Migration and Health: Indigenous Immigrant Communities in the U.S.

Indigenous communities make up an important culturally and ethnically diverse segment of Latino migration to the U.S.[1] Migration of indigenous people to the U.S., mainly from Mexico and Guetamala, has been a growing phenomenon since the early 1990s.[1] In the U.S., Latinos as a whole constitute the fastest growing major demographic population, with Mexico as the most common country of birth.[23] According to 2015 estimates from the International Organization for Migration (IOM), 26.8% of immigrants (~12 million) living in the U.S. were born in Mexico.[4] In Mexio, there are some 68 officially recognized indigenous languages and over 364 registered dialects, which then make their way into U.S. communities through migration.[5] Health statistics seldom describe the vulnerable health status of indigenous immigrants, who tend to fare the worst in most health outcomes when compared to the general population in their respective places of origin.

The health of indigenous people is highly vulnerable in their countries of origin as well as their migratory destination. In Mexico, rates of maternal and infant mortality as well as malnutrition are higher within indigenous communities compared to the general population.[6,7] Mexico's Southern region, where most indigenous immigrants originate, has a prevelance higher than any other region in the country of ill health in all disease and injury categories in conjunction with the highest mortality rates nationally.[8-10]

The Facts

- In Mexio, 15.1% of the population recognizes themselves as indigenous. The states with the highest percentage of indigenous people are Oaxaca (14.4%), Chiapas (14.2%), Veracruz (9.2%) and Puebla (9.1%). The most used indigenous languages are Nàhuatl (24%), Maya (13.7%), Mixteco (6.8%), and Zapoteco (6.8%). [5,10]

- Although considered minimum estimates, greatly affected by undercounting, the 2000 census indicates that 407,000 people indentified themselves as "Hispanic American Indians," 165,000 of those living in California.[11] There is no new data about the estimates of the last eighteen years. Existing data on indigenous farmworkers is far more abundant and estimates that this population has increased since the 1970s, changing from 7% of farmworkers in 1993 to almost 29% in 2008.[12] Nationwide within this category, the most represented countries of origin were Mexico and Guatemala.[1] In the National Agricultural Survey (NAWS) 2013-2014, 68% of all farmworkers were Mexican, and of this group, 5% recognized themselves as part of an indigenous community.[13]

- Although California and Texas have been states with the highest concentration of "Hispanic American Indians,"[1] according to the 2010 census, the presence of indigenous migrants is now registered within all 50 states. In total, 29 "tribes" (a U.S. census term not commonly used in Mexico or Guatemala) are recorded in all 50 U.S. states, the most predominant including: Mayan (with a presence in all 50), Purépechas (within 47), Tarahumaras (in 41 states), Mextecos and Zapotecos (in 40 states), Otomíes (39 states) and Nahuas (36).[5]

- The Indigenous Farmworker Study (IFS) is the most comprehensive study regarding indigenous farmworkers in the U.S., but it is limited to farmworkers living in California. This study estimates that approximately 165,000 Mexican indigenous farmworkers live in California, the majority coming from the states of Guerrero and Oaxaca. Approximately half of indigenous farmworkers speak Mixteco, 25% Zapoteco, and 10% Triqui.[14]
- These groups make up the fastest growing farmworker poplation in California.[15,16]

- Approximately 40% (70,000 people) of the number of farmworkers in Oregon are indigenous immigrants from Guatemala and Mexico.[14]

For the purposes of this brief, Indigenous people are those that identify themselves as such and maintain cultural and linguistic ties to cultures that existed in the Americas before the arrrival of Europeans in 1492, having lived through a process of colonization and adaptation.

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The Issues

Health Disparities in Communities of Origin

In Mexico and Guatemala, as in most Latin American countries, indigenous people have higher illness and mortality rates than the population as a whole.[8,18-20] Women are particularly vulnerable. In comparison with indigenous men, indigenous women are more likely to be illiterate and monolingual (speak an indigenous language but not Spanish), which can hinder access to health care. Furthermore, low social status of indigenous women, combined with culturally sanctioned early age of marriage, early age of childbearing, and low levels of formal education endanger women's health and place them as high risk targets for various forms of abuse.[19]

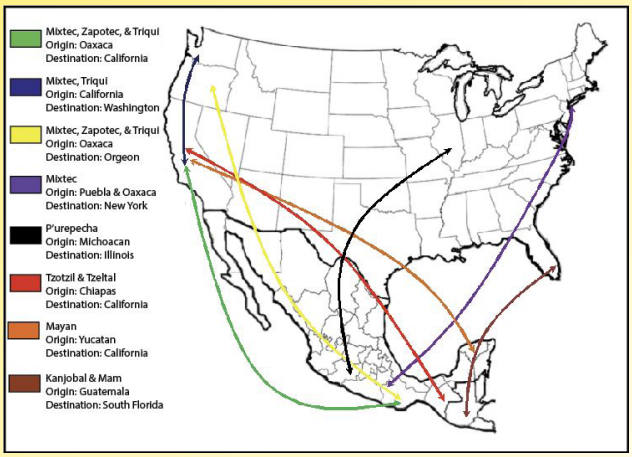
Artisans of Oaxaca: An indigenous Amuzgo woman embroiders a blouse in San Pedro Amuzgos, the main center for embroidery in the Mixteca region of Oaxaca, one of the poorest areas in Mexico.

Although Mexico has made progress in these areas, health disparities are still pervasive across the country. In 2010 the state of Guerrero, home to a large indigenous population, had a maternal mortality rate five times more than the lowest within the country found in Coahuila[40]. According to a study published in 2014, Mexican indigenous women had five times more risk of dying during childbirth than non-indigenous women.[14]

Social Determinants of Health

Low social and economic standing translates into worsened health outcomes and a shorter life span at every step within the gradient of socioeconomic status.[21] In Mexico, indigenous communities are educationally and economically marginalized. In 2015, 16.6% of the indigenous population older than fifteen had no education, and 17.8% of this group were illiterate, three-fold the national percentage.[10] An estimated 55.5% of indigenous populations in Mexico live in impoverished communities under adverse circumstances. Oaxaca and Chiapas, the two states with the largest concentration of indigenous people, have the highest percentages of households under extreme poverty, making them contribute significantly in U.S. bound migration.[1,22-23] Indigenous migrants living in the United States tend to be younger, recently arrived, less educated, and speak less English (and Spanish) than other Latino migrants, in part, explaining why they are poorer and have few assets.[12]

Working Conditions: In the U.S. Latino immigrants are concentrated in low paying and often dangerous occupational sectors, where health and other employee benefits are rarely offered.[13] Farm work is among the most common employment for indigenous immigrants, and also among the lowest paid.[12] Also, 30% of all the farmworkers in the U.S. have total family incomes below the poverty line.[25] Compared with U.S.-born farmworkers, indigenous farmworkers have less probability of receiving an employer bonus, and more probability of having a total family income below the poverty line, despite working more hours (between 2-3 hours more) and having a strong role in the U.S. food economy.[27]



Undocumented Status: Lacking legal status restricts eligibility to health programs within the U.S. Fear of deportation or stigma serves as a significant source of stress and interfers in typical health seeking behaviors.[16] The vast majority of indigenous immigrants are undocumented.

Housing Conditions: Indigenous immigrants often live in overcrowded, substandard housing conditions conducive to ill health.[8,26] For some indigenous farmworkers (3%), home is a shack- or tent-like area in someone's backyard, consisting of arrangements with limited access to basic facilities like water and electricity.[12,26] Only 11% of indigenous farmworkers own their homes.[12] These sub-standard living conditions increase risk of poor nutrition, infectious disease, delayed development in children and domestic violence within the home.[26]

Dietary Changes: Worldwide, traditional diets are being replaced by westernized food habits, which in turn has brought increases in obesity and chronic diseases.[17,18]

Data from 2014, shows that 17.8% of migratory and seasonal agricultural workers (MSAW) have hypertension and 11.7% obesity or diabetes.[28] Migration to the U.S. can be expected to accelerate dietary changes already occurring in many indigenous communities and early life exposure to malnutrition may also predispose individuals to obesity as adults.[18]

Substance Abuse: Given a social context of isolation, poverty, and lack of opportunity, alcoholism is a primary concern for many indigenous communities.[18] Additionally, the use of tobacco, alcohol, and illicit drugs may increase between first and second generation indigenous immigrants.[30,31]

Access to Healthcare: Overall, indigenous populations access healthcare at very low rates (especially indigenous males).[12] Poverty, undocumented status, discrimination, language, cultural differences, unfamiliarity with U.S. medical processes, and confusion surrounding health-disease relationships hinder indigenous immigrants' access to health care services.[8,18,16,32,26] Although undocumented laborers[ii] contribute to Social Security, and federal and state taxes, they are ineligible for most government assistance programs in the U.S.[26] Health insurance coverage for this population within and outside of the U.S., is often precarious.[26]

In 2008, 77% of indigenous farmworkers did not have health insurance. In 2010, only 19% of indigenous women and 9% of indigenous males had health insurance, versus 50.6% of non-indigenous migrant workers.[12,14,25,33] Immigrants' health is affected by their migratory experience, which is often accompanied by a sense of isolation.[16] Among immigrants, lack of supportive social networks exacerbates stress due to changes in diet, housing, environment, culture, and sources of health care.[16] Indigenous immigrants are vulnerable to discrimination on multiple fronts, in the mainstream population as well as among other Mexican (Latino) immigrants. Studies indicate that among farmworkers in the U.S., indigenous status is linked to the lowest paid, most labor-intensive jobs, and most crowded housing conditions.[8,17,26]

Culture, Language, & Health

In the U.S., when health care services are available to indigenous immigrants, health care providers rarely speak the indigenous language of the populations they serve or have adequate translation services available.[17,18] Furthmore, they possess different world views regarding disease, treatment, and healing that leads many to avoid accessing health care resources until the condition is extreme.[34] This contributes to a high risk of misdiagnosis or delayed diagnosis by physicians or non-aherence to treatment by members of indigenous communities.[32]

Oxnard Strawberry Workers: Strawberry workers in Oxnard, most of whom are indigenous immigrants from the Mexican states of Oaxaca, Guerrero and Michoacan.

Though traditional medicine practices vary, many indigenous communities share the belief that cold and hot elements or forces in the world influence health and illness.[18] Traditional healers called "curanderos" in Spanish, often use medicinal plants and rituals to provide healing and restore balance between cold and warm forces.[35] The difference between indigenous medical practices and those used in mainstream U.S. health clinics can lead to barriers on both sides in fostering effective care for indigenous communities.

The tension and controvesey over medical procedures, like ceaserian sections is also largely influenced by the aversian many indigenous people have regarding modern medical practices. This does not necessarily mean that indigenous people will not seek the help of medical professionals, but instead that their is a lack of familiarity and understanding that needs to be addressed. Though indigenous people might not be completely against mainstream health practices, there exists a significant amount of doubts, concerns, misconceptions, and rumors.

Occupational Health

The agriculture industry is one of the most significant sources of employment for indigenous immigrants.[31] Unfortunately, it is also one of the most dangerous.[26,36,37] According to data from the U.S. Bureau of Labor Statistics, agriculture was the third industry sector who had more fatal accidents in 2015, with 22.8 deaths per 100,000 full-time equivalent workers.[38] Occupational health risks associated with agriculture include pesticide exposure, skin disorders, infectious diseases, lung problems, hearing and vision disorders, and strained muscles and bones among others.[36]

Indigenous farmworkers are vulnerable to poor working conditions as they are perceived as unlikely to complain

and more reluctant than other farmworkers to report law violations or seek medical attention for illness or job injuries.[39] This coincides with the studies showing that indigenous farm workers are often assigned the most difficult and dangerous jobs, which in turn exacerbates health risks associated with agriculture.[39]

Policy Recommendations

Improving the health and social status of indigenous immigrants requires combined efforts at the regional, national and local levels.

Regionally

- Promote fair legal treatment of indigenous immigrant laborers, and work to educate workers on their rights.

Nationally

- Policies must encourage and require companies - especially those in the agricultural sector - to maintain safe labor practices and provide adequate housing.

- Consideration should be given to a new temporary worker status (with support from immigrants and employers) that would include safe and legal border passage and guarantee workers the freedom to change jobs to foster reduction of power differentials between employers and employees and to avoid unfair treatment of workers.[8]

- Mandating health access for all - be it through a private employer based plan or government program - is the policy option with the greatest capacity to improve the health of indigenous populations, and indeed all immigrants in the United States.

Locally

- Implement programs fostering cross-cultural understanding, especially in the workplace and health clinics, and encourage the development of culturally competent health materials.

Conclusions

In order to address the health needs of indigenous immigrant communities in the Unites States, policy makers must take into account these communities' long history of social and economic marginalization. Every effort should be made to promote sustainable, long-term development for these communities that provides them with a safety net as well as long term prospects for integration, that respects and is informed by their native heritage.

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