with plastic on top of the mantelpiece on the dining table, figurines, and frames that one finds in a home shopping catalog neatly decorating the wall.

I am immediately struck by Fernando's frame: he is tall, thin, and yet his hands and the way he slightly hunches over makes him look tired as the weight of the heavy labors of his lifetime finally weigh on him. He is constantly sniffling while we sit, and I can see in his puffy eyes that he is one of many in the Central Valley with allergies that are especially bad as spring starts to roll in and the moisture creates a comfortable home in the damp fertile ground for mold. As we begin talking about his work life, Fernando told me that after he migrated north he began working for the government as fumigator to fight a malaria outbreak.

> *Through the government, they sent us out in groups of five with insecticides to spray in the houses. We would go to villages, ranches, they would give us an area to go and spray. Do you know what sectors mean? ... They would give each of us a sector, a sector of a town or a village or ranch, and we had to be inside the homes, putting insecticide in the homes.*

I asked him if he ever thought about connections between his health and the work he did.

> *It didn't affect me on anything that I notice lately, but I've thought lately that there could have been something, some problem, because of how the insects died, and we had contact with that all day.*
> *Well we found people in certain houses, people who were paralytics, like they had some sort of mental problem, and they would just be laying there all the time. The rooms there would smell bad. But in any case, we had to be there, we had to spray there.*

Fernando, like many others described earlier, worked in heavy labor most of his life after migrating to the United States. For him, most of the time he ended up working in agriculture. This type of work took a toll on various parts of his body, from the muscoskeletal to the immune system.

> *Nothing but agriculture, very rough! Very rough jobs, yes! Since I've arrived here I've been hurt a lot. I spend most of my time injured. And in Mexico I also did hard labor, those were tough jobs, and over there I did not get hurt. I just arrived to the United States and I've been nothing but injured. One learns to overcome the tough jobs over in Mexico, right?*

I asked him to further explain why the jobs here are particularly more difficult and make him more prone to injury than those in Mexico. Much of his response was ironically tied to the mechanization of agriculture, which is shared by the majority of the participants. It is ironic because as technologies get introduced into agriculture and humans interact with these technologies, it produces a totally different meaning to the identity of an agricultural worker.

> *Well the jobs that I did here was to move, because I worked in irrigating [fields], to move pipes, and in the wet, in the wet dirt, that was a very hard job. One of the first times that…the second day on the job my feet got, I'm not lying, this swollen.*

Fernando pointed to his legs, and holding his two hands out by his left calve, extended each of his arms out about half a foot each side to show me just how swollen his feet had gotten from working in irrigation out on the farms. His wife nodded eagerly to confirm, and as I would later find from interviewing participants, women in the lives of the participants were perhaps the best experts on the health of these older men.

> *My feet were so swollen. I was in the room there lying because I could not stand up, I could not move, because supposedly it was because…they got swollen because there was some sort of medicine in the water and I was just there, in the water.*

The connections between health and immigrant labor have been documented in other places (Salinas and Peek 2008; Walter et al. 2004). What the stories of Fernando bring to the table are those where we see how public health and business technologies intersect with the personal lives of workers. On the one hand, as Fernando sat there, sometimes with labored breathing, he wondered if there could have been any long term effects in taking part of a public health campaign to end malaria. On the other, agribusiness technologies aimed at producing better fruit and more fertile land have consequences that are still largely unknown to the workers.

Farmworkers in today's mechanized agribusiness are invisible to a society that perceives the mechanizations to erase the farmworker altogether, and because many of them are undocumented, they join those invisible millions. However, the laborer, even in today's time, is not separated from his labor. The alienation in this case does not simply occur from a worker not being able to connect to his job, but society disconnecting from the worker. Only then can there be a place where things such as dumping chemicals into water to improve economic output is exercised without much knowledge about the effects this will have on the people who are directly in contact with these chemicals. Fernando was not the only one who has seen work take a toll on his health, and in turn how this affects everything about his living patterns.

When I asked participants what type of medical issues he was currently dealing with he responded that he needed reading glasses because if he took them off he would only see "a little bit blurry." I asked him when he first noted this health issue, instead of associating the health issue with some sort of pain, he began to tell me about the work he did for many years in an airplane factory.

> *Well I worked in a factory in Los Angeles that would make parts for airplanes…As part of the process we had to place them under a big blue lamp…those that were broken we could see a liquid we washed them in had leaked once they were under this light…then when it was winter and it was cold, we would go out of the factory into the haze…I had to leave that job because it was affecting me and I said well, no, it's not right.*

While most did not pay the immediate ultimate price for their hard labor in death, others did get diagnosed with several chronic diseases. One in particular, Roman, 65 and separated, knew that his job had cost him the ultimate price of his life, as he was diagnosed with cancer four years ago. His work at the frozen taco factory had taken a toll. They paid him well above the minimum wage while he worked there, but he did not know it was because of the risk

he took. As he perceived it, there was a link between his long work hours, the environmental exposures of his job, and his cancer diagnosis.

> *Yes, they paid me. They paid me because my health was at risk. I would get tired a lot. I got tired a lot. I wouldn't rest, and to this day I still feel tired. But I've grown accustomed to it. If before I didn't know why, I know now. I used to blame it on working excessively. Excessive workload and all that. But once they diagnosed it, I mean I didn't like it. Who would like that?*

Participants explain their work experiences as a string of narrative that begins at childhood, and continues on to their later years. Some participants continue to be the heads of their families and are the primary breadwinners, while others have retired and moved on to the redefining their work. All participants however, can reflect clearly on what the effects of years of labor have done to their bodies. As Fernando and others noted, working in agribusiness however, has unique consequences for people over the years that it does not have for people engaged in farmworker labor of other sorts. The conceptualization of health is inextricably tied to the labor narratives of the participants.

The relationship between the economy and health is an important link to continue to understand if I am to truly capture what immigrant health and the health of all people means. As Virchow (1848) said so clearly, the use of humans as machines, and alongside machines in agribusiness and the larger food business sector has effects that we have yet to understand. However, researchers have known for a long time, through small studies here and there, that this work has some sort of deleterious effect on health. Likewise, as an older Mexican immigrant man sits in an examination room, he is not only his bodily frame, or his high glucose and cholesterol labs, rather, he is also a sum of the economic sector he has engaged in for most of his life. All levels of the person must be observed to understand his health status and health behaviors, from the systemic structure

and the barriers they have encountered, to how they have come to conceptualize these sectors and how they see themselves within.

Chapter 5: Conceptualizations of Health and Illness, and Aging

Estar bien: The Autonomy of Good Health

> *Well to me health means everything because if there's no health we have nothing. We have to be healthy to be able to do what we want.* (Josue, 67, Married)

What does it mean to be healthy? This is the question I first asked participants after asking about their personal history. During a word analysis, the quote "estar bien," or "to be well" came up the most as said by participants. Health is equated to wellbeing for participants, but not in the way that I think about wellbeing. For them, having good labs, a healthy weight, and a good mental state are not the ultimate rewards for doing what one needs to do to "stay healthy." There are two notions of wellness that appeared in the data. There is the notion of "feeling good" and another of "being good." For them, being well and staying healthy had largely to do with autonomy.

There is an emotional aspect to autonomy, because when I ask them what is illness, the response revolves around a sadness, partly about not being able to do what they would like to do. Emotions are a big part of this notion of autonomy.

> *I always go for a stroll, I feel good, and it doesn't matter if it is raining…I go out and I go on a stroll and it is useful for me, like I feel good, like I have to do it, no?*

Another part of this has to do with aging. The "feeling good" comes as a result of doing what one can with what one has. For example, Antonio knows that he can no longer walk for miles around the small town he has lived in for most of his adult life. But it is sufficient that he is able to walk to pass by the houses of his different siblings several blocks away and make it back:

> *And now I don't, I feel more...I get more tired, I shouldn't walk a whole bunch anymore. I just go to the school, and just from there I return. But every day, every day I have to do it, I have to do that because I want to do it.*

He has learned to adjust his pattern, but being able to continue his walk is a big part of what motivates him to engage in regimens his daughter tells him when it comes to visiting the doctor and eating certain foods while avoiding others. While he does not fully follow her advice, he does see the benefits of avoiding certain foods and eating more of others.

Participants also related other definitions of health that are directly tied to bodily functions and the how this relates to what they feel as normal health status.

> *Well health means to be well, to not suffer any delays inside one's body... Being well moving the hands, the feet, see everything well, and then live like that, live life almost like normal.*

Others were also cognizant of the value of health. This value is not monetary, but it is as if it was, perhaps because participants relied for most of their lives as their own ability to do labor as the only source of income.

> *Well, it means a lot because a healthy person is rich, while they are healthy they are rich because many times there are many people that I have heard that people prefer to have health not money, because with health you are happy and you can do whatever you want. Without health you cannot do that.*

This attribution of health to value, while it can be monetary, in old age also circles back to the idea of autonomy, and what they are able to do if they have health, which is described here as "whatever you want." The bodily functions then are tied to a value that is both tied to money but also autonomy in old age.

Health status was also perceived as a homeostasis of how Mexicans should be, not too sick, but not too healthy either.

> *Well I believe that living well, being happy, not wanting for anything-- you can have everything, but if you-- you can have food and a house, but if*

> *your health is not good then-- but you can't have it all. You can have everything you want. You can have your health and not have someplace to live. You can have a house without having a job. For everyone to have it all-- no. Some of us are missing a shoe, others are missing-- when people have everything they need, they're calm. But us Mexicans, we're not too low or too high, we're just about in the middle. It looks just about normal. But how many of us don't feel hunger, let's say. Well to me, like I said, your body feels good. I am pretty bad about going to the doctor, unless I'm practically on the floor.*

Here participants see health and autonomy is attainable. However, there is a limit. This limit has to do with their identity as Mexican immigrants, and how being this identity determines their life structure and chances, which shape their overall health. Therefore, this middle ground will cause them to only seek healthcare when their health has drastically declined, as this will be a sign that much of what they value is at risk. At the core of this analysis is the way in which his gender, race, and class place limits on his autonomy and drives his analysis about when the cost of not seeking care outweighs the costs associated with seeking care.

Masculine identity and autonomy were hand in hand as participants talk about their physical independence, as I also asked participants what it meant to be a healthy man, many of the same answers emerged.

> *A healthy man, walks right, moves right, and does not need any help with anything, can go up and down stairs or come and go walking, that to me is healthy.*

Humberto is a man that saw his father work his own land, twenty hectares as he tells me, and his father taught him as a child how to do agriculture labor. He migrated to the United States in the 70's, and like many other participants, had his life and family shaped by migration. He was married and had some children in Mexico before he migrated to the United States and then completed his family once they all lived here. He is not shy to recall how he relied on many

people help him throughout this process, including his relatives of his wife. When I ask him what it means to be healthy, he tells the story of a man he knows to illustrate his answer.

> *Well I have seen people simply, where I worked before in a ranch, there is a man that is a bit past eighty years old, I think, and you know what? He is still working on irrigating the fields. I don't know if it is because he needs to or because there are people that can't just stay at home. Because he is the type of person who is already collecting his social security, so they are already giving him what is due to him. So I refer to the fact that this person must feel good and healthy to be at his eighty-plus years still working.*

This viewpoint of a man being both aging and working as healthy is what is problematized by Walter et al. (2004) in their ethnographical study of day laborers. In both cases, immigrant men praise the ability to work and contribute to the family instead of staying home and being dependent on others. However, this work is carried out in places that have been set to be at worst structurally violent economic forces that make it difficult to build a life beyond the reliance of daily labor to be alive (Walter et al. 2004). At best, this is an example of how agricultural spaces are "grey zones" where people like this 80-year old are able to work without the fear of being fired, yet farms like these are a part of the reason why this man does not have a retirement plan that would make it not necessary to work at that age (Holmes 2007).

Sadness and Other Emotional Aspects of Illness

Matias has been living in a rural town in the Central Valley most of his life. He came to work as a teenager, and worked as a migrant farmworker following crops in other states such as Washington and Idaho. He has been working at the same place for over 30 years, and has fiscal and residential stability in the United States. He is comfortable speaking with me in English, but most of our interview takes place in Spanish. Most of his networks are in the United States.

When I asked Matias about his health, he revealed he lives managing several diseases. As I will lay out in later chapters, he is someone who actually approves of the health system and supports it, and yet does not always do what his esteemed doctor of nearly two decades tells him to do. I begin talking about Matias because he represents what most of the men had to say about how they conceptualize illness, and how his masculine identity comes in play much more than his systemic barriers to health care. Most men attributed illness as having to do with an emotion, and something devastating. Matias was no exception.

I asked Matias who he received health information from, and he told me just from his doctor. He relies on his doctor for all of his health information. I asked him if his family was involved in any information sharing about health or illness, and he said that his doctor is the person he trusts to receive health information from, and with his family, these talks are not allowed. He states, "Every time I see my family or my brothers, well every time we see each other we don't talk about that stuff." I asked him to try to tease out what kind of information was okay to talk about with his family regarding health and illness. He agreed that sometimes talking about ways to stay healthy was allowed, but not talking about illness.

> *Yes, we talk, but not like that about illness, because I have a brother who says, "No, why should we talk about sad things? No, not those types of conversations. Now that we see each other, better not to talk about illness or sad things.*

To Matias, the precious time he had together with all of his siblings was a time for joy, and illness did not fit into those conversations.

This theme of illness as a sadness is one that has gender tied in to it very clearly, and that was the thread of exactly how health and illness were gendered. As health meant autonomy to the participants, illness meant sadness, and both of these are gendered constructs.

> "*Illness to me is a sadness" –Ramon*

"If I'm sick I can't be out there with my plants"- Tomas
"I'm sick and I'm constrained to my house, I can't breathe inside here [home] I feel asphyxiated"- Humberto

It was at this point that I first began to get clues into why the stories from the health providers of these men had women inserted in them at every step that required them interacting with the medical system.

Illness was emotional, and emotions are a realm of medicine that was originally reserved for women. As I analyzed the sad realm of illness, an image came to mind:

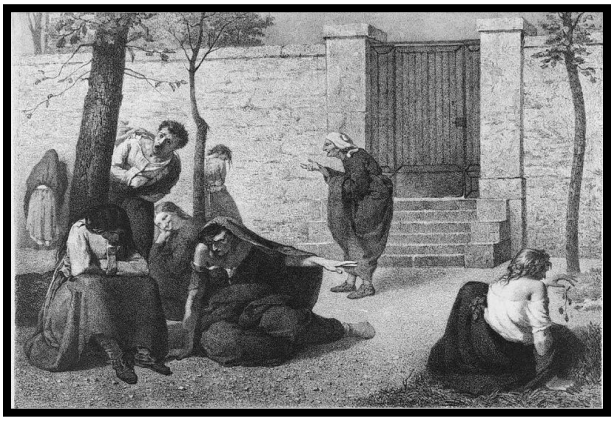

Figure 5. Gautier, Armand. 1857. "Salpetriere."

This picture is Armand Gautier's 1857 portrayal of dementia, lunacy, mania, imbecility and hallucination. Conversations in the medical community then focused on localizing the essence of femininity. Nowadays, the conversation has shifted to physiological diseases such as breast cancer, where little is known about the cause of the problem but there is a plethora of intervention and preventive measures geared towards women (Brody et al. 2007).

The infatuation of women under the medical gaze remains, and in this translational conversation of Mexican immigrant men and their conceptualization of illness, the notion of the femininity of illness transcends borders, class, and educational status. Biomedicalization is seen clearly here, as culture affects the way medical care and its technologies are organized. These

interviews are a reflection of a system created under gendered concepts, and where physiological illness is localized at the gendered and social bodies, yet is not treated as such.

> *Well illness means one thing, a bothersome thing, sadness. Because that person is no longer healthy if he has any type of illness. It starts there, and as the years go by, other types of illnesses begin to appear. For example, when I was fifty years old we could say I did not feel anything, and as the years pass by more illnesses have begun appearing, well like I tell you, they are not mortal but they always affect me because I have to be constantly taking my medicines, I have to take medicine, and so then I can become ill.*

There is even a sadness that risk itself brings to participants:

> *Well when I decide to go, I always go with fear. I go with fear because maybe they will take out another illness, and they will tell me, "You not have this and that other," and so now when I go I go with fear.*

When I asked him how he would feel if he was diagnosed with something else he clearly said, that he could immediately feel sad, but he could overcome this. "Well immediately I would feel sad, but then later one starts to forget because if not the same sadness will kill."

Masculine identity is central to the avoidance of feeling ill. The effects of being ill are seen as the opposite of being healthy, being autonomous. Roman illustrates this point as he talks about his own illnesses and the constraints that they place on his daily life. Space here is just as important as it was when they conceptualized health, the boundaries of their life are defined by their ability to do what they want. If they are constrained by illness, these boundaries are enclosed and limited.

> *Well sometimes I feel a bit-- how should I say-- sad because-- due to loneliness, but at the same time I remember that I'm diabetic and with that problem my blood sugar level will rise or drop and so I try to forget all of that and I'll go outside.*

Roman sees the cure to illness not within the medical realm, as that is an illness that must be managed, not cured. Instead, he copes with it not by engaging in "healthy behaviors" of a

diabetic, but by going outside, to the place of his autonomy. While walking or going outside may be seen by public health as a health and wellness behavior, the reasons why men do it have less to do with wellness and more about autonomy.

Autonomy as participants described meant doing the things they enjoy doing, or need to do to fulfill their identities as workers, breadwinners, fathers, or aging men. Autonomy is at the core of what drives decision-making, including their motivations for doing things such as walking or eating healthy. The idea of feeling good drives the status of being able to do what they want. This "being good" is a status that is not about wellness or behaving properly, rather, it is about fulfilling their identities in the interpersonal things they enjoy doing. This fulfillment of identity happens within the larger context of how structural forces like the economy, migration, and aging constrain their economic and social resources throughout their lifetime.

Biomedical, Transnational and Economic Knowledge

Participants discussed their own migration experiences within the larger immigration and transnational immigration frameworks. The pattern within this type of conceptualization helped frame their own understanding of their predispositions within the food, immigration, and health-seeking behavior debates. Systemic control over their individual lives in these three areas was clear for the men from an intellectual level, which also allowed them to place themselves at the margins or outside of those systems. Participants spoke of the changes in the immigration system since they first migrated, of the changes in their diets due to migration and shifts in food economics/access and of their place within the larger biomedical complex from an economic angle.

I chose to write about these three themes together because they reflect their conceptualization of health and illness from a meta-narrative perspective. While the majority had limited formal education, and several did not know how to read or write, they put together a

sophisticated sociological narrative. Of further discussion will be how they have used their networks, mainly their families, as sources of knowledge transfer about societal issues. Furthermore, the results in this section helped build my understanding of the reasoning behind and ways in which they employ their agency as patients through the lens of their gender, immigration, and aging identities.

A lot in this section of the chapter is focused around the words of Marciano. This participant had expressed his ideas about the role of the evolution in technologies within the immigration, labor, food, and healthcare systems. Marciano is the only participant that I interviewed who was a self-identified indigenous person from Oaxaca, Mexico. He also was one of two who could not read and write. Interviewing Marciano was a treat for me as a researcher, as it allowed me to gain insight on how a tradition of oral history can prove to be just as stimulating and intellectual as a written history.

Conceptualizing Changes in the Immigration Systems through the Decades

Most participants migrated to the United States decades ago. Throughout this time, their legal status has changed, and with it the way in which they think about the immigration system. Whether or not the presence of immigration officials has changed for the better or for worse can be analyzed by its economic, political, or familial impact. I begin with participant conceptualization of immigration trends as explored in their opening narrative about their background and history of migration.

> *Well before the immigration officials were tough here. One couldn't work comfortably and they wouldn't let you work. There would be times where if time wasn't on your side, three days of work and that was it, you'd get sent back. There wasn't any freedom to walk around in those days.*

Several participants described their experiences of living illegally in the United States when they first arrived as feeling like criminals. There was a sense among all of them that persecution was just around the corner if they were not legalized.

> *I lived here for three years, and by the third year I didn't feel comfortable because I was, as one would say, I was like a criminal, fleeing because the immigration officials would often arrive to the fields at that time.*

This identification points to the interpellation of their identity vis-à-vis the criminal justice system and their own concepts of what they were doing as they migrated. They were being labeled as criminals by the government, and that led to the constant seeking out of undocumented immigrants in places like supermarkets and their workplace. At the same time as this was a powerful force assigning them the identity of criminal, participants did not ascribe to that view of their legal status. Rather, they saw themselves as workers. Most of the participants who felt this way grew tired of feeling criminal and went back to Mexico until they could enter the country again legally.

While some believed that immigration was really difficult back then, others see that now immigration has become more difficult. Luis thinks being an undocumented immigrant has become more difficult, but not for the same reasons that he found it difficult. Before he married and became legal, Luis was deported dozens of times, he described it as a time of suffering. He acknowledges that others agree with him that it was much more difficult to stay permanently in the country because immigration often picked them up and sent them back to Mexico. Coming back was the easy part compared to now. He tells the story about how he would come back easily, and now the cost and the risk of crossing the border has become too difficult to make it worth the trip.

> *I achieved much. When I worked on the ranch I had a brother who was here legally. He worked with us and when they would catch us, he*

> *wouldn't go back with us because the wait to get back here was too long. There was the fence, you made a sandwich, and you went. Right now you can't come over for anything. You just can't. My brother, about two or three years ago, brought two over; 8000 or $10,000 he paid. Back then it was calm but today we're struggling a lot with the things about the fences and the lines…. they're becoming more strict and it's getting harder and harder.*

Whether people belong to the past generation of people who often got deported or those who take immense risk nowadays to cross, this comes at a toll on their bodies, their social ties, and their psyche. Even once Luis was legal, he struggled to maintain cross-border relationships. He recalls, "I came over here. And they kept telling me my dad was sick, so there I went. I went. The day they called me, there I went. Well, he had already died." Tears swell up and gather in his eyes as he recalls this incident. There are many sacrifices related to migration, and the possibility of losing a parent without being present due to immigration restrictions is a reality that many face even today.

The role of age is also an important factor to this day with migrant workers in agriculture. Matias remembers that as a teenager migrant, he was more concerned about his age than his legal status.

> *And the man that gave me work told me: "I'm going to let you work but don't go out to the streets, I don't want you to go out because it could go very bad for us if the police sees you and you are a minor, and you should be at school.*

This story also brings to light how they conceptualized their work as children and youth. Just as they did not resent working while they were schoolchildren on their farms, participants did not resent having migrated as teenagers and begun work before the legal age. While they did not internalize the idea of them being criminals, so much about their lifestyle as undocumented immigrants also blurred into other illegal processes such as working before the legal working age.

The idea of studying conceptualization, how people think and define medical concepts and experiences, through interviews rather than surveys becomes very important when I interview Marciano. He lives with his wife, their adult son, and his wife and two children. He tells me very enthusiastically after the interview that he is going to be retiring soon, after undergoing an accident at work. Marciano often travels back to his hometown in Oaxaca often, and like many indigenous people in the Central Valley, is well connected with people here and back in Mexico.

Marciano is not living in poverty, but he has experienced his share of poverty since childhood. His hometown is now mostly full of houses that lie empty for most of the year, except when the workers from the United States return after their respective work seasons end in whatever crops or type or food manufacturing season they follow. For Macriano, his vacations back home revolve around the fruit processing plants that make juices and packaged fruit products. He is someone who has always had food at the core of his life, from his parent's farm, to his own work in agriculture, and as he and his wife manage their diabetes.

Marciano speaks about the situation in his remote town, how farming became impossible after a drought:

> *When I was born there were no highways, no medicine, there was none of that! We were in a marginalized area, we left there because the drought came very badly.*

Research about this issue has been done in the United States about the Dust Bowl era. However, Marciano's encounter with drought is something that is becoming more common as we begin dealing with climate change (Reuvny 2006). He then talks about how he was able to return to his hometown after the drought ended. I asked him whether or not his family was able to work in the farm again:

> *Yes they farm but the production is not the same, all of the lands they used to farm would produce, but now the lands refuse and well, one takes the risk and goes looking for something else.*

Other participants share Marciano's perspective on how farming has changed over the decades. While it may seem like a mere observations about how the world at large has evolved, this farming evolution has dramatic effects on the lives of those who work the land. Most of the participants worked as the most modern technologies bloomed post WWII (Olmstead and Rhode 2004). Josue notes that for him, the most important change has been the replacement of working with animals to working with solely machines. He notes, "I worked in the in the fields, in agriculture…in that time we worked with animals but now some things have changed." Antonio also talks about how the production has changed here in the United States as well. He acknowledges that work life would be very different now, more arduous, than it was back then because of how the trees have been genetically engineered.

> *It's very rough, but it would be enough because it was by contract. It would be enough, we would gain, because they would pay us for something. I don't remember how it was but the orchards were different than they are now. The trees were old, they were big trees, and now they are not, the trees are already made by the machine. If they were to pay us by contract, it would be easy, now we would make good money in those orchards that are around now. Before we did not make much, when we would work on those trees, those old trees. We would struggle to finish a tree and to shake out all the almond tree because those were older trees, orchards from years and years old. Now they are not, now they make an orchard of trees and the longest that it will last is eight or nine years.*

As I drove around the from county to county to do the interviews, rows and rows of trees revealed what Antonio talked about. In the beginning of the year, when the ground is damp and the trees reveal their dark barks and branches covered with blossoms, there is a calm to this and other types of orchards as one drives through the country roads. By the fall, the trees are full of branches with green leaves and machines are parked at interval distances from the trees in the

afternoon, and shaking the tries violently during the day. Antonio best describes how this landscape has changed, and the effects he thinks this has had on the trees themselves.

> *The orchards are done because the machine wears them out. Before, because these were older trees and because we would just pick them by hand, well they would last twenty or 100 years. Who knows how long they would last? But not now, they make the orchards and they finish them off soon because the trees get sick or the machine finishes them off. Since the machine bangs on the trees they finish them off soon or something but then they finish them.*

The violent shaking of the almond trees changes the trees, just as hard labor alongside these agricultural technologies takes its toll on the bodies who labor over them. Both the trees and the bodies suffer in the long term, and participants were well aware about the changes that occurred to their bodies and the bodies of the trees over time. Not all the trees respond the same to the mechanized manner of their harvest, just as not all the bodies of the participants suffer from the same ailments during their working years and as they retire. Participants are aware that health outcomes are due to more than just chance and physical strength.

Conceptualizing Risk and Genetics: Biomedicalization in Old Age

I begin this section with a portion of an interview with one of the participants:

> *Question: What do you think someone of your age, a Mexican man living here, needs-- what do you have to do to be healthy? What type of things should you do?*
> *Response: Well, I don't know, but I think that those things might come from family-- being strong, I don't know. I'm telling you that my older brother is about 70 years old and he came to work here in 2000 picking up pipes and cutting them and he looks better than I do! .....I think it's inherited from the family-- because not all families have this gift of living-- the gift of having good health.*

While this is not an erudite discussion on genetics, it reveals how many of the participants felt about their own health, the health of their peers, including their wives, and their risk to illness vis-à-vis family history. Families share genes, and the potential of having diseases that their

family members had during their lifetime (CDC 2013). Among the participants, the vocabulary of family history revolves around the gifts. The conceptualization as to the way in which genetics can influence people is also revealed when the participant mentions the family, and that strength is a measure of having good genes. Genes are then manifested in the type of labor one is able to perform. In this case, being able to work at old age is a display of strength, and thus good genes and health. However, when talking about the effects of genes, participants did not just limit their discussion to strength, but also illness.

Within this discussion of genetics there was also an interwoven discussion of the risk of becoming ill. Many participants understood risk of illness, and that there are things, like cancer, that have they have an increased risk for due to aging, but also conceptualize it as a risk that has increased over time. When a participant had a bad experience with one urologist that was running diagnostic tests for prostate cancer, instead of completely withdrawing from the system, he chose to continue with the screening process with another doctor. He attributes the risk of metastasis, should there be a cancer, for his decision to continue to seek care.

> *Well I think that also because of mistrust that there is possibly the risk, because I know that sometimes cancer can spread right? That it [cancer] may come at one time or another, because you hear a lot about the cancers no?*

There was also a skepticism shown by many, both during the recorded interviews and after the recorder was off about the health system in general, and within it particularly the idea of risk. This questioning was also revealed about the doctor patient relationship, which I discuss in a later section. With risk, there was skepticism about how things would play out in their lives if risk was conceptual, and it meant that not everyone would get "x" illness from "y" behavior.

The theme of risk came up the most when discussing the different types of cancer participants had been diagnosed with or undergoing cancer screenings. While I will discuss the help seeking process at length in Chapter 6, when it comes to thinking about cancer, most participants dreaded the screening process, whether they had been diagnosed previously or not. However, this fear did not stop them from engaging the health seeking process.

Fernando has had two prostate biopsies, but so far he has not had a cancer diagnosis. He describes that the first one in particular was very painful because he did not know how it was supposed to feel. He remembers vividly as they took out a piece of flesh and they put them "in certain things to take them to the laboratory." The second procedure was more intense as they took more samples, and he remembers there being so much blood it fell on the hospital floor and the doctor wiped off the blood. However, if he has to do it again, he would do it. I asked Fernando, why he still chose to engage in cancer screenings even if he did not want to or feel that they were completely necessary. To him, the most important factor in deciding was risk.

> *[The doctor] said "No, well, I'm going to have you get some more labs done by the urologist, who is the one that does the biopsies." Well, sometimes because of mistrust or because there might be some sort of risk, and because I know that sometimes cancer can spread. You hear a lot about those types of cancers that go to that place, the place of the prostate, right?*

While some like Fernando continue to have symptoms without a diagnosis, and therefore seek further treatment because of the risk of getting cancer and having it metastasize, there are others who are cancer survivors and have to conceptualize risk in totally different ways. Roman left work when he was diagnosed with prostate cancer. As mentioned in Chapter 4, Roman thought that working in the frozen taco factory was a job with great risks to his health, which is why they paid him more than other jobs he had worked at in the past. He lives alone in a small one bedroom apartment. While he still visits his daughters and his wife, most

of his daily interactions with people consist of going to AA meetings. He talks about how his life has changed into a life where he feels more isolated, but he feels he is coping with it better than other people might cope with the same diagnosis.

> *Oh yeah, different from even four years back because four years ago was when they diagnosed this illness. And from what has been heard and seen about this illness, not every person has the ability to overcome it. And it's difficult. Sometimes you feel, in my personal case, you feel a certain rejection from people just from them knowing that you have cancer and that-- that hurts. More than anything it hurts emotionally.*

The pain reflected in Roman's story is about how other people conceptualize risk affect their interactions with him. I asked him the reasons he felt people had to reject him while being a cancer patient:

> *It's fear and ignorance. As a student, you know that this is not a contagious illness…It's not contagious. It could be hereditary, but not contagious. Many of the times, I feel bad because they say "that person has cancer; I don't want to get close to that person" and that's depressing.*

As I will mention in Chapter 6 during the discussion on fatalism, Roman does not feel he is defeated by the illness, or that the sadness of being isolated is overwhelming. He feels the sadness involved with having cancer but also feels that this has been a learning lesson for him and talks about continuously working to become a better person and treat his body better than he did in his youth. Roman does not blame himself for getting cancer, but as he becomes reflective about his life some and his health and lifestyle behaviors, like drinking and eating poorly, he sees a need to change.

The last question that remains about how risk is conceptualized is around the motivations to think about risk at all. In essence, this is related to the larger theme of wanting to be healthy to remain autonomous, but other there are also other reasons. Erasmo, for example,

described that he felt that he needed to be available, with the necessary strength to be there for someone else who needs to rely on him.

> *One thinks that the whole life has been pretty, and that which is coming is also pretty, being able to look out for oneself, not feel any pains, and be strong in case someone weaker needs you and you can help.*

Erasmo's response did not surprise me. As I sat in his living room, the women in his household, including his wife and adult children hovered over in the kitchen. He had been injured before, but as of the time of the interview, was still the primary breadwinner in the family in charge of driving everyone around making the principal decisions for the family.

Marciano sums up how many thought that risk had changed over the years, when it came to labor, illness, and immigration. Overall risks have evolved, as many epidemiologists will tell us, and patients are just as puzzled as scientists as to what new factors are contributing to this and other endocrine related diseases (Canaris, Tape and Wigton 2013). Marciano had his hyperthyroidism treated with radiation over two decades ago. When I asked him if other people in his family had this type of illness, he responded, "No, back then you didn't hear too much about that over there [Mexico]. Now you start seeing it more." He sees migration, along with other changes associated with migration as causing what he sees as an increasing rate in thyroid disorders. He also explains how we are all really at risk.

> *When it is infected is when it begins. We all have it, but since they are only five, we all have these five little balls that are around here (points in chest and neck area). These little balls make the entire organism work: the heart, all of the digestive system, urinary system, nerves…everything! These are what help us to live, but they are also very delicate.*

Marciano is among millions of people in the United States who suffer from some type of thyroid condition (Canaris et al. 2013). However, as Canaris et al. claim, the perceived increase in prevalence of thyroid disease may be due to screening, but the screening mechanisms that are

often hampered because the range of symptoms for thyroid disease is so broad. In addition, there are a few known risk factors for getting thyroid disease, but studies have revealed that women and older people are more likely to be diagnosed. Furthermore, research about the environmental factors associated with thyroid dysfunction are still in their nascent stage (Bren 2010). Thyroid conditions are only one example of many that researchers are still assessing risk, the role of genetics, and methodological questions about determining prevalence. Patients, in this case older Mexican immigrant men, are also finding ways to conceptualize these same issues. As Matias notes, the notion that he has pre-diabetes does not mean he will later acquire it for sure, but if he does, he is not uncomfortable with his diagnosis.

> *There's a chance that I'm almost getting it…I'm not scared of any illness, we are all going to die of something. The doctor told me, "No but if you take care of yourself, I'm going to give you this medicine just in case." I take one pill a day and that's it.*

The role of nutrition and food in disease management is also an emerging area of research that participants discussed.

Conceptualizing Changes in Food/Diet: The Postcolonial-Biomedical Attack on the Tortilla

Migration into another country changes many things in the daily life of a person, not just the work, but the exposure to culture, including food. As migration takes its toll, so do age and the onset of disease. This section is about how all of these changes are conceptualized among participants. Changes to diets, especially the changes in eating tortillas, were significant not just on a health dimension, but took personal and attached their concepts of culture, autonomy, and happiness.

Tortillas came up in several interviews as items that participants enjoyed eating and that they had been asked to cut back on by their health professionals. I decided to ask two different

participants what eating healthy meant to him and what it would mean to him if tortillas were restricted medically.

> *I eat very well beans, tortillas, eggs, nopales, milk, bread, water*
> *Question: And so, if they said you couldn't eat tortilla...*
> *Answer: I would feel bad. I would eat less but I would still keep eating. I wouldn't care if that's bad for me…That's part of my culture, of the way of I've lived my whole life.*

Another participant said he would also feel bad, and that he would refuse to do such a change, mainly because if he did not feel ill, he would see no reason to make that change. He has been diagnosed with diabetes and feels like exercise, not eating habits have contributed to him feeling good.

> *If I feel bad [not eating tortillas] I'm not going to do it. If I'm feeling bad and they tell me no more, then it must be for something, but if I don't feel bad, then I'm not going to stop.*

The struggle to keep incorporating the tortilla into their diet is not just about health, it is also about the politicization of culture as migration occurred. As Homi Bahba says, the effects of migration on culture can be that of entities demanding acculturation through a social system such as the health system (1996). However, the participants also politicize this aspect of their culture when they refuse to let it go.

> *I'm going to tell you that the tortilla is the only thing that fills me. So that I'm left satisfied.*
> *And well they tell me that the wheat bread or whole wheat bread is….well yes I'll eat it but I also have to eat at least one tortilla so that my stomach is left well. But if one takes care of oneself, it doesn't matter what you eat.*

Not everyone felt this way about the tortillas anymore, some had gone through the process of slowly fading it out of their eating habits. Erasmo lives with his wife and adult children. He makes a lot of the healthcare decisions himself, and is motivated by feeling well. He had a knee injury but now continues to exercise regularly and reports he eats vegetables. The process of leaving tortillas for him was about a diagnosis. He had diabetes and saw that his

glucose levels would rise. When he first began his process of no longer eating tortillas, he would eat about a dozen tortillas a day. On the doctor's orders he left the tortilla over time. He describes this process:

> *Oh! At first I felt like drunk spells, like I was going to fall, and I would tell my wife, "No, you give me my tortillas." I told her, "I'm not going to make it like this." [She said] "No, you are going to get used to it and you have to get used to it." And yes, about a week or two later I got used to it, and now, if I eat an apple, or a cucumber or a banana, or a carrot, if I eat that all day, I am left as if I would have eaten tortillas, I'm full.*

The notion of being full is one that came up when ranking the importance of leaving foods like tortilla or changing eating habits altogether. The main concern for men before they left a food would be whether or not they would feel full. In the case of being full carried health consequences for Erasmo and Marciano, both talked about falling or passing out if they did not feel full.

Food is a big component of how keeping healthy is conceptualized. However, not all thought the same about food, and two different ideas on restrictions emerged. Some participants thought that eating with restrictions is the way to keep healthy, while others perceived eating anything that wanted to would make them happy, which to them was perceived as having good health. Before the interviews, I did not expect participants to embrace any type of restrictions; given my conversations with providers about the difficulty they had of getting older patients to follow eating behavior restrictions. Luis talks about how he has adopted new eating habits over the years as a diabetic at the behest of his doctor, and how his siblings have that same new attitude about food.

> *If right now I eat something, I won't eat it again all day. Like a bread or whatever, I won't eat it repeatedly. I'll take one thing and that's all. I'm not like other people eating here and there; picking, picking and picking. I'll eat in the afternoon, have my beer, sit down, cut the lawn, sit down and watch TV, take a quick shower, and go to sleep. I don't know if I had*

> *more energy-- sometimes I'm here and it's late, I'll go outside and water my plants, flowers, and the grass. But I don't feel like I tire, no. My siblings are the same.*

The theme of control over food arose in two ways. On the one hand there is the control directly implemented by the doctors, vis-à-vis regimens of diet and nutrition. On the other, however, is the implementation of self-control over food and diet. This implementation of governmentality is aided not just by participants themselves, but also other institutions such as their family and the media. However, as Matias notes, the penalties for not controlling food are implemented by the health system:

> *He has me very under control, the doctor. I drink soda, eat meat, I eat everything! I don't go…I don't have a diet or anything. He told me that all of those things like potatoes, pasta, tortilla…everything, everything, everything was bad for me! He told me that is what I should try to do, to not eat much or something like that, but no, I always eat what I want and I go to him… he tells me, oh Matias, zero, zero! What happened? "I don't know"*

For most of the participants it is clear that some of the regimens required to be "healthy" do not fit in their lifestyle for cultural, but also systemic reasons. Fernando describes how the process of changing eating habits do not only have to do with control, but with external factors as well. He is a diabetic and has gone to many nutrition classes since his diagnosis. While he is able to make the classes, even though sometimes transportation can be an issue, his problem is implementing the recommendations that are given by the nutritionist. He starts this conversation by describing in depth what they tell him about the food pyramid, and the food groups, and the different portions he should attain to eat per day.

> *Maybe a rich man can follow everything from the [food] pyramid, you see? And well, a person must nearly be fully dedicated to make those types of foods, and well, who has the time, right?*

For Fernando, the food pyramid is aspirational. However, he believes that the dedication and resources that following the food pyramid require are not resources that are available to him and his wife. There are also other systemic barriers identified related to the ability to work. Marciano notes that feeling full is necessary, and not being full can actually prove to be dangerous. I asked him about what type of food restrictions he now had as a diabetic, he said they told him to eat less and cut out tortillas, but he did not believe that adhering to such regimen would carry positive consequences:

> *Oh you will feel exhausted. You get exhausted because your stomach is…if you go and work and then you go with your stomach empty, well it is not the same anymore. You faint, you can fall and things like that. To work hard one must eat well. If one does not eat well for a hard job, well one faints…for us we are used to eating tortillas.*

Many men that I interviewed talked about work in the context of most health-related questions. Most however, were retired and no longer going to work, but still considered themselves as working men.

Marciano notes that eating well is necessary, but that the notion of eating well has changed. He notes that doctors tell him to avoid eating tortillas and too much meat, and he agrees that these are things that he thinks should be eaten in moderation. However, he says the quality of the food has changed. He begins this conversation by talking about how farming has changed. He says, "The type of agriculture that is happening today is not the same as it was before. Now there are a lot of chemicals, many changes." When I ask him how things have changed, he goes on to describe the food as changing from organic to something new.

> *Well, how can I tell you, well, the food that we consume today is not organic anymore, and back in the day everyone produced things just organically…Organic means that everything from the grain is produced by the people. People would produce, but without using chemicals. That is organic, and now in this time, more is getting produced but now it is with chemicals…this naturally has effects!*

His discussion on people consuming organic food is organized around his ideas about food production. To him, if farming is done with chemicals, it is no longer organic, it has not been produced by solely human labor, but with chemicals. He does not know exactly what the chemistry is of these chemicals, but he knows they have some sort of effect. Marciano notes that effects are both nutritional and for the body at large, he does not separate the body as a whole from the nutritional value of food.

> *I have seen many people suffer from cancer. Very, how do I say, it is advanced ...very often you see people with cancer. Also, many people say, well not scientifically right, but they say that it is because of what we consume. Before, we did not see this so much. People would get better just by taking herbs! That's how people would heal then.*

The threads between migration and the economy, risk, and food are interweaved by the overall effects that each of these has on health and health seeking behavior. As Marciano mentions, people used to cure themselves with herbs and did not need to see the doctor. Now the diseases are more complex, and they require more technologies. The irony, is that they also see the increased technologies as the cause for further complications of their health issues, and have put them at an increased risk for more complex diseases. The next section further elaborates on how health seeking behavior has changed as they have aged, but also as the systems of migration and biomedicine have changed.

Conceptualizing Changes in Health Seeking Behavior

The third aspect of how migration influences health knowledge is how participants reflect on themselves as patients within a large US biomedicine system. Most of the participants did not reflect a general mistrust of the US healthcare system in comparison to the US. In fact, many praised the US system in comparison to that of Mexico. Fernando's interview illustrates in a unified narrative what most of the participants alluded to in their

decision-making about healthcare. In particular, his journey with all the diagnostics interactions with the healthcare system in old age illustrate how others processed seeking, delaying, or abstaining from health care. While he does not feel resentful towards the healthcare system, there is skepticism for all of the labs and tests the doctors tell him to do all the time.

> *But sometimes I think that no, it's not safe, because they also do it to get money, eh? They say they have the obligation to look out for our health right, but sometimes I gather that partly they do it to get money, or to practice.*

Fernando, who complained about the food pyramid, expands on the process of getting to the point where he thought a rich man is the only one who could actually follow such a diet:

> *Well first of all the doctor sent me to a nutritionist. They put a person for me that's specialized in that. And yes, they tell me, they give you a paper with a pyramid that says you should eat this at this hour, and recommendations on what I shouldn't eat, but that's a problem… It's a problem because those diets they give you are very expensive, and for one to be buying all of that, all types of foods that they give you are expensive. Aside, from that, it's hard to make those foods right at the designated time to eat.*

Conceptualizing the changes for him in this context have less to do with the actual food than the process of adhering to the diet. This could be said for other non-food regimens as well. His concern is that if his doctor or a specialist is telling him to do something which requires extra resources than the ones he has, he does not see the payoff in doing any regimen.

Roberto had his knee operated in 2010, which is when he was forced to retire. He recalls working until the point where he had to be mostly sitting down, which is when he was forced to go to the doctor. Roberto worked on irrigating the fields, so his job required him to be on his feet most of the time. He talks about waiting three months, until the pain disrupted his work enough to make him seek help. He had surgery done on his knee and spent several months in therapy. He was not aware of the long term effects of his surgery until after he was done with physical therapy.

> *Oh yes, I was like a month or two months in therapy. Then later they released me, and that's when I went and told the doctor, "Doctor, well, I'm well now, I can do it. "No," he said, "forget about working, no more working." I said, "But I feel fine, it doesn't hurt."*

The doctor told him that they had put in several screws in different parts of his leg, and this would make it impossible for him to return to the factory and continue doing his same work. This was not the only change he had to make. Since he was considered overweight, the doctor also put him on a diet and he lost about 50 pounds.

Participants identified three distinct changes in their health-seeking behavior. The first, is that they encounter more and more diagnostic exams both as they have migrated to the United States and began to interact with the healthcare system and as they have been diagnosed with more diseases over time. The next is that new health behaviors and even seeking help may come at the price of having to exert more resources to get a desired outcome. Finally, seeking help may change their lives completely in terms of their principal identity as a worker. All of these changes are inextricably tied with both migration to the United States and aging. Most of them said they did not seek much medical care before migrating to the United States, and many also reflected on the fact that they did not begin to deal with their health issues or encounter health issues into later life. The next section highlight some of these stories and the ways in which the narratives varied.

Conceptualizing Aging: Convergences and Divergences among Perspectives on Old Age

Mexican immigrant men are among an increasingly growing aging population in the United States. While they have endured different life paths than native born Americans, their interactions with society have many similarities. For example, they worry about losing their jobs because of their age, and how the appearance of weakness in aging will negatively impact their chances of employment. However, they are unique in gender roles, seeing themselves as

providers and heads of family even as their adult children work. The resulting narratives highlight thinking about aging as another just another phase in life while negotiating work, the level of burden they perceive to be for their families, and how their health will play a role in each of these contexts.

When asked, "What does it mean to be a healthy aging man?" the notion of what it means to be aging healthy is largely related to the autonomy in doing the type of activities a person would like to engage in for pleasure. Much of this is tied to leisurely activities for those that are retired, but it is tied to work for those that are not. As Humberto noted with the example of the 80 year old man who was working, and therefore he thought he must be healthy, the ability to work, even when it is not necessary, is a sign of wellbeing.

When aging begins, and when one begins to feel "aged" varied significantly among the group, speaking to the larger research discussion on the social construction of age. For Marciano, life after forty began to signal aging, and more difficulty in mobility to do things like go to the doctor.

> *When I have an appointment I go, and that's how we carry on, but life gets difficult when we have this age. Once passing forty years old, or forty-five, life gets difficult.*

He goes on to talk about how things have become more difficult for him as he ages:

> *Because one gets more sick, if it's not one thing it's another that attacks and one begins to go to the doctors more often, well because, what else? One doesn't feel, one doesn't feel like he is the same person.*

This particular insight is important because it speaks on how participants conceptualize identity changes as aging occurs, but it also notes an increased interaction with a system that may have been avoided in the past, as was the case with many participants who did not go to the doctor when they were younger. Interactions with the health care system for many become part and

parcel with a new aged identity. When I asked why he felt like a different man, he talked about the new need to care about things like pain.

> *Up until forty-five years old one lives very comfortably, very…how do I explain?, one feels very solid, well because one is new. For us we don't care about people, older people, we used to be astonished about the older folks. On my part I was very bad, now that we are of that age we feel what those old folks would feel. I would say, "Well is it true what that man says that this and that hurts, that this other thing is happening to his body?" What is that? They complain that a certain part of their body hurts, but when one is young [one asks] "Is it true? Maybe he is lying," but no! Years pass by but they don't pass in vain [laughs]. And one doesn't feel the same. I don't feel the same anymore, no! I have …since I've entered my sixties I'm not the same.*

Other participants thought getting older meant having to shift their conceptualization of health altogether. When I asked Matias what the word "health" meant to him, he could not separate the meaning from his own context as an aging man.

> *Well I think the word health is a pretty word…of course people like us at my age, we do not have health like we would want to, because health is the best of the person, to no have any pain. At our age it is very difficult to be without having something hurt. If you work a lot, you come home all achy and tired. I say, health is like when one is 40 years and younger and works and does what he wants, and doesn't ache. However, now at my age, it is very difficult to say "Well I have good health." I can say I have good health because I have not gone to the emergency room, I have not been to the hospital.*

Health and aging for Matias and some others was about keeping something until they had that first episode of what they would consider a health crisis. This first event of something catastrophic, can be defined as the first time they have a health issue that disrupts their autonomy. While most are living with several health issues, including chronic diseases, until any of these have a noticeable physiological effect that poses a challenge to them resuming their daily activities, they will not consider them truly life altering. This will be key in helping to explain why many of them do not adhere to prescribed regimens to manage their chronic diseases.

Motivations to delay that event as much as possible is motivated by a number of factors, but most cited their families. Erasmo strives to stay healthy in order to be able to grow old and see the different generations in his family.

> *Oh well you know life is so beautiful! First and foremost is life, what one can reach and look into ones future. I have my kids, my grandkids, my great grandkids. This is what motivates you because life is so beautiful during this time, so why can one expect for a bad life to come as one gets older?*

This perspective is not universally shared, however, as many see older life as inextricably linked with losing autonomy and physical deterioration. Marciano reflects on this perspective not from a point of sadness, but a point of inevitability of deterioration. Just as he marked aging to begin at the age of forty, he marks this aging through bodily changes linked to deterioration.

> *One changes a lot! The changes that come are because the body is not the same anymore. The entire organism begins to change because you feel the changes. Simply eyesight is something that begins to change. The ears, my ears already bother me as well. Now in the way one moves, bending down, standing up or any movement that you move, it is not the same, not anymore!*

Many, though not all, shared this perspective of aging as deterioration. Marciano talked about how this perspective on aging changes his own expectations of what he is seeking from a doctor-patient interaction. As he was talking about how he and his wife go to the doctor now more than ever, I asked him about the types of changes he sees and the reasons for these changes. He notes that the relationship with the doctor is focused on survival.

> *One goes to the doctors to survive, but I don't think that the doctors make us new [laughs]. This is what I think now, although science is very advanced, it is not going to make us new. Every day or every year that passes by is many changes that we can notice in our bodies.*

The word "changes" summarized the conceptualization of aging for all participants. However this meant different things to different people. For some, it was simply the number of years passing but nothing else changing, including their ability to work. For others, changes

were based on the waiting on that one crisis or life even that would cause a physiological change big enough to disrupt the autonomy of men over their bodies. For others, change was an all-encompassing inevitability, whereas the years passed the body begins to deteriorate. These changes of the physiological body point to another factor men consider before interacting the doctor. Will the doctor interrupt their way of life until now, or does going to the doctor signify a necessity to help older men survive as their body, piece by piece, gives up.

In my analysis of the diverging perspectives on aging, I could not find a factor that predicted how men would perceive aging on the spectrum mentioned above. This may have to do with my line of inquiry, but may also have to do with the fact that aging is not something that men themselves have fully conceptualized as part of their larger life narratives. That is, men identify themselves in ways that aging does not fit for most. The markers of their life continuum have been jobs, migration occurrences, and family formation. Aging alone fits into these narratives only at the very end, as an epilogue to their actual lives. As this part of the research requires further inquiry, worth mentioning is the fact that aging is not value-laden for all participants. Not all see it, or even their conceptualizations of the declining body as negative. Perhaps reflection of aging through their own fathers may reveal their thoughts of men as aging men than having them reflect on their own aging.

This chapter has focused on moments when men think about health related concepts and their identities in the world as they have seen it change. This has revealed notions of their identities, how they have shifted, and how they are coming to terms with their identities as they change in old age. In addition, the chapter has revealed some very key conceptualizations of the systems that they interact with, and how these systems define them as men, as workers, and as healthy individuals. Participants were very aware of systemic barriers that challenged how they

saw themselves, and also these systems shaped identities, such as that of the healthy patient, that were unrealistic to them given their own resource constraints. The next chapter will reveal how these conceptualizations and identities factor in as they decide to seek health care.

Chapter 6: Health Seeking Behavior Processes and Complexities

Mapping the process of health seeking is one of the central undertakings of this dissertation. One of the ways that this research sets itself apart from past research is the in-depth interview process that occurred in trying to, from interview data, map courses of action that result in interactions with the healthcare system. In addition, the line of questioning in this research sought to understand with whom these men interact in the healthcare system: Do they seek it alone, rely on someone else, and what are the factors that will affect who, if anyone, will help them navigate the system? Finally, this section, along with other chapters, seeks to draw from the interviews and ethnographic data the ways in which larger structures influence personal decisions, and how these are a shared or unique experience for this group based on its social location.

All of the men sought health care in the United States within the past 10 years. Most were of the opinion that the US healthcare system was an integral part of their lives, and characterized their interactions as generally positive. Yet they had varying thoughts about what that actually translated to on a case-by-case basis. The majority had not sought healthcare, preventative or otherwise, before aging or a major acute illness such as cancer.

Systemic Barriers to Seeking Health Care

Each of the themes in this chapter unfolds to tell the story of how older Mexican immigrants seek help for their health in the United States. It is important to note how within each of these themes issues of money, lack of access, language barriers arise or play a role in the decision making process to seek or abstain from care. More importantly, seeking resources

in a market where those resources are scant, such as affordable health care is central in mapping behavior of any marginalized subsection of the US population.

This past year and a half I have spent a lot of time in hospital and clinic settings. I spent some time gathering data and meeting with people about recruitment for my study, but I also was there as a patient advocate for several family members and friends of family. While I will not focus on them, something that made an impact on my perspective the role of systemic barriers over personal choices was the interactions that I saw homeless people have with the healthcare system.

I encountered a woman in a 4 day stay at the hospital, before being transferred to an elderly home facility—coincidently enough the same facility the women at my church volunteer at, because it is one of the "last stop" elder facility in the Central Valley, where rejects, difficult patients, and the poor of other facilities go to live out the rest of their days. I also encountered a homeless young man through the course of a week as he was admitted, readmitted, and sought admittance a third time, finally being escorted out by security from the pharmacy section of this particular hospital. My interactions with those homeless individuals pointed me towards a better understanding of how the homeless are an extreme case that make real how much the US healthcare system is not a silo institution, and how the interactions with other social institutions, like the economy, religion, education, or criminal justice will shape how and when a person seeks medical help.

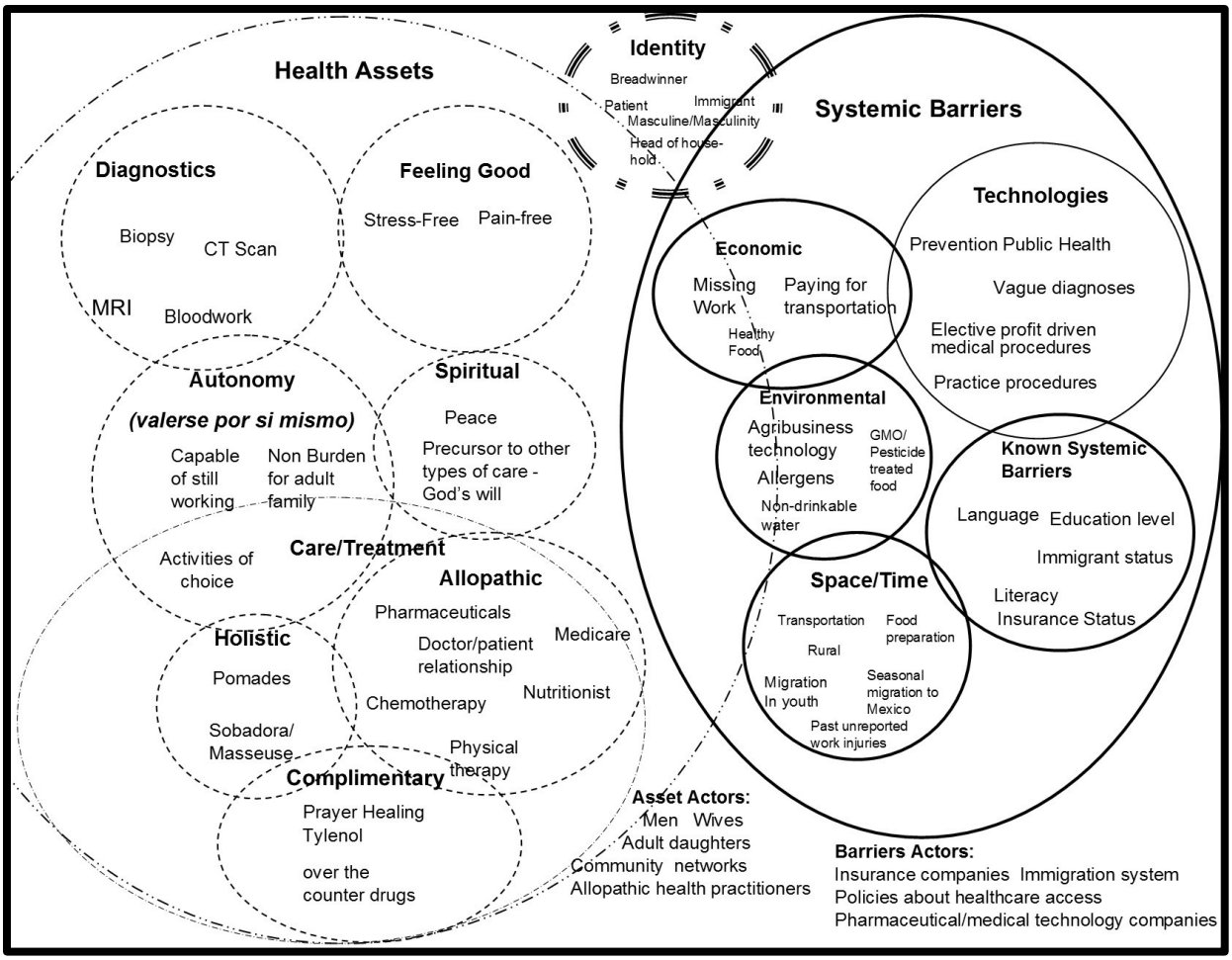

Figure 6. Map of Conceptualization of Health Assets and Systemic Barriers

The map seen in Figure 6 summarizes the data found in the interviews about what men have or perceive as health assets, the barriers they or previous research have identified as keeping them from these assets, and the different identities that are at play throughout this process. It also identifies human and non-human actors that are part of this dynamic of assets and the barriers to these assets. While this map is not exhaustive of all experiences, the health assets category is defined as that which encompasses what most of the participants identified as things they gain from seeking any type of health care and having good health (*estar bien*). On the other hand, the barriers are defined as what people identified as keeping them from seeking care and what contributes to their not feeling healthy. In addition, through coding of the

interviews, four principal identities arose as those most implicated in their health conceptualization and health seeking behavior.

There are four categories of assets that do not have to do with treatment, which are medical technologies, feeling good, autonomy, and spiritual. Medical technologies are those that participants sought out before they knew they had any illness. Most of these were for preventive purposes, and screenings that had to do with them being in remission for things like cancer and back or knee injuries. These medical technologies were described in ways that reduced anxieties about risk to illness and deterioration of the body. Even as the medical technologies themselves make them anxious, for example in the case of Fernando questioning the whether it was necessary or not to get a third biopsy for prostate cancer screening, he and others note that the risk of a debilitating illness outweighs those anxieties.

The spiritual aspect of assets deals with the state of mind that participants have and seek from health care. At the forefront is the opposite of the anxious state that has ruled their lives as breadwinners and immigrants throughout most of their adult lives-peace. In addition, participants talked in depth about God's will, which will be covered later on in this chapter. Before thinking about seeking any type of health care, many participants connected care seeking with seeking out God's will. This spiritual aspect is also related to another non-treatment asset category, which is feeling good. Participants highlighted pain and stress-free lives as precious ways of living. While some stated that aging hindered living in a way consistent with this feeling good category to its fullest extent, most men wanted to attain a state closest to being stress and pain-free.

The last non-care treatment asset is autonomy, which was described in Chapter 5. While autonomy itself is an overarching state of being for participants, "being autonomous" or in

Spanish, *valerse por si mismo*, it is also an asset that men seek to acquire when they decide to seek care. The criteria here is "will engaging in the healthcare system result in regaining or sustaining of my autonomy?" Just as some people go on a diet to lose weight, others go on a diet to look their best or get their diabetes under control. Everyone has a different reason or a combination of reasons for engaging in any type of health care. For participants, autonomy is the core asset they seek from the healthcare system.

The last aspect of the health assets category are care/treatment related assets that people seek out when they decide to seek care. You will note here that they are looking for things that many people, regardless of gender, age, or immigration status may seek out, such as pharmaceuticals or a nutritionist. Some are also related to their identity as immigrant men who are using complimentary medicines alongside their allopathic care. The alternative category recounts the times participants mentioned that they had some sort of ailment, and sought out known cures from their childhood or hometown in Mexico. Many of these speak to their identity as men who do not feel marginalized, as they seek out an engaged doctor-patient relationship. However, what they seek that plays out differently in real life as I will discuss in-depth in the next section of this chapter.

The next section of the map is devoted to systemic barriers participants face when seeking to attain desired health assets. While there are certainly interpersonal barriers at play, participants linked many of their barriers to their desired health assets to system-wide issues. The literature has identified systemic barriers as those having to do with policy decisions such as limited access to Medicaid as well as those related to the socioeconomic status of patients such as income and education level (Pacheco et al. 2012; Timmerman 2007; Trevino and Coustasse 2007). Those barriers are important and are noted in the category labeled "Known

Systemic Barriers." Known systemic barriers are integral to a complete understanding of what immigrants face when attempting to attain their self-defined health care assets.

Other systemic barriers identified by participants are those that have a direct detrimental economic effect on their lives. These include missing work to go to an appointment, which participants identified as something they had to consider constantly throughout their working years. This is explained by another barrier having to do with the nature of their work, which embedded within the agricultural industry. The jobs most participants held offered few benefits for sick leave. For most non-management positions, there is no sick leave in farm labor work unless they are year-round workers. Those jobs are seldom, and it became evident driving through the deserted miles and miles of grape vineyards during the spring season, as only those involved in irrigation are employed. The piecework characteristic of farm labor means that as long as there is something to do, people are employed, and when the crops do no need attention, people are out of work, so they must make the most of their employment during the time they do have work. In the in-between time, most will not take a break, rather, they will look for other crops that need attention or move into the other parts of the agricultural system, such as packing houses or frozen food factories.

The nature of the way many rural towns have been set up to provide hands for the different crops and packing houses means that they are mostly isolated from large hospital institutions. Several participants did not have their own transportation, and reported that getting someone to take them from place to place was costly. At one of the recruitment sites, I also encountered a woman who had a question about the clinic, and asked me what time she thought it would be open because she was paying someone to give her a ride. In addition, paying for food that is healthier becomes a problem for many who are in these isolated towns with little

access to anything but liquor stores that carry high-priced food items compared to large supermarkets that are available in bigger towns. For one of my interviews, I waited 20 minutes for the participant to get back from grocery shopping in the nearest large town, which was a 15 minute drive away, with no public transportation available to take him there and back.

The temporal aspects to healthcare behavior, feeling healthy, and the barriers to both of these were the most surprising aspects of this analysis. While many have discussed the long term effects of hard labor, aging, and immigration, none in my research had identified that participants themselves conceptualized the combined effects of all of these on their health (Salinas and Peek 2008; Trevino and Coustasse 2007). However, participants described their conceptualizations about the type of labor they engaged in for most of their life was one that put them at higher risk of injury and internal harmful effects. The "Environmental" and "Space/Time" categories attempt to capture when some expressed that the illnesses they battled with now are held at bay as potential diseases like pre-diabetes, and they said it had more to do with the accumulation of their life experiences than anything they were engaging in at the moment of their interview. Barriers therefore, are not just things affecting participants now, such as literacy, lack of transportation, or insurance status, but they are also lived experiences that carry with them lifelong health consequences.

Understanding Health Seeking Behavior

The way a person moves through the US healthcare system is hardly a straight path, rather, it is filled with twists, jumping in and out of the system engaging in complimentary medicine, and systemic and interpersonal roadblocks. While there is little research about older Mexican immigrant men anywhere in the healthcare system, I wanted to find out their progress within the system when they do choose to engage. During the course of my interviews, I had to be a patient advocate for an older man, not a participant in this study, and during the line of

questioning in the emergency room, he was asked by the advice nurse: "When was the last time you came to this hospital." At first he told me that he had never been to that hospital, but the nurse insisted they had a record of him. After further inquiry, he told me he had not actually been to that building, rather, had been to the hospital that closed down nearly a decade ago.

I asked Antonio to explain to me in depth what makes him take the first step in seeking help, since he refuses to see the doctor as regularly as she has recommended him to do check-ups and blood tests. Even though he is very conscious about his health, is proud of walking every day, he will not see his doctor unless he feels bad.

> *Well because I feel good, because if I was to feel bad, I will go to the doctor and I'll tell her.*

What exactly does bad mean? As stated in the description of the meaning of health, participants see health as autonomy. Therefore, when it comes to behavior, they will act out what their concept of health and illness, and seek care when their idea of health is slipping. Antonio acknowledged that when something impedes him from carrying out his normal activities, he will go and see the doctor to seek diagnosis and treatment.

> *I have told her before: "Look, I have this, I'm deaf. I have this other thing. My eyes, I can't see." I was struggling, well I had these cataracts. So from both eyes I saw blurry, I couldn't see anymore, I couldn't see. I would struggle a lot to drive. And they cured my and fixed my vision, you see? That's why I say that if I feel bad I would go.*

There are clear assets he sees within the healthcare system that he can attain by engaging with it, so he chooses to go to the doctor at the point where he needs these things like a diagnosis and treatment. As much as older Mexican immigrant men are part of a marginalized section of the society, they are aware of the market purposes of the healthcare system, and engage with it in a market mentality of gaining and giving resources. In the case of this participant, he is willing to

give his autonomy and time for a diagnosis when he sees the benefit of going to the doctor supersedes the cost.

Feeling bad meant not only the impeding of their autonomy, but also physical acute episodes. While this seems like the logical way for any person to seek health, for participants, acute pain was only one of many factors. Luis remembers what he felt when he first went to see the doctor about his diabetes. At the time, it was an onset of severe symptoms that drove him to take the first step in seeking healthcare.

> *I was feeling very thirsty, I would drink water the coldest that I could, I could almost bite the water but I still felt thirsty. And that's the way that I went to the doctor.*

However, as occurred in this case and that of some of the other participants, even severe symptoms did not mean they automatically sought healthcare.

> *I waited for about a week. I thought it was a hangover that I had from New Year's, but no, I would take gallons of water [to work] with ice and I would finish them. I thought no, this isn't very…and that was the way I went to the doctor.*

The self-check between what is normal is coupled with the self-check as to what is tolerable when participants are first making a decision on whether or not to seek care.

There are many factors tied to these two criteria used to make the first step to seek healthcare. While for most, the onset of severe symptoms may be enough to warrant a visit to the doctor, older Mexican immigrants have a life painted with pain and withstanding that pain. Masculinity researchers have found that men will go through great risks that are part of their lifestyle (Connell 2002; Connell and Messerschmidt 2005). That masculinity and risk-taking will look different according to class and social status (Connell and Messerschmidt 2005). For participants, the risks they have taken and physical pain they have endured have to do with their marginalized position as immigrants and farmworkers. This sort of status meant that for them, as well as other laborers, the long life of risk-taking and abstaining from seeking care comes

from lifetime of enduring pain for long periods of time as well as from attempting to keep their autonomy as long as possible (Quesada, Hart and Bourgeois 2011). Feeling bad, therefore, is process of both identities and physical pain at play with systemic barriers that have shaped who they are and their past behavior before aging.

Not all participants considered feeling bad as the impetus for seeking healthcare. Others thought prevention was a key part of their health regimen. In particular, Marcos, who is diabetic, felt that he could not be seen as taking action about his health without staying active. While others talked about this notion of prevention as a conceptualization process of defining health, Marcos thought this behavior was just as integral as going to the doctor. When I asked him what behaviors he did in terms of health seeking he responded:

> *Staying active, like walking and things like that. This is because people who are diabetic sometimes do not walk, do not exercise or anything like that, and things begin to accumulate. No, I think that the body needs to have some sort of exercise to [be healthy]*.

Marcos reveals that staying active is a part of engaging in healthy behavior, but not staying active actually invites disease in the body.

There were not many other participants that thought prevention was an impetus for health seeking or engaging in healthy behavior, but his opinion is similar to that of many Americans. Likewise, his opinion is shaped by what other participants saw as important, risk. The risk of getting a disease, the risk of accumulation of diseases, led to Marcos and others' ultimate fear of losing their identities as men, as breadwinners, and as male figureheads in their networks. When participants still had all or most of these statuses intact, they strived to keep them this way by means of preventive health behavior.

Marcos has a unique manly identity, he wears a stylish white fedora and guayabera (cotton short-sleeve shirt worn by many men in Latin America for special occassions) for his

interview. Around his kitchen, I saw many family portraits that had him in the center of all of them. He talks about his walking and that he goes and talks to a group of friends regularly. He and Erasmo both wore guayaberas during their interviews, and were the most physically fit by appearance. They also both said they liked going to walk to meet up with friends and talk. Their status as figureheads is still mostly untouched as was evident by the way both of their spouses deferred to them when I introduced myself entering their households. Retaining this power status is a crucial impetus for healthcare behavior in the case of these two men, but all participants displayed a power status they still had related to their gender.

Conteptualizations of health and illness drive healthcare behavior for participants. These include their ideas about keeping their autonomy as much as possible during their old age. In addition, their behavior will also be guided by their assessment of risk, as they define it, and the barriers that they have faced throughout their lifetime to put them at that risk, but also the risk of further losing their autonomy. Finally the identities they have held throughout their lives that give them power status will also be influential in their health seeking behavior. Retaining that status for those that have it intact is important, and for those that have lost some of it, their behavior will be more influenced by their conceptualizations of health and be less likely to think about prevention behavior as an important aspect of their health-seeking behavior.

Community Healing Networks: How neighbors and family members shape health seeking possibilities

No one is born knowing how to navigate the healthcare system. Even those who are affluent and do not have all of the systemic barriers that participants in this study encounter must also learn from other people, networks, and other systems of information how to navigate the healthcare system. In this study, radio, newspapers, and television were secondary sources

of information. Personal networks of people in their lives whom they trusted were their primary information sources. I will go more in-depth into the role of wives and adult daughters in the next section, but in this section I want to focus on networks outside of these two groups.

Samuel is a 65 year-old who is divorced, and currently living with his sister and her husband. As I enter into the house, I immediately see how protective both the sister and her husband are of Samuel, asking questions and wanting to know how I could be contacted. Sitting down at their kitchen table, I immediately note that they have become a family unit. Samuel tells me that both his sister and her husband go with him to his doctor's appointments, and have helped him as he copes with being a divorced older man. His access to resources, his living quarters, and his source of affection and knowledge have shifted from his family unit of wife and children to that of his sister and her husband.

Samuel's change in the circle of his networks is an important one to consider as just one of the many dramatic shifts in networks that Mexican immigrant men undergo throughout their life. Judith Butler and literary theorist Walter Benn Michaels debate the importance of culture in a person's biography, and how this shapes his or her identity (Michaels 1992). For Mexican immigrant men, the beliefs and values of their families that shapes their identity is a family-centered culture. In this case, while beliefs and values are what make Samuel and other participants draw on their families as their closest networks, this has also been shaped by how fragmented their migration occurred. Many other participants who arrived with one sibling or one parent to the United States clung to that person and they relied on each other for resources, knowledge, and affection. Immigration affects this network structure, but so does aging and illness.

The idea that family is always the inner circle, and everything radiates outside of that is also shaped by the social construction of aging (Estes 2008). Ageism forces the narrative that older people, like Samuel, are dependent and burdens upon other people. When situations like Samuel's occur, when elders are no longer living on their own, the narrative is that they must be as independent as possible in order to exert their autonomy. However, the level of independence that Samuel can exert is limited due to lack of resources, but is also shaped by his culture. While he may not be able to afford to live on his own and provide his own transportation to his doctor visits, he may not want to because family interdependence is a valued aspect of his life.

Samuel's sister and brother-in-law are not only his family unit, they are who he relies on to navigate the US medical system. When I asked how he gets to his appointments at the doctor, Samuel responds, "They both drive me to my appointments." He recently had ear issues, and due to his lack of health insurance, had to rely on programs that would help him seek medical care. He was able to get a hearing aid at no cost through a community benefit program targetting low-income people who had hearing issues. His sister told him about the program, and she heard it from another friend. This flow of information also speaks to how most of the other participants received their information.

Neighbors and friends are also an important source of information, and a way in which information is transmitted. Erasmo is a perfect example of a participant that is both a health information distributor but also relies on what friends tell him to influence his own health behavior. Since his migration to the United States as a teenager, he and his family have relied on friends to help them establish living spaces, employment, and medical care. He and Marcos both seemed to be some of the most physically fit of all participants, and also had the most

extensive network of friends. While discussing different attitudes about illnesses, instances when he had been ill, and motivations to stay healthy, he recalled conversations with friends to illustrate his points. He is part of a group of senior citizens that gets together at a local park. This gathering tradition is not unique to Erasmo and his friends. Saturday mornings in the Central Valley are almost as segregated as Sunday mornings. On Sunday, each group goes to its respective place of worship, but on Saturday mornings, White older men can be found reading their papers at the local café and older Mexican immigrant men can be found in the local parks talking to one another.

Erasmo says many of his friends do not take care of their health, and other friends encourage them to be more careful. He says they are mostly "desabilitados," or disabled men. However, even among them, they are not always honest with one another about their illnesses. When they do open up about their illnesses, they give each other advice about what to tell the doctor:

> *When we've built trust with one another I say to them "Well go and tell them that you are going for this specific reason" Sometimes they say well I already went, and I tell them, "I went too…and they poked me with a needle seven times and they called my wife because they said I had something, and well, it turned out my sugar was very high."*

This notion of desabilatados carries many identity implications on health-seeking behavior. Most of them have become disabled due to work conditions. This leaves them without their role of breadwinner, even when many feel like they could still contribute to their household economically. They have redefined what it means to be pain-free or autonomous, from completely pain-free to just being able to do their activities of choice that are outside the purview of breadwinning/work. Their own community networks help them retain this autonomy, and the imperative to help each other is derived from this notion of sustaining their

get-togethers at the local park, which is also their place of peace. They are able to retain and enact notions of masculinity in these networks, as I will describe in the next section and in Chapter 7. Distribution and retaining of information within their masculine networks is also important because they establish a bond and a relation of equality between them. No one person is more powerful than the other, which makes these gatherings an important ground for information sharing.

Driving up and down the impoverished neighborhoods in the Central Valley, billboards with public service announcements are as frequent as the liquor stores and potholes. These are the symbols of places that are not yet forgotten, but sustained by minor, piecemeal initiatives. None of the participants reported getting their health-related information solely from public service announcements, television, radio, or the internet. However, this does not mean that these messages are not reaching them. These two facts together make an important finding of this dissertation. Older Latino men trust their networks to give them health information, but do not react to or notice direct health promotion. This fact was also alluded to in the methods section, where I described that many of the participants heard about the study from their adult daughters, wives, sisters, or friends. Even though their neighborhoods may be surrounded by billboards telling them to eat right or go to the doctor, the information reaches someone else before it will reach them.

The amount of influence networks have on participants does not stop at advice about how to stay healthy or conceptualize illness, but can also have an effect in real-time medical situations. Marciano also shares a story about having an overactive thyroid that led him to require surgery. He was in a pre-op room about to get surgery when his sister walked in. She

notified him that the resident who was going to do his surgery was operating on a patient who died in the OR table.

> *"I was already bandaged up, ready for surgery, but my sister came in and said, "No brother, we haven't signed anything, they just killed one guy… it doesn't matter if we only have you for three more years, but we'll have you" She took off my bandages and we left the hospital"*

Marciano relied on his sister to intervene in a medical situation, and while this situation was unique to Marciano, others reported sharing complementary medicine with one another and relying on others for transportation to the doctors or post-operative care.

The importance of personal contact as a route to how they receive information was not only limited to the trust they had for their family members. Doctors were the principal people to learn about illnesses aside from immediate family. Even when people did report seeing advertisements, they trusted the television ads if the actors were acting out the part of a doctor. Tomas, for example, considers himself "pretty healthy," mostly because he can come and go wherever he wants. He is concerned about preventing diabetes, because he thinks that is one of the most serious debilitating diseases a person can have. He says this about why he thinks diabetes is particularly harmful, "Well they say that everyone has diabetes but it just hasn't progressed enough-- I would say that is worse." When I ask him who "they are" who say this information about diabetes, he explains flow of information sharing that is consistent with what other participants shared.

> *I've seen it on the news, you know when the doctors come out, the ones who talk. Almost always when I go to the doctor; the doctor I go to, she's the one who told me all about it too.*

Learning about their different networks speaks to how relationships are not compartmentalized for these participants, rather, their relationships take on multiple forms. Their social circles are built around their families, and they many times also take the role of

friends aside from relatives. In addition, for those who have had long-standing relationships with their doctors, they are perceived as a trusting friend. However, even those who did not have friendships with their doctors still relied on the doctor-figure to give them information. When I examined this across my sample, this trust in information did not appear to differ if the doctor was a man or woman. Further analysis of knowledge transfer and who is a trusted information carrier should take into account which carriers are privileged over others and the influence of empathy of the recipient during the knowledge transfer (Collins 1993).

Power relations shape the messages that participants will receive from their family, networks, and doctors and how they will react to these messages. Family is the most important level of community for participants, and thus the primary source of information sharing. However, when friends and neighbors are in the picture they are a safe place to retain and enact the masculine identities in a non-threatening environment, even if they are all "desabilitados." This is particularly true when a participant is healthy enough to gather with them on a regular basis.

Participants see doctors as the ultimate authorities of health information. The analysis of the interviews beings to point to how gender was inconsequential because of their overwhelming power in the healthcare system compared to the identity of participants as patients. As Patricia Hill Collins points out, relationships among different levels of power can generate meaningful dialogues when they are intended for positive social change (Collins 1993). Participants in this case reported enough positive experiences with the health-care system that they could rely on doctors to be this authority role. In the question of who got participants into the system in the first place so they could come in contact with the doctors, gender not only mattered, but it was crucial.

Gender Relations and Health Seeking Behavior

Men were reliant on their social and familial networks, and no men in this sample, even the ones living alone, felt alone or in silos when it came to accessing resources or healthcare. The most important aspect of their networks that men describe is not how they are able to enact their cultural capital to gain power within networks like the healthcare system. Rather, the dynamics between them and the women in their lives makes it so that they are able to be in control and the heads of household, while relying on their wives, adult daughters, sisters or nieces to navigate the healthcare system.

The participants did not perceive this handing over of control of their health-seeking behavior and medical care as a threat to their masculinity. They embraced these gender dynamics as just letting the women do a part of their lives that was for them to navigate. In turn, the women who I saw during the interviews were empowered by this role, many already informal leaders in their small communities. None of the men I interviewed seemed particularly passive, especially when talking about how outgoing they had been in migrating to the United States as teenagers, but when it came to the healthcare system, they were passive within it, even if they enacted their own health regimens at home in conjunction with or against their prescribed regimens.

I begin this section illustrating the story of Antonio. His wife died several years ago suddenly from undiagnosed heart disease. As I sat in his kitchen, it was evident that while his wife was gone, his life very much continued. He lived in a small 2 bedroom home that had plenty of backyard and front yard, which he maintains. As I pulled the gate to enter his front yard, I noticed the lawn neatly cut, and flowers like rose bushes well-trimmed even for being winter, when most let their in the surrounding neighborhood let their yards go until springtime.

Inside of his house there was a mini-bar, with tequila that he was gracious enough to offer me a shot of after the interview, as he often does with guests. As we passed by his well-kept living room, we arrived at his kitchen table, where the interview took place. On the table lay a plethora of health and food related items, all demonstrating his extremely health-conscious lifestyle. He told me about his walking regimen, which I wrote about in previous chapters, and how seeing his many siblings who lived in town motivated him to keep walking every day. When it came time to get at the root of the numerous "Herbalife" food and vitamin products, he revealed the one person in charge of explaining to him the definition of a healthy diet, and preventive medicine: his adult daughter Lucy.

His wife was actually more resistant than him to seek care, which, according to him, ultimately led her to die prematurely. He reflected on the death of his wife with tears in his eyes, yet made it clear that it had been her poor health management that led to her premature death. However, he had never relied on his wife for health and health-seeking advice to begin with. Antonio has health insurance and knows English, but his adult daughter, Lucy, is his personal health care navigator:

> *"Lucy is the one that takes me to all of my appointments, she tells me who to see and what to take"*

Antonio was my first interviewee, and I his statements about how much he relied on Lucy helped me develop a new hypothesis about how the relationship of gender and health systems works in the United States for marginalized males.

As mentioned in Chapter 5, the conceptualization of health and illness carries gendered language. Men perceive health as autonomy and illness as an emotional state. In addition, their masculine identities are shaped by their status as breadwinner for most of their lives, which involved engaging in labor-intensive work. Their narratives about their work lives leave the

narratives of the work their wives did invisible. However, research shows Mexican immigrant women engage in labor that will leave them sicker than their male counterparts (Salinas and Peek 2008). How did women become the invisible navigators of the healthcare system to a group of men who have identified themselves through traditional masculine roles? I developed around this question a two-part thesis about the visibility and invisibility of women as actors in the help-seeking of older Mexican-immigrant men. On the one hand, men are not ashamed to accept the help of their female counterparts to help them navigate the health system, and on the other, their efforts are invisible as they become part of their roles as wives or daughters, or even sisters.

Adan and his wife travel back and forth from Mexico. Since they are both retired, they spend considerable amounts of time in both Mexico and the United States. When he is in Mexico, he takes care of his own health matters, he knows the doctor that sees him on a first name basis, and his wife also takes care of her own health matters. However, when they are in the United States, they rely on each other much more. Adan acknowledges his wife is much more knowledgeable and bold than he is when it comes to the healthcare system:

> *"My wife is not a doctor, but she's like a doctor, she's not afraid of them. She's the one that tells me what to take and how much."*

Adan is not alone in thinking his wife is more bold to speak to the doctors, but he also points out an important aspect of their relationship with the healthcare system when they are in the United States. Even though neither really speaks English, he talks about how she is not afraid to mispronounce words if no one is available to translate. She will try to communicate in any way that she can.

Not only are women essential in navigating the system itself, but men acknowledge that they help clarify the things that they miss within the doctor-patient interaction. Antonio, whose

wife passed away, relies on his daughter, and discussed how his daughter reminds him of his doctor's appointments and makes the interaction with the doctors more effective. I was not able to determine whether he likes that type of relationship or not, but it is their relationship nonetheless.

> *I always tell her, 'the doctor scheduled me at this time, or the doctor told me I have to go to such a place,' then she communicates with them or asks [the doctor] and tells me, 'yes well you have to go.' That is why she likes to go so she can listen to what the doctor says, so that she understands. I sometimes do not understand. [Daughter] asks me when I go "What did the doctor ask you? What did she say?" "Well the doctor says I'm fine, that I'm fine." She tells me, well next time I'm going with you so that the doctor tells me. [Laughs]*

Adan and Antonio both rely on the adult women in their lives to help them manage their prescriptions if the doctors prescribe any. Whether in a clinical setting or at home, women are helping men navigate through the healthcare system.

Fernando, who is managing his diabetes and seeing a nutritionist, talked about the systemic barriers associated to following a diet regimen that is in sync with the food pyramid. The time it takes for food preparation is also another barrier Fernando faces, but his wife is the one that usually prepares his food. He relies on her availability to have the time to cook the prescribed meals or else he finds it nearly impossible to follow the food regimen. He says, "Well, sometimes, she, well, sometimes she does have time and other times she does not, and one[himself] well no, we don't take up or put too much effort into [the diet]." He says he will attempt to do some of the work sometimes, but admits that if it is up to him, he will be way less successful in following the instructions of his nutritionist than his wife.

A question that emerged as I found this gendered relationship is that if many of the participants relied on women for their health information and navigation of the healthcare

system, why did they not always listen to their advice or hide information from them? Erasmo perhaps brings the best insight on this issue. He and his wife go with one another to their appointments and rely on each other heavily in other matters as well. Erasmo and his friends talk about health and are encouraged to take certain health actions by their wives. He notes that sometimes he hides certain things from his wife, that this is a common practice among his friends as well, and wives act in this way as well.

> *Well sometimes there are things that not even the wives know, and things that the husbands do not know about their wives. In couples many times we want to appear to be one way or another, to be firm, even though you can see right through it.*

However, he perceives that his identity as a man overpowers every piece of knowledge regarding positive health and health-seeking behavior. He says, "Sometimes we don't want to give the shoulder in to be bent," which is a way of saying that he does not like to give in, "and that's why I hide my illnesses [from her].

As has been reflected in other research, participants also displayed hesitated to adult ask their children for help, as they thought of that as an added burden to their children (Igarashi, Hooker, Coehlo and Manoogian 2012). When I talked to Moses, 65 and married, about his hesitance to go to the emergency room when he was feeling ill he responded:

> *"First of all if I would have gone to the ER at night, I'll be there all night, I won't get treated until morning…I'll be stressed about waiting…then it would have been a stress for my family….I didn't want to bother anyone.*

However, he like many others relied on his adult daughters and wives to take talk him through the healthcare system. Two of his daughters work in the health field and clarify information on prescriptions and tell him to go to the doctor if his symptoms seem serious enough, and another one helps him translate whenever he needs.

Gender relations within the healthcare system are complex, and yet they represent what research says about how power-relations within structures work. Older Mexican immigrant men have power relationships that are unique to their histories. In Mexico, while in poverty, most of these participants were not marginalized, they were part of a majority. They often cross the border as Adan, Marciano, and Carlos often do, and they become the majority there, having comfortable patient-doctor relationships. While I will discuss this more in Chapter 7, those participants who have female providers in the United States did not view them different from their male counterparts. When in the United States, all participants experience the healthcare system with more power relations inequalities than in Mexico. In addition, their relationships with the women in their lives changes dramatically.

The near complete surrender of healthcare navigation to the women in their lives is two-fold. The first is seemingly flipped power-relations, whereas women seem to be empowered within a system and men heavily rely on them for information, and access to assets within the healthcare system. The second is the work of implementing prescribed healthy behaviors. In both instances, women provide the open door, the light, and the foundation for men to walk through the halls of the US medical care system.

Both of these issues of surrender are complicated for women themselves. First, their gender is associated with the emotion tied to illness. For men, illness is what they associate with as a sadness and a loss of autonomy, which is being able to do the things they want to do. This gendered idea of the health care system is not unique to the men, as the system itself categorizes many things within its system by using gendered language and assigning certain diagnoses by gender (Kemper 2006; Martin 1996). Gender brain research that reveals how men and women have different roles in the social structures based on their innate strengths and

weaknesses are problematic at best in their science (Jordan-Young 2010). Science and health are examples of structures that replicate differentiated roles for men and women, and which gender the notions of illness. These constructs make the role of women as points of entry into the US healthcare system for the men in their lives ideal. Women seemingly have more power in the system than men in the study did, but this is more due to the fact that women are much more medicalized than men (Riska 2010).

The other issue for women when complete surrender of navigation is given by men is that it is invisible work. This work goes unrecognized, sometimes by the husband, but always by the healthcare system according to the interviews, and in both instances, this work goes unpaid. I rely on two of Arlie Hochschild's works to analyze this issue. When the women were present, none of them complained about having to be the navigators for their husbands or fathers, though some told jokingly stories of how the men in their lives did not always do what they wanted them to do or only went to the doctor under heavy persistence on their part. These joking mannerisms, whilst describing a heavy workload of convincing men to engage in health-seeking behavior was a form of emotion work. The comforting of men and pushing them while not perceived as disempowering them is an important balancing act. According to Hochschild, this is a type of emotion work, which involves mediating how women are supposed to be acting as supporting roles at the same time they feel the expectation of providing the care in their home (Hochschild 1979).

Another aspect of the issue of invisible work is that this work actually adds to their already heavily unpaid labor within the home. Women are in essence doing navigation work on behalf of the healthcare system when they are connecting the men in their lives to resources available in the healthcare system. This unpaid work is part of their second shift in the home, or

perhaps a third shift as it occurs in the home and within the walls of the US medical system (Hochschild and Machung 1989). Women are uncompensated, which is no surprise since this work is often not mentioned for any other purpose than to joke about how men are stubborn and women force them to take care of themselves, or as Erasmo talked about, a war between couples as to who gives in first. However, the invisible, uncompensated reliance of women for navigation has serious consequences. There is a lack of sharing of resources on behalf of the medical care system to the women in the lives of men. As was revealed in the interviews, a life without women navigating the system for Mexican immigrant men would ensure massive non-participation from men.

Going into the study, I did not expect to find such drastically divided labor of healthcare work between men and women, both in the home and in the healthcare system. I expected more of what Erasmo talked about, that men avoided the system at all costs, and women more or less coerced men into visiting the doctor. However, men persistently sought out assets within the healthcare system, which for the most part is a consequence of the hard labor they engaged in most of their lives and their lack of access to healthy and secure foods and environment. In order to successfully attain those assets, they relied on women to help them enter the system as well as sustain their prescribed healthy regimens. This comes as an added responsibility for adult women, and the amount of work they do is largely unnoticed in the literature. While community health workers in immigrant communities have been largely women, these roles are underpaid and not a reliable source of long-term income (Koskan, Friedman, and Messias 2013). The idea that men do not want to seek help was not the case as seen in this section, and their motivations to seek care and maintain a healthy status also contradict what some of the literature says about Latinos and fatalism culture.

Fatalism Myth: "God wants me to help myself"

In a 2007 paper, Sharon Brown reflects on the numerous intervention studies that have been conducted in Starr County, Texas. This population is important for research on Mexican American elders living in the United States because of the high incidence of Type 2 diabetes in this county among this population. It is estimated that over fifty percent of this segment of the population has diabetes. Despite negative odds, researchers have been able to study this group in depth due to several key factors (Brown 2007).

First, the population can be retained throughout the length of the studies at high levels (90% in some studies). In addition, participants are able to overcome the assumed genetic predisposition to diabetes, as was evident in several interventions where participants were able to reduce their HbA1c levels without medication. When participants perceived they had control over their diabetes, they had lower HbA1c levels, contradicting most fatalism theories that Mexican Americans will see their diseases as fate. Finally, the use of community health workers, people from the Mexican American community serving as navigators during the interventions, facilitated their success (Brown 2007).

I begin this section talking about Luis. He is a man who has lived in the United States most of his life, and is comfortable speaking both in English and Spanish. When meeting him, I notice that he was very interested at the notion of participating in research, and skeptical about what he could say on tape. However, he quickly opened up when his wife disclosed to me that he hated to go to the doctor. Instead of going to the doctor, even though he was insured through his work, he relied on self-medication and withstanding the pain for many acute issues. He frequently declined services, which I will talk about in the Chapter 7. When he stayed in this mode of inaction in regard to his health, he did not attribute it to any outside force other than himself.

> *No, I have never said "God, why have you done this?" If this is happening to me I don't question why it's happening. It's not because He sent it to me. If something is happening to me it's probably because of something I did, it's not that He sent it to me."*

When I asked him if God was capable of curing, he quickly responded:

> *Yes, if you do good things and pray in good faith. A lot of people say it doesn't work, but He's not a doctor. As the saying goes "God helps those who help themselves." If you don't put anything on your part-- that's how I think. I always think about that. When I wake up I thank God for giving me another day of life. I go to sleep and I hope to wake up in the morning. But I've always had a good mind; I always think the most positively that I can.*

Another participant who talked about God and the role of God in his health, on his health behaviors and attitudes about aging and illness is Roman. Roman is a man that at 65, has been diagnosed with prostate cancer. When he talked about how he managed his life in spite of the depression that came with having cancer and being separated from his family due to past alcoholism, I asked him if in spite of all of these barriers he still felt compelled to follow through with all of the recommended treatments. He responds:

> *Yes. Yes because that is my lot in life. And who am I to harm myself? I don't know if you understand me, if God gave me life it was for a reason, right?*

Roman actually sees his cancer diagnosis as a way to grow as a person, and this outlook is rooted in his belief in God. "I know very well that God has given me this privilege-- I'll call it a privilege-- because not every person is capable of dealing with this experience."

Finally, I return to Roberto, who enjoys walking regularly and had trouble leaving his habit of eating up to a dozen tortillas a day but did so because he enjoys walking. Again, the autonomy of walking around, visiting his friends, and doing his yard work keep him eating things that will not make his diabetes got worse. I asked him about his religious affiliation, and he pointed that he was Catholic, that this was his belief in God. When it comes to health, he knows he can ask God for help. He says, "Well for example, if one is ill, you pray to God, that

he brings health and all of that." For him, it is both about listening to the doctors and internalizing the notion of control over his health.

> *At first one starts to think many things that I'm going to die, now that I have diabetes, this and that. However, like the doctors say, "You carrying out everything under control, can last much longer than one who is good and healthy," they say, "being in control." Because I say that there are a lot of people that don't take up their diet, don't take control.*

Again, we see that the notion of God being present for participants is real, and that they rely on the presence of God for their health related issues. However, when it comes to explaining their behavior or their health outcomes, they refer back to themselves, and the role that their own behavior has in the matter of health. Further inquiry is needed in distinguishing between men's perspectives on the role of God in their health outcomes as compared to women. This analysis and future analyses must also problematize the overemphasis on personal control over health that participants displayed when discussing the role of God.

Systemic barriers to healthcare are present in both the lives of men and women who live in the Central Valley and who have had similar experiences in the healthcare and labor markets. However, it seems that men internalize the risk of illness and burden to change their behaviors. As masculinities theorists have pointed out, this overemphasis on the individual and the capacity to shape one's own future, even as men are plagued with chronic diseases and injuries that stem from systemic barriers, can have deleterious effects (Connell 2005; Riska 2010). Therefore, the analysis shifts in the next chapter to underscore the minimal role of masculinity in abstaining from care, but also that the role that masculinity plays in healthcare behaviors is still significant.

Complementary and Alternative Medicine Uses

The use of complementary and alternative medicine is an important measure of the interaction between populations and the healthcare system. While it is recorded that up a wide

sector of the US population uses some form of complementary medicine, it is not known exactly what motivates each subpopulation to use this medicine and in what way. However, among the older US population, their use of complementary and alternative medicines is largely unknown by their health care providers (AARP & NCCAM 2010). This section is intended to illuminate a part of the health seeking map in which participants ride on the borders of the US healthcare system, stepping back and forth between allopathic medicine, complimentary medicine, and for some, resisting and seeking alternative medicine.

Mexican immigrants are like other migrant populations, whereas they interact with a number of cultures, not just their own home culture, and this influences their take on alternative medicines and the type of complimentary medicines they engage. One place where this is illustrated is one of the flea markets where Mexican immigrants frequent in the rural central valley. In this place one can see Mexican alternative medicinal products, such as garlic, cactus, and other natural ingredient pills, powders, and liquids. There are also a number of allopathic Mexican products for sale, whether it is Mexican branded ibuprofen to illicit products like Mexican antibiotics and prescription grade naproxen. In addition, Chinese herbal medicines also abound the isles of the flea markets. Mexican immigrants live in a multicultural world of complementary and alternative medicine.

Motivations have both to do with systemic barriers and interpersonal beliefs about treatments that work for some things better than allopathic medicine. Participants in my sample reported that they only use alternative medicine for small aches and pains, and for everything else, they only use over the counter drugs or natural remedies or treatments as complimentary to the care they receive from the US medical system. This is important, because it points out that men are not living their lives at the peripheries of the system. Once they have decided to seek

serious care, they will look for it within the places of care available to them within the medical system. In fact, when they do use some type of alternative medicine or go to Mexico for care it is because they have encountered some sort of systemic barrier here that has prevented them from getting the assets they sought out from the system. Enrique experienced frustration with the US medical system, which led him to go to Mexico instead.

> *I would take a lot of aspirin or Tylenols to be more or less at peace. But when the medicine wore off either a lot of cold or a lot of fever hit me. So then I went, the doctor checked me she said "you don't have anything Well! And then I paid a part of it because I didn't have all of the money complete. So then I felt worse every day, more, more, and then I told my daughter take me out a plane ticket I am going to go to Mexico.*

When it comes to alternative medicine, the primary point of analysis is the native knowledge that gets transferred from Mexico to the United States. This knowledge gets transferred as a reference to culture, and beliefs, but also out of necessity. Both reasons are equally important and carry consequences for other systems beyond medicine. For example, Samuel knew that a teaspoon of oil will heal his stomach pains, and he carries that knowledge from his town and his family in Mexico. With pride, he talked me through a number of plants he knew that were useful for things like inflammation, muscle and stomach aches. His dad was the one that taught him what the plants were good for and how to prepare them. Now in the United States, he says people tell him when something hurts and he recommends a certain plant, oil or pomade for them to apply. However, he notes that not everyone takes up his advice because they do not believe in herbal medicines.

The consequences of retention of cultural knowledge after migration stretch to the economic sector as well. For example, many of the beliefs about plants and oils that were of common use in Mexico are now being mass produced and can be found at most local and

national chain drugstores catering to the Mexican population. As my husband and I waited in line at the pharmacy counter of a national chain drugstore, there were stands of bottles and powders that had Spanish names and included things like cactus-filled pills for a series of ailments. This is part of the larger worldwide phenomenon of plant medicinal knowledge traveling across towns and borders.

The ownership of this knowledge is problematic, as it is dispersed beyond local, state, and national borders and thus finding it's one originator is difficult. Within one generation of migrants studied in this dissertation, national movements were just as common as the international migrations. Mexico is one of many countries where large migration trends have occurred for centuries (Mexican National Institute of Migration 2011). As more and more drug development in the global North has emerged based on natural remedies used in countries like Mexico, Brazil, China, and many more in Africa, questions of compensation for native knowledge has emerged.

Samuel's family in central Mexico have used plants like arnica for generations, yet they do not receive compensation for the many homeopathic lotions and oils that are sold in stores, markets, and the internet. However, as historian Abea Dove-Asare found in Africa, compensation for knowledge is complicated, and the knowledge has traveled so far that it is nearly impossible to say where it originates (2013). This however, does not take away from the fact that people like Samuel have migrated from poverty while there are companies that will benefit from knowledge that has been passed down to him from his families. Some companies will not compensate for the use of this knowledge, but most will have the notion of compensation needing to do to individuals rather than villages (Dove Asare 2013).

As I mentioned, traditional medicine knowledge has not always been retained for cultural purposes only, but out of necessity. Josue and his wife said that their reason for recurring to a masseuse or sobadora is that it is too problematic and costly to get referred to a specialist and then pay for the injury. Josue is currently struggling with persistent pain in his knee, when I asked him if he mentions it to the doctor, he said the doctor tells him it is arthritis and tells him to take Tylenol. He thinks that this is the doctor's response because of his lack of health insurance.

> *They don't recommend that you go to some specialist because of a lack of money. I go to the doctor for low-income. When you have insurance they tell you to go to a specialist. But for us they think "He can't pay for a specialist that costs $1500 or $1600." So they just say "Here take these aspirins and when it hurts take them.*

So instead, he goes to see a *sobadora*, an informal masseuse, who is a friend of the family. They like her and even talked to me about seeing her if I needed. At this moment, I saw how easy and prevalent the spread of knowledge about alternative medicine is within the Mexican immigrant community. Any conversation about health is an open invitation to transfer knowledge about people, plants, and places where one could find another type of treatment outside of the US medical system. Josue's wife tells me about how the *sobadora* can also cure evil eye, which is a belief that a person can fall ill from someone looking at them with envy.

> *She is very good. When the kids needed help after playing soccer, that girl would help.*
> His wife adds: *If you have indigestion, she'll cure you too. Indigestion. If you're scared, she'll pray for you. Or for the children that get ojo [evil eye]-- you know about that right? Who get ojo, that too. When you want, just call me.*

In this chapter, I have explored the health seeking behaviors that older Mexican immigrants engage in, how they do it, and their motivations to engage in such care. I propose that at the core of understanding their healthcare behaviors is understanding what they seek

from the US medical care system and the barriers they face to gain what I call, healthcare assets. In addition, there are actors that facilitate their journeys through the healthcare system as well as those that are involved in creating and sustaining the barriers. This is the social world in which all healthcare navigation will take place for older Mexican immigrant men. The individual decisions that they make are shaped by their internal motivations, their identities, and the type of care they seek. Those decisions are then filtered through the barriers that they and other marginalized populations face in the United States.

This web of connections leads to a new understanding of how individual decisions shape behaviors. Past debates have focused on two polar conversations about how Mexican immigrants and elders seek care. The first camp looks at the decisions to not seek care as deterministic, where their fatalistic attitudes leaves them resigned to a sick, and deadly fate. The other focuses on the systemic barriers, and how interventions that address issues of language, health insurance, literacy, and transportation can lead to more use. Both have been incomplete at capturing the portrait of an older Mexican immigrant man seeking healthcare in the long-term, for both acute conditions and managing chronic diseases.

Their decisions to seek care start with how their identities as males, breadwinners, immigrants, and heads of household shape their ideas about what is worthy of seeking care and what can wait or be treated outside of the US healthcare system. These identities have been shaped by their histories as marginalized individuals working in hard labor for most of their lives. They are not able to navigate the system by themselves and thus seek help from their community networks, their wives, and daughters. Contrary to some beliefs about fatalism among this population, participants stated that they have an active role in the sustaining of their health, and God is only involved in healing if they cooperate, or "help themselves." While they

use herbal or over-the-counter medicines as complementary are, their reasons to do so are sometimes out of necessity. At each of these decision-making points, they are using their own decision-making to navigate through the healthcare system and its barriers. In the next chapter, I talk about instances when they chose to stay directly outside of the peripheries of US medicine. Even then it was important to understand that systemic barriers are playing a role alongside individual familial decisions.

Chapter 7: Identifying Agency through Identities while Navigating the US Healthcare System

This chapter analyzes how agency is enacted in garnering knowledge to construct health, and I describe how men articulate what it means to be healthy, and how they will engage with the healthcare system. These are stories of men who have chosen to behave and think outside of the prescribed confines of what biomedicine prescribes to individuals about health and illness, and how patients are supposed to behave. These messages are not difficult to grasp and participants were very aware of what society, and the healthcare system wanted them to do to be healthy. However, these are stories that go beyond blatant refusals to health prescription; rather, they are ideas about health that translate into behavior that may seem like compliance to participants but not to the system. In other ways, men's behavior may be purposefully noncompliant because compliance would mean restriction of a greater valued state: the state of autonomy. Therefore, the chapter attempts to distinguish how their identities are shaping their agency as well as the systemic barriers that drive their decisions to abstain from healthcare.

To begin explaining the data found in this category, it is important to define both agency. The idea of agency in this dissertation is grounded on Pierre Bourdieu's understanding of habitus. The habitus is a way in which we achieve goals, without being conscious that this is the process by which we are attaining them (Bourdieu 1980: 53). Habitus is shaped through consumption, relationship dynamics, and cognitive beliefs about the world we live in. All of these things that make up habitus are not unique to the person. Rather, they have been developed through what Bourdieu refers to as a "collective history (Bourdieu, 1980: 54)." The shaping of habitus then is the interplay between the conditions in which we find ourselves and the actions we take under those conditions (Bourdieu 1980: 76). Therefore, agency can be

described as the performance of actions and thoughts that are reflective on the power relations of the agent and the social systems within which he or she operate (Caldwell 2007). This type of agency allows the actor to engage in certain behaviors that are personal, but that are also shaped by the social structures that surround the actor or agent.

Finally, it is important to describe other research that has revealed similar findings to the ones found here, where people knew about health behaviors and their consequences, but chose not to engage. Lupton and Chapman (1995) documented that an Australian sample of adults was well aware of the behaviors and lifestyle that contribute to a prevention of heart disease, they reported their annoyance and resistance to such knowledge. While Lupton and Chapman observed that when participants engaged in behaviors prescribed as healthy they saw it as an achieved status, participants in this study did not relate it to health status, rather their ability to retain autonomy.

Webb and Quennerstedt (2010) studied how physical education teachers knew about the dangers being overweight and injury and embodied the need to live up to these ideals. However, the teachers were not living out these identities, as some resisted living up to being young, fit, models of health. Again in these findings, there was a need to live up to this health ideal, while in this study the sample talked about the ideal being an autonomous body. Being able to move around as they pleased was more important than an abstract perception of health as an adherent citizen. The idea of citizenship will also be discussed in this chapter.

The messages that have been crafted for the United States population what healthy means and what healthy behavior should look like are clear and ubiquitous. They are on billboards indicating that Americans of all ages should strive for wellness, on TV screens that reveal shows where people go to great lengths to be thin, and only the beautiful thin people are

worthy of seeking a life partner. They are also in newspapers, radio and the internet where messages reveal the latest research that tell the populace what they must do to live a longer, happier life. Even as this research is fluid and contradicting over time, it is revealed to Americans with great vigor that if people are not doing everything possible to be "healthy" or "well," they are not taking their citizenship seriously and instead of taking charge of their personal responsibility they drag the rest of the system with the costs of their healthcare.

Identities of a patient, older patient, male patient, informed patient take different meanings as we move from the systemic to individual meanings. We can take Barthes notion of horizontal and vertical with Homi Bahba's politization of identities to illustrate this point (Bahba 2000). The horizontal systematically predetermined notions are about what these patients are supposed to think, look and act like. On the vertical plane there are symbolisms of what those identities look like to those who are being identified in these categories. In attempting to define agency among older Mexican immigrants, part of what I attempt to draw out is how these two directional planes of identification are revealed in their interactions with the healthcare system.

The data revealed that participants overall perceived themselves as compliant patients of the United States biomedical healthcare system. However, they along with the healthcare system do not see how the symbolism of what a compliant patient means takes another form completely when this identity is taken up by the patient. Participants thought they were compliant patients without resentment towards their doctors and grateful for the healthcare system. Through their behavior, it was evident they were resisting the horizontal definition of compliant patient. When the health care professionals learned they were not taking their medicines as prescribed, did not do preventive screenings and lab tests, or negotiated their

health regimens, they were seeing non-compliance. While systemic barriers no doubt contribute to their behaviors, it is important to see the individual thoughts and ideas about who the participants perceive they are within the healthcare system. This is consequential both to the health status of patients and how the healthcare system and society at large respond to their behavior.

The data showed that overall participants had very positive views of their doctors, the hospitals or clinics hey attend, and the US medical system at large. Roberto, who lives in a rural town and migrated to United States from northern Mexico as a young adult notes that he frequently interacts with the health care system, and has no complaints about it.

> *Well I say, in all of the doctors that I have gone to see, they have all treated me well. I don't have to complain about any of the doctors. Wherever I have gone they have treated me well.*

This was the overarching sentiment that men had towards the system, few were disgruntled, while some expressed mistrust in certain cases. The key here is that while their overarching sentiment was positive, in a case-by-case basis, they expressed discomfort with seeking care and expressed moments when they absolutely refused to seek care.

Roberto's journey through the health system reveals just how patchy a picture we have of the health seeking behavior or this particular population, but potentially many others.

> *When I'm sick with the flu I never go to the doctor. My wife tells me I should go because diabetics can have complications…. Me with the flu all I do is give myself a [rubbing] alcohol bath, with that I cut the flu….you give yourself a bath of alcohol and then you cover yourself to sweat it out. The next day you start feeling alright. I don't think that it complicates things, because it doesn't have anything to do with the medicine I take.*

There are undeniable systemic barriers that impede men from seeking care. I asked Carlos about why he would sometimes avoid going to the doctor. He recalled a time when he had to go to the emergency room.

> *I used to go and help my brothers in the ranch over there, but the work in the fields is very tough, and since I never drink water, when I came back I came with intense kidney pain. I bent down and when I wanted to come back up I could not. From there they took me to the emergency room and there you are dying until it's your turn. I couldn't move until it was my turn.*

For him, the thought of emergency rooms means long waits where patients must endure pain and wait for their turn. Previous research on this reveals that what Carlos perceives as a cruel waiting period is tied to larger systemic barriers at play. For example, long waits in the emergency room are a complicated mix of federal, state, and local policies along with hospital administration procedures that are beyond the reach of the doctors, let alone the patients, to change (Pacheco et al. 2012). However, at the micro level, Carlos only sees the waits, and doctors only see the next person on their list to treat, and this has great influence on decision-making for Carlos and others like him to abstain from care or to seek help.

Masculinity as Machismo is not an overt driving factor to abstain from seeking care

Mainstream science continues its infatuation on the scientific findings about innate brain differences between men and women even though they have methodological issues that are often overlooked (Jordan Young 2010). On the cultural side, the stereotypical notion of a Mexican male has been constructed as the "Macho," the mysoginstic male who sees women as inferior persists in images and even within the healthcare system when an attempt to explain why men refuse to go the doctor. As I was doing this project, I encountered civil rights activists, health professionals, social workers, and average citizens who had one uniform answer to why men did not seek care, "Oh, it's because they are too macho to go to the doctor." Neither brain science, nor cultural anthropology, nor common beliefs reflected the answers that men gave for abstaining from care.

On the interview guide, one of my first questions about health conceptualization was if they believed women experienced health different than men. The answer was a resounding no. All of the men I interviewed said women and men experience health and illness the same. The men did not see that their experiences were different from women physiologically, and this shapes how they do not see them as experiencing the healthcare system differently than them. However, participants did not problematize the relationship between them and women within the healthcare system juxtaposed with their power dynamics at home. Healthcare navigation management was the task of a woman if there was one available in the household. Refusing to go to the doctor in respect to their masculinity was less about them being too tough or Macho to go to the doctor, and more about the dependence on women to navigate the system for them in addition to their masculine notions of retaining autonomy over their lives. While masculinity was prevalent in their reasoning for not seeking care, it was not from the notion of being too manly. Other masculinity research has also talked about the oversimplification of machismo among Mexican immigrant men, which is also evident in this sample (Broughton 2008).

I go back to one of the participants I described before, Humberto, who migrated here as in his twenties and illustrated his perception of health based on an 80 year-old man who is still working in the fields. He describes his health, like many as the ability to work. However, he is different than other participants who have retired, because he is still struggling with the notion of working while injured.

> *Well when one is sick, one simply cannot do the job that one has or one wants. If I am at the house well I don't like to be inside. I don't like to be inside, so I go to work and well sometimes I go with the pains in my heart. I don't tell anyone, it almost always hurts. If it hurts or not, I just [stand the pain] ...Do you get it?*

I asked if what barriers he faced when talking to people and why he did not feel comfortable telling others at work.

> *Well, let's assume there are other people that can understand you, with whom you can talk, and also there are other people that speak to you like if they were talking with an animal who will say they don't care about anything…but there are people who know, because there is one person I am always talking to, and we can understand and comprehend one another.*

While men had a close and substantial network of people they had developed over the decades since migrating, participants talked mostly to the women in their lives regarding health. This has both to do as Humberto says about lack of understanding from other men, but also the emotion associated with illness that was discussed in Chapter 5.

I asked another participant what he thinks prevents people from telling others they are ill. He did not refer to his gender, or his needing to be a man. Rather he pointed to the vanity of appearing what a person is not, in this case, appearing to be healthy when a person is actually ill. While masculinity may be at the core of this, his conceptualization is about his own status within a group, and masculinity, along with many other identities such as father, worker, leader, are working in tandem to prevent him from speaking out about illness or needing health care.

> *Well many times because, see, there are many of us…we are vain, we want to show off what we are not. Many times because of shame also there are things that we don't say. You don't want people to know so you don't say it.*

Erasmo touches on this very concept, the notion of how vanity impedes men from seeking help or engaging in health sustaining behaviors. He has a lot of friends who have begun to seek the detrimental effects of diabetes. While he is not diagnosed with diabetes, the doctor has told him many times that he is pre-diabetic. Several participants mentioned vanity, which seems difficult to analyze, were it not for Foucault's notion of surveillance (Foucault 1975; 1979). Under a Foucauldian analysis, the men in this study have received messages about staying healthy and engaging in health-seeking behaviors when needed. They have received these messages externally, but most likely from their wives or adult children who have been the

ports of information as immigrant men enter into their roles as American citizens. They are indeed expected to thrive in this role (Ong 2003).

> *Well the temptation of things that one should not do but does anyways. For example, food. To say it this way, look, if you go to your kitchen and you are very hungry and they tell you that you can't eat that but you are so hungry. They tell you this and that, but if you are diabetic, if you don't die from hunger, you are going to die from what you will eat. In any case, you are taking a risk. So you just end up eating well at least, in case of emergency, a taco or something, as an emergency. So that is what is hard about this.*

In this case, Erasmo presents shows how participants perceived health regimens as constrictive. In this narrative Erasmo takes me on a hypothetical journey into his kitchen, where even as he is alone, "they," which can mean anything from the medical professionals, public health messages, or women as the vectors of these messages, are ever present as surveillance. Men as immigrants and as having received most of their health-seeking information from women make them an example of how medical knowledge and behaviors become part of citizenship in a society that genders its medical knowledge (Ong 2003). Their citizenship then depends on adoption of the messages not just through direct enforcement but also through their own self-enforcement.

Even though as adhering to guidelines about diabetic eating regimens are laid out, and expectations are clearly understood, men still abstain from following these regimens. Erasmo lays out what for him is ultimately the deciding factor on his actions- the risk/benefit analysis of adherence. He does not just see risk as something that will result from his non-adherence, but his adherence as well. This finding was not expected, and others related to notions of feeling dizzy or, *morirse de hambre*, which means dying of hunger because of adherence to restrictive dieting regimes.

Erasmo's life as a migrant, first an undocumented immigrant and then a seasonal worker has produced a life that while stable geographically in the Central Valley, carries much uncertainty about citizenship, economic stability, and health. It is not surprising then that even in his health regime, his role as immigrant influences his decisions about how to live out his life and decisions on healthcare and health sustainment on a case-by-case basis. If he is in a hunger emergency, he states, he will go ahead and eat what he feels is needed, without regard to his prescribed diabetic diet. For him, his role as breadwinner and an immigrant male drive his masculine identity. This is different than an inherent need to be a rough, sturdy male that protects women, as machos are perceived. While Erasmo is not devoid of some macho-isms entirely, there are an array of other feelings and attitudes that are more about his immigration and breadwinner identities.

Erasmo goes on to further explain the situational importance of his decisions. When I inquire further about situations in which he would not follow through on his diabetic diet, he gives me the example of being at a buffet.

> *When you go someplace and everyone is just there eating, even if it is not a buffet but like it. They are eating and invite you to eat and all of that. Even if you really want to, in order to not insult someone and also because you know you like it and everything will already be all prepared for you.*

This narrative that Erasmo presents was also talked about by numerous other participants under a diet regimen and carries both clinical and theoretical implications. Clinically, participants described how the key to their diabetes education is self-preparation of food, which for them, inside and outside of the home, they do not perceive themselves as always in charge. This notion of not being in charge again further disputes the "macho" narrative for not seeking care but also speaks to masculine identity concepts. Culturally, they

are not in a place where they are in charge of food preparation. However, they do not perceive this as a badge of macho pride rather helplessness and them resisting adherence because they are in a passive role, although they still make the decisions themselves to eat, they feel culturally obligated to do so.

Masculine norms of what it means to be is at play. This masculinity is in the background of their larger social surface as aging immigrant men. Some participants feel that there are economic restraints to engaging with the healthcare system. Others feel that their identities as breadwinners have been situational for much of their lives because of their immigrant status and thus they also perceive health seeking situations and adherence to regimens as situational. The interplay between masculine identity and their social situations create the driving factors to not seeking care, rather than just one or the other.

Previous chapters point to how conceptualizations about staying healthy and what health and illness mean are gendered. Motivations for not seeking care are also gendered, as many participants related their not giving in to illness as a form of masculinity through vanity. However, the systemic barriers that are involved with giving in or adhering also lead to decisions not to seek care. While these motivations to not seek care may appear on the surface to be overwhelmingly about systemic barriers, participants also revealed a sense that there was not any type of intervention that would make them change their minds about not seeking care. For them, revealing their illnesses is relinquishing control, both from the medical system and the women in their lives but also to self-control based on the biomedical model. Therefore, the points in which they intervene are those where they are grasping that control back based on their own priorities as older Mexican immigrant men. In the next section, I discuss how this control

is asserted not just in the decision-making process but during interactions with the healthcare system.

Yes Men and Just Fine Men: The doctor patient relationship

"Yes" and "Just Fine," two phrases I most often heard when participants were describing instances when they had decided to not adhere to biomedical rules. I also heard this from many of the women present in the interviews and during my ethnographic data collection process as they recounted how they interacted with their husbands or fathers when they asked them about their health status or their interactions with the doctors. The most important aspect revealed in this section follows one of the trends the interviews revealed that were contrary to my beliefs about why men did not adhere to their regimens and as the literature states. While the literature attributes non-adherence as having to do with things like literacy, previous chapters have revealed that men did not have literacy issues. My own pre-conceptions guided my understanding of their non-adherence as pure mistrust of the system. The interviews do not reveal a middle ground between previous literature and my own hypothesis, but rather a third space where men do not see themselves as recalcitrant or judgmental, and lack of understanding the doctor's orders comes from a space where what the doctor is saying and what they are feeling do not match.

I start illustrating the interesting relationship between patients and their doctors with Marcos. Marcos has been going to the same doctor for nearly two decades. They are on a first name basis. Marcos knows a bit about the doctor's family and the doctor knows Marcos and his family's medical and personal history well. There is never a sign of contempt when he was describing his doctor, or the US medical system for that matter, he is very grateful for the medical resources allotted to him through his insurance. However, when it comes to the level of

control that the doctor is able to take over the health behaviors of Marcos as he manages his diabetes, he approaches it with skepticism.

> *I don't take all of the pills that he [doctor] tells me to take; I only take two and I have to take three. I only take two every day...sometimes I don't take any.*

When I ask the participant why he does this he responds: *I feel good!* Marcos' skepticism is not because of some larger distrust of the medical system, rather, because he does not "feel" the difference between adhering to the medical regimen and how that will interfere with his idea of health as autonomy. When I asked him how his labs turn out when he gets them done, to which he responds *"Perfect!"* The gender of the doctor is non-consequential in the type of relationship participants had with their doctors when it came to their behavior. Some were more likely to feel a friendship relationship with their doctors if they were from the same sex. None were more likely to trust a male doctor over a female doctor. Antonio for example, had a male doctor for many years who he formed a friendship with, but now he was assigned a new female doctor at the clinic he attends. He says, "I don't know what her name is, but she is very good, she a very nice person with me. She treats me well, you can tell they like and take care of you there." Participants had positive attitudes about their doctors, and regardless of whether or not they had a friendly relationship with them, they were no more likely to comply with the care prescribed to them by friends, males, or female doctors.

Relationships with doctors are complicated, as their interactions rely first and foremost, on the patient being able to relay information to the doctor. Don Simon has had a number of medical issues, and while he revealed many more of those once the recording was off than on, his actions captured a characteristic of interactions he noted having with medical providers as well. When I asked him about his interactions with this doctor, he summarized it as this:

"When I'm at the doctor, I feel fine." His wife added, "He always tells the doctor he doesn't feel anything, yet complains to me." Other participants characterized some of the interactions with their doctors or specialists in the same manner.

This is just the beginning in many of the barriers that are related to relationship dynamics rather language barrier issues. This issue goes beyond the participants, and through my experience as a patient advocate for many people, have encountered this many times with people regardless of gender, ages and socioeconomic status. It is not always the issue of forgetting to tell the doctor something, but sometimes it is intentional reservation of information. Some research points to the cause of such a disconnect between what is said and what is withheld to be related to the expectations patients have of their doctors (Britten, Ukoumunne and Bolton 2002). These expectations are related to their conceptualizations of health. If there is a threat to their autonomy by disclosing information, or if they feel like the doctors will not be able to help them, then they will not disclose.

The communication between the doctors and the patients is not just a two-way conversation for Mexican immigrant men. The adult women in their lives also facilitate the communication, and so there is another added breakdown in communication that happens. Antonio goes to the doctor by himself sometimes, and then does not always communicate everything back to his adult daughter Lucy, who helps him with implementing all of the things his doctor says. Antonio will go to all of his appointments, but the interactions are processed and summarized as "I'm good."

Participants not only rely on their own bodies and their autonomy to do their preferred activities to opt out of certain parts of the healthcare system, they also use biomedicine itself. Most participants were knowledgeable in what type of glucose levels were healthy for them,

what cholesterol levels were concerned within a healthy range, and what blood pressure was preferable. One participant describes his refusal to continue to do the recommended three and six month periodic blood and urine tests for glucose, cholesterol, and prostate cancer markers.

> *No, not anymore. The doctor wants to send me to the specialist and I say, "No, no, no, I feel fine." She tells me, "Well, we are going to send you so that you can get your tests done. She does the tests for the prostate and everything. They take out four or five little bottles of blood, yes…She has also told me "Yes, yes you are well, you came out fine, and you are fine." So then I say, well I must be well, you see?*

Given these tests come out normal, he does not see the need to do them so often. He tells the doctor, "Don't give me any more tests because my arm hurts from all those pokes that they give me." In addition, he has decided that he will wait until absolutely necessary to do a new blood test.

> *I don't get them done every three months, but after I take a while the doctor tells me, "I have to run them on you." It is okay, it's fine, I know that they know what they are doing, I know they know…but yes, I don't want them so often, I feel better once she makes me do them every six months.*

This narrative also reveals the type of negotiation that happens when participants choose to engage in some part of the health care system, and that doctors are willing to do this negotiation with them as active participants.

While passive when communicating with the adult women in their lives and their doctors, participants are also negotiating with the doctors about their regimens. In addition, they are enacting their agency to make their own decisions about their healthcare. Marcos and Antonio illustrate the stories of participants who knew what the implications were for not adhering, did not have immediate systemic barriers to prevent them from following the recommendations of their doctors, and still chose to resist.

The ways in which they enact agency are subtle, yet have a huge impact on their lives. This type of behavior is geared towards the type of medical care that is focused on their lives beyond sexuality and their male hormones (Riska 2010). Men in this study are dealing with chronic diseases, recovering from cancer, and navigating all of the risks, technologies, and body disciplines involved. Men are interested in body enhancement insofar as it relates to their autonomy, not their sexuality. They will therefore resist medical systems to redefine what they feel is healthy, and the level in which they will engage in the technologies like medical screenings or bloodwork (Foucault 1970). Again, it is important to underscore that this is a redefinition, not adherence to what biomedicine considers as "healthy."

Interpellation, as described by Althusser (1971 in Hall 1996/2002), is the way in which subject and structures, each taking part in the identification of the subject, redefine it as something new. While the behavior of participants as they abstained form health care in one way or another may make them sicker by biomedical terms, it may not be making them less healthy. Some actually take up the biomedical knowledge, as Matias does, to state that since his labwork comes out fine, he can continue only taking some of his pills. Others are not engaging biomedical knowledge, and may in fact become sicker or die suddenly, but their actions at those moments of disengagement with the healthcare system are enabling them to continue to do what they like, which is how they define health. This analysis is only relevant to data where there was long-term management of disease or preventive medicine. Systemic barriers are at the forefront in the decision-making process during moments of acute illness rather than disease management.

Interplay of Systemic Barriers and Agency in Health Seeking Behavior

Power dynamics within the healthcare system are stratified. Power lies in the hands of many actors, from those who invent the technologies to deliver cost-efficient care to those who are recipients of such care (Foucault 1997; Hafferty and Light 1995). This section unravels what those power relationships look like within the healthcare system at the moment that participants want to resist the medical system, yet their decision-making process is confined within the systemic barriers they encounter. Systemic barriers are defined as those which prevent people taking action steps within the process of seeking care, such as the application or eligibility processes of health insurance or making an appointment to see a doctor. As the data revealed in previous chapters, participants are not just patients, but actors that have a varied access to power depending on their social situations. Most of the examples of this are about acute health care situations. In my pilot study for this dissertation, I also found that men and women were most vulnerable to encountering systemic barriers that would prevent them from making choices from a higher power status.

For participants, one of the most powerful identity stance was that of breadwinner. Their most feminine and least power status was being ill, as they conceptualized illness with sadness and loss of autonomy. In the following stories, participants are in healthcare situations where the way social class, gender, and immigration status are stratified impact their moments of exiting or delaying participation in the healthcare system (Thornton Dill and Zambrana 2009). Their access to resources, even those that are used to refrain from healthcare, are limited due to their working class status (Andersen and Collins 2007).

I begin with the story of Luis and his tooth. Luis is very open about his own insecurities as a male, having, discussing the fact that men sometimes will be too afraid of recognizing

illness because then they have to confront the treatments. When talking about a tooth pain he endured for two years, Luis mentioned he refused to go to the doctor, not only refraining from the US medicine system, but in Mexico as well.

> *"Well, I thought 'let's see if it goes away' but it never went away. It was getting worse and worse and worse. I went to Guadalajara-- in two years I went twice. But it wasn't the kind of pain that would kill you, only every once in a while. Well, it broke and I was-- I went down there and my sister said "Come on. Let's go. They charge very little." And I said "No, I have insurance and they won't charge me anything." But, well, I think that I'm Mexican and we're so chicken.*

Luis is not alone in refraining from any type of care, but what is interesting here, is him drawing on his ethnicity and earlier in the interview, on his being a male to talk mention the fear of recurring to medical care. He refused to go to the doctor even though insurance was not an issue. For Luis in this instance, he was not seeking any type of asset that healthcare could offer him, as he only had the pain once in a while. However, the emotional fear that he jokingly talks about was mentioned by many others when it came to describing illness.

The gendering of the medical system and illness by the participants, but also as a consequence of the medical system itself, prevented Luis from seeking care. The fear of being labeled as ill is not only an imperative to refraining from care, but also paralyzing. For Luis, this means he is wary of any type of medical treatment from his doctor, not out of mistrust, but out of fear of what the consequence of illness will mean to him.

> *The other day they were going to give me a shot because I'm very allergic to flowers and I was struggling. So I went to the doctor and they said "I'm going to give you a shot" and I said "No, no, no, no shot. Get away from me with your shot." I didn't want one."*

Luis has severe allergies according to him and his wife, yet he says that since it is only seasonal, he does not feel that he needs intervention. His masculine identity of breadwinner is at the

forefront, so feeling ill only temporarily does not require intervention, as that would mean engaging with the sadness of *being* ill.

Luis still works as a commercial gardener that has a contract at a large institution. He has not retired and talks about how his own job, but also about how his class status and that of other Mexicans is precarious at best. Luis says, "..us Mexicans, we're not too low or too high, we're just about in the middle. It looks just about normal. But how many of us don't feel hunger, let's say." This situation where he still depends on his work in old age to sustain his and his wife's lifestyle reveals another layer of his resistance, one where economic barriers to being labeled as ill play a strong role in his decision-making to not seek care. This is a systemic barrier that cannot be resolved with more literacy, or even insurance. Luis understands his illnesses, but will not sacrifice losing his job over them.

> *What else can I ask of God? Many don't have all the things that I have; thank God. I have my children, I have my job, and I'm not thinking 'Tomorrow I won't go' and all the years I've been working I've never felt like 'Oh, don't go to work.' There are some people who think 'Oh, everything hurts.' Thank God, and my age and everything is good.*

Luis is satisfied with his health care decisions as long as he is able to have those things that are important to him, which include his job and being able to provide for his family. However, this situation makes it so that he walks on a tight rope when it comes to his health, careful of not falling and losing what he values.

Courtenay's (2000) analysis on risk is important here, as Luis perceives it as risky to not receive healthcare. This risk is only defined as such because class status and his masculine identities that relate to his breadwinning capacities. Not working carries economic consequences for his ability to be that household breadwinner. Untangling the systemic barriers to healthcare from his agency of "feeling fine" is difficult, yet it is clear that both are at play.

He has the ability to enact his masculinity by continuing to provide instead of succumbing to illness. However, he takes a risk that other men in more stable economic situations would perhaps not take, as they take other types of risks (Courtenay 2000).

As mentioned in Chapter 6, networks are imperative for participants if they want to seek care. For many, the fear of saturating these resources is motive enough to not seek care. Moses is recently retired, and in the process of my interview to my follow up with him, he was hospitalized and finally diagnosed with Valley Fever. This is how he recalls the events that ultimately led him to seek health care, along with his apprehensions. He resisted seeking care for the same reasons the majority of those who resisted acknowledged, fear of burdening adult children, wives, or the fear of losing their job for those still employed.

> *"I had an intense fever… I was drenched…my sugar went up to 600… She was the one who wanted to take me to the emergency room, but I didn't want to go" (Wife in the background: "Next time I'm going to tie him up and take him")*

When I asked what stopped him from seeking care after these episodes, he responded that he would have had to bother his daughters and wake them up to go with him to the ER, which he did not want to do as he perceived it to be a burden for them.

Moses recurs to his daughters, who are all married with children, for everything health related. While his wife accompanies him, it is them that help him get to the doctor, translate, and help him understand how to take his medications. The fear of using them up too much was a theme that came up with others. Particularly, when those women were not available, participants did not seek care or adhere with their health regimens.

Lorenzo is an 80 year old man who relies heavily on his daughters to seek care, but also has many health issues that he has not dealt with. This is an example of resistance that most men have, where given the choice to go or not, they make an informed choice not to go.

However, here systemic barriers drive the decision-making process and not identity factors. He has been battling with an eye issue, where they water frequently, and although he is in regular contact with specialists for other health issues, he does not seek care for this particular issue.

> *"If I make an appointment they [clinic] will give one to me far from now, and without a ride, the girls [daughters] sometimes they can take me sometimes they can't…I haven't talked about it to the doctor anymore….He's [specialist] so far away anyways, 1 or 2 hours away"*

His daughter or sometimes his son will drive him to his appointments, but for complicated procedures, he feels most comfortable if his daughter is able to go with him. She too feels the frustration of having to drive far to go to his appointments, but also because of the lack of help available to him money-wise."

The monetary and time costs were the most prominent barriers to seeking care, but once they are at the doctor's office, other barriers emerge. The majority of participants had not sought healthcare, preventative or otherwise, before aging or a major acute illness such as cancer. As one participant noted and the majority echoed, "When I was young I never went to the doctor." Now, with diseases that have surged in old age coupled with chronic pain, many men do have some reason to visit the doctor. These interactions are on the basis that they will get to a state where they will regain autonomy over their lives. Once this is achieved, most participants expressed skepticism about needing to go back, or have constant tests to assert their health status.

The hesitation starts with going to the doctor to getting invasive tests repeated over time. Matias does not like to have to visit the doctor every three months, as his doctor recommends. When I ask him why he does not like to get a check-up he responds, "I don't need to go get the check-up if I feel good…..If I'm cured, why should I be seen again for the same thing?" This notion of being seen for the same thing when there are no symptoms common among most

participants. Antonio for example, does not like that he has to get labwork done. He feels that since his prostate cancer has not returned, the labwork is a reminder of something he does not feel anymore. He says, "I'm cured already, I don't need to get more blood taken out unless I feel bad." While both check-ups and lab blood draws are only slightly invasive, other larger preventive procedures are also met with much hesitation.

Matias and Antonio are both largely dependent on the women in their lives for navigating the healthcare system. When I asked Matias what his motivation for staying heathy is, he says, "I would be scared being sick and have my family depending on me." This economic dependence is the driver for much of his healthcare decisions, yet it is intertwined with masculinities and the necessity of being a breadwinner. For Antonio, his principal motivation is autonomy, and he is hesitant and follows up with conversation about not needing to go get checkups with stating that he does go, when he feels bad. Both are perceived from the outside as similar situations, yet the role of identity and systemic barriers differ depending on their social location- Matias is still working, caring for a daughter with Type 1 diabetes, still paying his house and Antonio is retired, lives alone, and owns his home.

Fernando has had several biopsies done on his prostate, which to date have not revealed any malignant cancer, but doctors insist his PSA levels are abnormal. However, he does not feel he should keep getting them, and regrets the last one he had, "I regret having another biopsy done very much. I don't know if something will happen when they do it...hopefully it doesn't, but let's see." For Fernando, the notion of risk coupled with the fact that the results have so far come back negative leave him struggling to find the balance with how much he his autonomy is at risk by either undergoing a biopsy or getting cancer. This risk benefit analysis to

engaging in health seeking or resisting is also relevant when it comes to changing health behaviors.

Changing behavior depended mostly on what it meant for participants to make the change. For those that did make behavioral changes after consulting with the doctor, they felt like they could do such a change because it did not make much change much of their current behavior, or things they felt the enjoyed. One participant notes that the doctor restricted several foods and behaviors after being diagnosed with diabetes. He said that many of those things he no longer did even before the doctor told him, such as smoking. In terms of adding more vegetables to his diet, he did not really see a problem with this new diet.

> *In reality well, like, I have always liked vegetables, right? But there are many people who do not like them, and there is the problem, making that change. But not for me, I do not find it difficult because I like what I eat.*

I asked the participant if he didn't like vegetables, could he speculate if that would be an issue for him in following the doctor's orders. He replied a fervent "Oh yes!"

Most participants encountered some sort of systemic barrier that prevented them from seeking care. I have documented elsewhere that what are perceived as interpersonal conflicts within the healthcare system, such as waiting too long for care, or appearance of rude treatment from medical and medical services personnel is in fact traced back to larger systemic barriers (Pacheco et al. 2012). It is important to systematically work towards seeking out how the intricacies between perceived interpersonal reasons for not seeking care, systemic barriers, and resistance work together to create a full health seeking picture of this and other marginalized.

In this chapter, there were three different ways in which systemic barriers shape the outcomes of resistance, but also how participants use their own agency to influence their own health seeking process. While the common perception about the reasoning behind the lack of

seeking care within this population was *machismo*, participants said very little about their innate manhood as preventing them from seeking care. As Chad Broughton found, identities that male immigrant men take on are a combination of many relating to their position as head of household, breadwinner, and adventurer (Broughton 2008). While I did not see the adventurer identity prominent in my research, the identity of an aging man was also prominent, and helped shape how they thought about health and health behavior. However, the overall notion of autonomy drove many of their decision, whether they drove them to seek healthcare or abstain from seeking help.

The medical system as a structure where illness abounds, which for participants means sadness, is the default way of perceiving the medical system. This is different from an antagonistic attitude about the controlling or invasive nature of the system. When participants used their agency to refrain from care, they used their own concepts of risk assessment, if they felt like they no longer needed treatment. They also feared for the saturation of the use of their networks whom they depended on to navigate through the healthcare system, particularly their adult daughters whom they did not want to overburden. Finally, it is important to note that there were instances when participants wanted to use their agency to seek care instead of refrain from it, but systemic barriers prevented them from getting adequate treatment.

This narrative moves the perceptions of the agency of older Mexican immigrant men as coming from a place of lack of knowledge to a place where their analysis of the system as it interacts with their identities and systemic barriers is used to make decisions about care. The interactions between identity as a man and their decisions to seek care are real, but they are much more complex than mere refusal to seek care because it is the manly thing to do. Participant interviews revealed that they do not refuse to seek care because it is a feminine

institution, a place where they are faced with illness and all of its emotional implications, much like the rest of American society experiences it as a feminized institution (Martin 2006). While I was not able to capture more about the notion of femininity deeper, it was evident that other factors, such as weighing the risk of continuing to seek care played key roles as well. No participants resisted in engaging with the health system completely, and therefore used their agency to make decisions about their own health and health seeking regimens. As I drive and walk through the UCSF campus, I see that there is a deep emphasis on "Women's Health" and droves of women and children recur to seek care as the men in their lives drop them off, or go as visitors to visit loved ones.

Chapter 8: Conclusions

The purpose of this study was to begin to understand how older Mexican immigrant men conceptualized health and illness and how this drove their health seeking behaviors. Men are largely understudied in contemporary medicine, and much of what is understood about Latino health has women overrepresented in the samples (Carbajal et al. 2013; Hawkins, Kieffer, Sinco et al. 2013). By focusing on older men and their experiences with the healthcare system, I sought to find out how men perceived health, illness, and how these drove their health-seeking behavior. In addition, the study examined motivations in moments when participants abstained from care.

Identity as Necessary for Understanding Health Processes

Men are at a crossroad where their migration stories, their lifetime as laborers in the food system, and their emerging aging identities shape every aspect of what illnesses they have and how they manage these illnesses. It shapes who they are within their families, and the expectations they feel they have as long-time breadwinners and heads of household. Their work left them with many debilitating conditions or injuries that have lasting impacts. Even as they battle with debilitating chronic conditions, they still described their daily realities as breadwinners, heads of household, and persons seeking to retain their autonomy.

How did these men then, given their histories, become "patients?" Hall (1996/2002) describes this process as political. In this study, part of what guides the process of their patient identification is their need to adhere to the requirements tied to health regimens and "wellness" messages that guide the citizenship into American culture (Ong 1998). This study was supported by medical providers and seen as needed, both as researchers lack an understanding

about what drives the Latino Paradox, but also because of the research that points to the low participation of immigrant men in the healthcare system (Markides and Eschbach 2005; .

While participant male immigrant identity is political, it is undeniable that their identity was also shaped by their age, race, and class (Andersen and Collins 2007). These all had different influences of power within the social structures they interacted with such as the family, work, and the US medical system. Their identities were a process, and immigrant transformed from meaning one thing in their youth to another as aging men. Yet the continuity of that role as being different, informed so much about the work they got, and this was consequential to how some perceived the medical system treated them based on their limited availability of resources.

Having stated the above, the most important contribution of Stuart Hall describing identity at the psychological and social realms remained salient in this data set (Hall 1996/2002). There is much more to be said about what drives health seeking behavior that cannot be captured as a survey that tackles to describe this population's demographics. Going back to Figure 5 on the assets and barriers to care illustrate this more in depth. Life history, their immigrant status, and how they have shaped their definitions of health and illness were all imperative in how participants sought health care. Most importantly, their masculinities shaped the decision-making beyond the immediate assets that have been traditionally recognized as helping people get healthcare such as insurance, language, education, and access to providers.

Findings about their work life and religion perhaps help shed the most light on how masculine identities were enacted within the health seeking process. Therefore, they are the most fascinating points for further analysis of men and masculinities in this population. Their work life revealed, that like other ethnographies and masculinites research states, men who see themselves as providers or breadwinners will go to take extraordinary risks and go to great

lengths to continue to work while injured, or to work in environments that are hazardous (Broughton 2008; Walter et al. 2004).

Other research has revealed that there are social factors beyond fatalism preventing people from seeking care (Abraido-Lanza et al. 2007). Participants in this study described how religion revealed a calling of them to do something for themselves, before God could help them. The push and pull between the systemic and the personal are an important reason why identity theory must continue to be integrated into health seeking behavior research about Mexican immigrant men. As Bahba (2000) notes, identities are beyond their anthropological view, in this case, the view of religion as reason for fear and inaction. This conceptualization of the role of God was, as Bahba notes, not perceived as a perception from a unified front on an aspect of identity of "us older Mexican immigrant men" or any other group identity. However, the group feelings about fatalism do need to be further studied, as the view of "God helps me if I help myself" was shared by the majority of participants.

The significant finding about the role of masculinity was contradictory to my initial thought about the reasons men abstained from seeking care, which was consistent with all of the anecdotes I collected from healthcare professionals and lay people alike. While we all believed that men abstained from care due to some sort of machsimo identity where they perceived themselves as the stronger sex, in fact, participants noted very little attribution of their masculinity as a superior gender as a reason to abstain from care. They did not have preconceived notions about their bodies being physiologically different than women when it came to health or risk of illness when I asked them if they thought men and women were different. This however, does not mean that they were not enacting their masculine identity at all within the health seeking process. In fact, so much about who they are in relation to their

masculinity shaped their behavior, as other studies about men have found (Riska 2010: Walter et al. 2004).

It is important to note that the findings on their own conceptualization of the temporal aspects of their systemic barriers, along with their deep knowledge of biomedicine, risk, and their working conditions calls for a new definition on the term informed patient. Participants are not logging on the internet and printing out long pages of research or perusing through health blogs to get the latest information on their health. Rather, they are taking in the information that the doctors and their adult children or wives are telling them about their health and analyzing it. They are also highly reflective on their environment and how it has changed over time, including the labor they once performed. They then weigh in both that information and their life experiences to decide how to proceed in within the healthcare system. However, like other informed patients, they are lacking all the necessary data to make an informed decision about their health that maximizes their life span and quality of life.

Implications of Health as Autonomy and Illness as Sadness

What participants considered healthy or a healthy lifestyle did not always match what the regimens were that were being prescribed. For them, health and wellness, as described by biomedical markers such as weight, glucose and cholesterol levels, were not the ultimate prizes or aspirations for their own sakes. For those that gathered around with other men, they gave each other advice about health care, but did not use their health numbers as a status among their groups. Participants wanted to "be good", but for them that meant autonomy, not wellness.

This notion of autonomy is tied to aspects of gender, aging, class, race/ethnicity, and migration, which all put them at a societal disadvantage in terms of amount of control they have over many aspects of their lives. Whether it be work or health, risk for discrimination and loss of autonomy increase with age. Gender affects the magnitude at which the effect of the loss is

felt. Men have many points in their lives at which they may experience control, particularly in their lifelong role of breadwinners, and women of this generation may have not have experienced this level of autonomy, and thus are less shocked by its decline.

Autonomy has not been described in previous literature in this context, thus it is important to continue doing research on what autonomy means for older Mexican immigrant men, and how this may translate to men of other ethnicities. On the one hand autonomy indicated the ability for them to retain their head of family status. On the other, it was tied to how their new aging identity could be autonomous, which sometimes meant being able to tend to their garden or being able to be mobile enough to get together with family and friends. This may change as life histories may differ, but I hypothesize that there may be some similarities insofar as masculine identities are involved in their conceptualizations of who they are.

The notion that health is defined as autonomy and not biomedical markers is an important contribution to understanding agency within these participants. The notion of their disregard of wellness for wellness sake is not to be taken lightly, or dismissed as ignorance or naiveté. I refer back to biomedicalization here, and how the health "numbers" are what American society defines as having health and what drives discourses about bodies (Clarke et al. 2010; Riska 2010). Participants, in defining their health as autonomy, did not totally shun biomedicine. Most participants did not see themselves at the margins of biomedicine, and even participated in the self-disicplines that are involved in chronic disease management.

Participants also used biomedicine and its numbers to justify why they did not need to seek care as prescribed. However, the most important use of biomedicine discourse for participants is that the technologies that revealed their numbers and the numbers themselves were not defining how they wanted to live their lives as "healthy." As many participants

outright stated, health to them is invaluable, even moreso than money, and yet, it meant doing what they wanted. Therefore, even if, as Humberto did, prematurely die of a heart attack because he did not seek healthcare, he died doing what he wanted and needed to do. While Humberto's story is marked with systemic barriers that are crucial and not to be disregarded, he also made the choice, and moral aspects of dignity, and self-realization must be further studied to tease out how exactly to deal with autonomy when patients choose not to seek care.

Illness is described as a sadness and loss of autonomy among most participants. Both sadness and the loss of autonomy carry gender consequences for both men and women. In this study, as Courtenay (2000) points out, men played a role in reinforcing the stereotypes about who they were. They deferred to women when it came to such important decisions about their body, while reinforcing stereotypes of women taking care of that which is emotional, such as they described illness. Their definition of illness goes beyond the as preventing their male actions as Courtenay describes, is only part of the reason men described illness as a sadness. However, when it came to chronic disease management, participants did not only see their actions as "male actions," nor did any of them differentiate between their experience of illness and that of their female counterparts. Many of the participants still engaged in biomedical disciplines because they helped them retain their autonomy, and did not see that as interfering with their superior male status.

There needs to be further theorizing about what people need out of the healthcare system versus what the healthcare system has to offer. While it is not always possible to reach the needs of people when they are seeking a diagnosis for example, there may need to be a re-framing about how management prognoses are presented to patients who may be seeking a cure. For men in this study, their fears of losing autonomy or having medicine or health regimens that

impeded them from continuing doing the things they enjoyed drove them away from the healthcare system. Conversations about the effect of prognoses in men's lives should be looked at not as a luxury item of conversation, but a way in which the patient buys in to the prescribed changes. Men in this study were aware that they were entering the healthcare system with limited resources, yet still expected certain products within the healthcare system that would return them to a good or tolerable health status.

The Role of Identities in Health Seeking Behavior

Most participants had not engaged much with the healthcare system prior to aging. Thus, the fact that they are in their old age is further evidence they have waited to seek care until their autonomy was threatened, because as long as they were able to work, they did not bother seeking out healthcare. They did not perceive this as a neglect on their part, as many described their work life as all-encompassing, leaving little time for much else. The sadness they associated with illness was part of this interruption of life, which they avoided for economic and social reasons. Defining health as autonomy and illness as being the loss of autonomy was the principal factor in their decision-making process.

Their decisions to seek care were as aging men was based on how they defined healthcare, and the individual choices they had to make about engaging in care and what that would mean to them. Risk was a major decision driver around seeking healthcare and adhering with prescribed health regimens. However, the risk was not about getting sicker or being labeled as sick, but the deterioration of the body and the consequences this would carry on their autonomy. Their masculinity played a role, as it has in previous studies, on the extent to which they are willing to wait before seeking care (Riska 2010). Therefore, messages of public health, while participants understood them, only had an effect if they spoke to a risk of losing their autonomy.

Older Latino men trust their networks to give them health information, but do not react to or notice direct health promotion. This fact was also alluded to in the methods section, where I described that many of the participants heard about the study from their adult daughters, wives, sisters, or friends. Networks are an important aspect of the decision-making process for participants, and these got more expansive as they became older and stayed in the country longer (Carter-Pokras, Zambrana, Yankelvich, et al 2008). For most participants, their networks were shaped by their work and ethnic identity. However, it is important to note that networks outside of the immediate family were only important as transfers of information, not as people they sought to for help navigating the healthcare system.

Women, such as wives and adult daughters help men overcome systemic barriers. They are the vectors, intermediaries, and ambassadors between the men and the healthcare system. This role of intermediary and navigator has implications for men, women, and the United States healthcare system. There is evidence to suggest that having family involved in the disease-management process can be effective (Armour, Norris, Jack et al. 2005). However, there is also evidence that suggests that long term effects of these and other public health interventions diminishes as time passes (Carbajal et al. 2013).

The US hospitals and doctor's offices or clinics were definitely the first and major point for participants to seek medical care. While some traveled back and forth to Mexico, very few relied on getting care in Mexico as their primary point of care. This also goes with new hypotheses that contradict the salmon-bias to explain why Latinos live longer than their white or other minority counterparts (Arias 2010). Sick participants were not fleeing to Mexico to treat their health care, they perceived the United States to be their place of permanent residence, regardless of their health status. While the United States is their permanent home and the US

medical system is their primary source of care that does not mean that they use this system with high frequency.

While they defined health and illness in their own way, and shaped risk to be based on the sustainment of their autonomy, this did not mean that they were always able to exercise their own decisions about healthcare. Systemic barriers were present for this population as they are for many other Latino communities in the United States (Salinas and Peek 2008). For most of their adult life, systemic barriers prevented them from seeking care. Their tenuous immigration statuses coupled with enormous economic constraints and the fear of losing work prevented them from thinking about their wellness. However, in old age, they are now tending to injuries they incurred many years ago. Accessing medical care meant having transportation to visit the doctor, but also having a navigator, usually an adult woman family member, available to help them through the process of seeking care and adhering to prescribed health regimens.

Their health seeking decision-making process differs depending on whether the circumstance. When it came to seeking healthcare for chronic disease management purposes, most of the participants were guided by their decision-making process as defined through their identities and needing to retain autonomy. The instances in which care was needed for acute purposes, systemic barriers guided this process for the majority of the participants more than any their weighing of risk to their autonomy. Therefore, the distinction of acute versus preventative or management care is needed as further research continues on this subpopulation.

Further theorizing needs to occur around what is keeping men from going to the doctor. This focus of this research as attempting to explain health seeking behavior went beyond systemic barriers as predictors for seeking care. For most participants, lack of formal education did not translate into lack of knowledge about the healthcare system. It also did not translate

into lack of knowledge about their own diseases or those they were at risk of getting, and this has also been reflected in previous research that shows Mexican American men care about biomedical markers of health like their glucose levels (Schapira et al. 2011).

Informed decisions about what the biomedical system was telling them to be healthy sometimes matched. However, other times the regimens required to be healthy did not leave them feeling healthy and the medicines made them feel worse. Other literature has found for older Mexican men, there it is a long road between understanding health information and agreeing to enact the prescriptions (Kelley, Wenger, and Sarkisian 2010). Most of the interviews revealed a deep understanding about their health conditions, and the health regimens they needed to follow, but they still chose not to adhere all of the time.

Data Issues

Recruitment has proven difficult; this is generally an understudied population. When I first attempted to recruit only through community health centers and the church, it became clear that direct recruitment to participants was not going to be an effective way of reaching them, let along get them to agree to an interview. As mentioned in the section on gender relations, there was heavy reliance of the adult daughters and other adult women in the life of the participants for navigating the health care system. In addition, they are strong influences in the health systems they choose to engage in, and to what extent. For example, women persuaded the men to go to the doctor, but many also influenced them into participating in the study.

While all human research protocols were enforced, the traditional view on how these are carried out do not apply to the studied population. Women had to be their point of entry into the research, and while it was ultimately up to them to decide to participate, women had to be the first to buy-in to the study so that the information would get relayed to the men. I had several daughters and wives contact me about the study, regardless of my point of recruitment. Most,

even women, were not familiar with research, and so recruitment for this population was a longer process than I anticipated, leaving me with only 20 participants.

Future Work

Further analysis of data to explore the role of religiosity, and general agnostic belief in God is needed. Early findings reveal this as a motivation to seek care rather than fatalism, which is the belief of powerlessness over personal health outcomes. As most participants said, God played a major role in their health outcomes, but only insofar as they made changes to their own health behaviors. Furthermore, there was no blame on God when participants had encountered a diagnosis like cancer, rather, they attributed this to random events that were still not understood. The role of God does not prevent them to seek care, but can serve as an impetus for action, and should continue to be studied.

The family needs to be furthered studied within the strict purview of health, health seeking, and resistance to healthcare. While in this dissertation I sought to understand migration patterns, and even established networks that affected socioeconomic and legal status along with health seeking, I did not fully grasp how the daily interactions within the family resulted in the dynamics that affected health seeking behavior and conceptualization of health. While this level of analysis would be helpful, it is also important to have an ethical discussion about what to do once the information is attained.

Do researchers and the medical system map a social engineering project that manipulates the innermost dynamics of a family for the purpose of better health outcomes? Within this discussion those parties should also take a step back to see who must learn from whom, should the family system be manipulated to fit US biomedicine standards, or should the US biomedicine system change in its flexibility to allow for different family dynamics. For example, should the doctor discuss with the patient the information he or she needs to relay and

then turn and talk to the adult daughter or wife about how health-related changes will need to be implemented in the household?

Deeper levels of the visual material and neighborhood observational data are needed to shed further light on systemic barriers to health care, particularly food desserts, lack of access to drinking water, and public transportation. While observational data in this study showed that there continue to be basic needs that are not being met, such as access to fresh drinking water and air, there are also other systemic barriers that are more difficult to reveal without deeper investigation, such as racism within their own towns, counties, and the policies that reflect this racial climate to the detriment of their health. This deeper analysis will also be helpful in providing more data that reinforces or adds to Figure 5 as a map for understanding the role of systemic barriers in the decision-making process of seeking healthcare.

In terms of research populations, it is important to note that I was only interested in people who had some sort of permanent connection to the United States. Other work around more migrant workers who still follow the crops and consider Mexico as their primary home must still continue to be done, as the type of work Seth Holmes (2007; 2012) continues to do and others who are interested in migrants of other countries or are of specific ethnic groups. I only had one participant who identified himself as being of an indigenous Mexican ethnic group. Further studies on this subpopulation must be conducted as many times these are perceived as double minorities, being marginalized in Mexico and in the United States as well (Holmes 2007). However, research on older Mexican immigrants who have chosen to remain in the United States must continue, as this will allow us to further understand factors at play in the paradoxical nature of their health and wealth status.

Finally, a meta-analysis is needed to provide further evidence of the overrepresentation of women in Latino health seeking behavioral interventions. The implications of having such overrepresentation also need to be further studied. The absence of men in health interventions points to a hesitance and perceived invisibility of them in the healthcare system. However, participants in this study did not have a recalcitrant attitude about seeking care, rather, only sought it out when health issues or the risk of health issues prevented them from having autonomy over their lifestyle. None of the participants said they had never seen a doctor, so their lack of participation in studies speaks to the difficulties in recruitment. However, if interventions are being shaped on the evidence that already exists on Latino health, where men are mostly absent, there is a perpetuation of the designs that do not attract men and are therefore not giving a clear picture of what overall Latino heath looks like, just women's health. This has implications for both men and women as I describe in the next section.

Implications

A summary of this information will be presented to a group of medical professionals at the conclusion of the study and analyzed for clinical significance as part of the recruitment memo of understanding between me and one the medical recruitment sites. One of the principal implications for this study is the role of identity construction in health and health seeking behavior. The effect of their identities as immigrants, workers, older people, and breadwinners, cannot be understated, as they mentioned how each of these played a role in every aspect of the health seeking process, from conceptualization of health and illness to resisting the health care system.

Understanding how each of these identities interact with each other is also crucial. For many, they still considered themselves as working men well into retirement. Their eating patterns and decision making around health care then was also centered on this identity. For

example, many still recalled leaving things like the tortilla difficult because of they felt it was necessary for them to do work, even as retired persons. However, there is not a process to re-conceptualize both the notions of eating and working men within that aging context, neither by them or their healthcare professionals.

Many men retired from places they had worked for many years. This seems to be a place of possible stability that may provide proper entrée to others wishing to research this subpopulation in the future. While many critiqued the mechanized labor and the effects on their health, they did not attribute it to their particular place of work, but rather as a sign of the times. Therefore, reasons for contentious relationship with the company as a result of research may be low. Company loyalty is also useful to help us understand the effects of prolonged farmworker labor from a conceptualization place rather than strictly physiological. There are many studies like Salinas and Peek (2008) that have documented the effects of prolonged labor on the physiological body, but effects on their economic situation, their family dynamics, and their health-seeking behavior remains to be investigated.

As the new healthcare law seeks to include patient navigators as key people that will make the new system successful, it is important to see how this may be a process reliant on gender roles. Women play a strong role as navigators for men in this study, but they are also assets to their larger community. Their knowledge is important to participants in this study, but also may have deeper influences over other members of the family, such as siblings and adult children. Women as navigators are important, but their advocacy role is perhaps the one that may have the deepest impact. They know the dynamics, what gets their husbands or fathers to finally see a doctor when they are resisting and have acute conditions, and also what does not work. As advocates, they have a responsibility to their families, not the healthcare system at

large, and this must be considered when any interventions placing navigators in the household are implemented.

Public health campaigns targeting this population must address their conceptualizations of health and illness, the notion of being "cured" and the emotions tied to illness or behavior changes that go unaddressed. In addition, the health-seeking process must be reframed to include the realities of the straddling men do between the US healthcare system and alterative care methods. Many participants reported that they did not do alternative medicine because their doctors had instructed them not to take anything other than what they were prescribing. This has two possible deleterious effects according to participants- they will not seek any type of care when they do not wish to seek allopathic US healthcare, or they may seek complimentary care and keep it from their doctors. The reality is that men are seeking care straddling in and out of the healthcare system, sometimes seeking care for something, other times not, and other times doing something in conjunction with what the doctor ordered. This must be interwoven in any intervention aimed at bettering their health outcomes.

Older men are thinking about their health and acting in ways that they feel is the best interest to their health. This however, means something different to them than it does to their providers. Engaging in formal systems of healthcare is something they are familiar with at old age, they are not invisible, rather only seek healthcare sparingly. This low level of use is dependent on how they view health as autonomy. Illness is a sadness, a feminine emotion state that they avoid feeling or accepting as part of their identities. There are numerous systemic barriers that prevent these men from seeking care when they want to seek care. However, they are still using their own agency to make decisions about when to seek care and when to abstain.

They are actors, active in their decision-making process, yet still constrained by the economic, health, and food systems in the places where they live.

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