Poverty and Health
A Crisis among America's Most Vulnerable

The Importance of Place in Determining Their Future
Chapter 5

Poverty, Place, and Health along the United States-Mexico Border

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This chapter discusses the relationships among poverty, migration, housing, homelessness, and health on the U.S.-Mexico border. The border is a region where poor Hispanics experience a disproportionate burden of exposure to health risks. This chapter uses environmental justice as a framework to discover where health disparities are prevalent among border populations. The Centers for Disease Control and Prevention (CDC) defines health disparities as follows:

[Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources. (CDC, 2012)
The disparities around poverty, inadequate housing, and poor health along the U.S.-Mexico border must continue to be addressed for a higher quality of life to be shared by all. Yet things have worsened for the poor since the economic crisis that began in 2000, according to the U.S. Census Bureau (2011a). In 2009 the poverty rate of the U.S. counties along the border was 20.12%. This is more than twice the national poverty rate, which averaged 13.8% between 2006 and 2010 (U.S. Census Bureau, 2012a).

Numerous cases of disproportionate negative environmental impacts on the socially marginalized have been documented (Brulle & Pellow, 2006; Chakraborty, 2009; Grineski & Collins, 2010; Mohai, Pellow, & Roberts, 2009), and a growing body of research has focused particularly on environmental justice along the U.S.-Mexico border (Collins, Grineski, Chakraborty, & McDonald, 2011; Grineski & Collins, 2010; Grineski, Collins, de Lourdes Romo Aguilar, & Aldouri, 2010). Environmental justice (EJ) is defined by the United States Environmental Protection Agency (EPA) as follows:

The fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. Fair treatment means that no group of people, including racial, ethnic, or socio-economic groups, should bear a disproportionate share of the negative environmental consequences resulting from industrial, municipal, and commercial operations or the execution of federal, state, local, and tribal programs and policies. (Bullard, 2005, p. 4)

The U.S.-Mexico border region has a high percentage of Hispanics and Native-Americans, many of whom are vulnerable to a variety of social and contextual factors that contribute to poor health. The region has a high prevalence of noncommunicable diseases, communicable diseases, infections, environmental health hazards (water and air quality), and substandard housing, as well as high rates of poverty and unemployment, low rates of literacy, and limited access to affordable health care (Grineski & Juarez-Carrillo, 2012).

The significant disparities in terms of wealth and development—on both sides of the border, as well as between and within respective border cities—have created a social and physical landscape that is conducive to socially marginalized people being exposed to environmental injustices (Grineski & Juarez-Carrillo, 2012). In El Paso County, an intracategorical analysis between non-Hispanic Whites and Hispanics found that ethnicity (i.e., being Hispanic, even when having higher socioeconomic status than another White non-Hispanic group) had a greater influence on cancer risks from air toxicities than did social class (Collins et al., 2011). Many unplanned semirural subdivisions, called colonias, are located along the U.S.-Mexico border and are mainly inhabited by socially marginalized residents, predominantly Hispanics with a yearly household income below the poverty line. Residents living in colonias are subjected to poor water quality. A 2012 study found that residents living in El Paso County colonias without access to water from a public water supplier had increased predicted odds for diarrhea, stomach cramps, stomach pain, and bloated stomach—all conditions that were associated with their water supply not meeting the free residual chlorine EPA Safe Drinking Water Act (SDWA) standard (McDonald, 2012). The border has a high concentration of non-White populations living below the poverty line, especially among Native-Americans and Hispanics. Hispanics share a larger burden of health problems and higher cancer risks due to air pollution in El Paso (Collins et al., 2011). Studies have consistently shown a high concentration of air pollutants in and around international bridges linking the U.S.-Mexico border (Olvera, Li, & García, 2012; Olvera, Lopes, Guerrero, Garcia, & Li, 2013). Yet some health risks are not as high as one could initially expect for the border region in comparison to other regions—for example, border rates of diabetes or obesity among adults are not the highest in their respective nations (Ogden, Lamb, Carroll, & Flegal, 2010; SINAIR, 2011). Nevertheless, at both national and local levels, there is an upward trend among minors developing diabetes at an early age.

A contested issue in the literature delves into the "Hispanic health paradox" and its potential application to Latinos along the border. The Hispanic health paradox comprises the empirical puzzle that, despite living in poverty and having grown up in Latin America, many Latino immigrants have better health upon arrival and as they age compared to U.S.-born Latinos (Jasso, Massey, Rosenzweig, & Smith, 2004; Turra & Goldman, 2007). The causes of this puzzle have not been fully attributed, and many nonconclusive hypotheses remain in need of further research.

This chapter begins with a general overview of geographic, ethnic, and cultural life on the U.S.-Mexico border. Through the lens of environmental justice, this chapter addresses variations in ethnicity, language, health practices, migration generation, and other variables that lead to socioeconomic and health inequalities along the U.S.-Mexico border. This chapter then moves on to discuss communicable and noncommunicable diseases prevalent in the region. Later, it considers how the increase of violence amidst the "war on drugs" in Mexico has affected the physical and mental health of border residents.

On December 12, 2006, former Mexican President Felipe Calderon ordered thousands of troops to the state of Michoacan to combat increased rates of drug-related violence. This move was regarded by many as the beginning of the "war on drugs" that has affected many regions of Mexico, including Ciudad Juarez. Although accounts as to how many acts of violence and murder vary between government and nongovernment sources, it is estimated that approximately 10,000 people have been murdered in Ciudad Juarez since the "war on drugs" began.
General Demographics

The U.S.-Mexico border is more than 2,000 miles long, stretching from the Pacific Ocean to the Gulf of Mexico. The landscape ranges from rural to semirural to urban settings, creating important differences among the 44 contiguous U.S. counties and 80 municipalities in Mexico. The counties along the U.S. side of the border have more than 7,589,980 million inhabitants; of these people, more than 80% are Hispanic, 6.34% are Black, and 6.99% are Asian (La Fe Policy and Advocacy Center, 2006). The U.S. border is also home to 881,070 Native-Americans, who belong to 154 Native-American tribes and 25 Native-American Nations (EPA, 2012; U.S. Census Bureau, 2010b). The diversity of ethnicities, income, education, culture, languages, health practices, and immigrant generations, among many other characteristics, makes for a complex and multidimensional reality along the U.S.-Mexico border. Acknowledging the particularities found in each county along the border, this chapter addresses key issues shared by the four U.S. states along the U.S.-Mexico border: California, Arizona, New Mexico, and Texas. It homes in on the largest border cities, where most of the population resides and upon which most of the research has focused.

In 1985, federal environmental authorities in the United States and Mexico signed a cooperative initiative to implement a multyear plan to protect the environment and the public’s health in the U.S.-Mexico border region. This collaboration, known as the La Paz Agreement, defines the U.S. Mexico border region as all the land area straddling approximately 61 miles on either side of the border, stretching from the Pacific Ocean to the Gulf of Mexico (EPA, 2012). This definition has become a common spatial designation used in public health and social sciences literature.

The EPA (2012) estimates that the population of this strip of land on both sides of the U.S.-Mexico border exceeds 12 million people, with this population expected to keep growing at higher rates than other areas in either country. According to the 2010 U.S. Census, the border states of Texas, New Mexico, Arizona, and California have a combined population of 70,850,713, representing 22.9% of the total U.S. population (U.S. Census Bureau, 2010b). The estimated combined population of the six Mexican border states in 2010 was 19,984,418 (INEGI, 2010). The population of the Mexican and American border undoubtedly exceeds 90 million people, as many scholars recognize that the U.S. Census historically undercounts populations; most notably minorities, the socially marginalized, the poor, the undocumented, people double-up, and the homeless—all groups prevalent in the border.

The population of the border states nearly matches the overall population of all of Mexico: 112.3 million (INEGI, 2010). Thus, if the border states were to form a country, it would be the 15th largest in the world in terms of population. These comparisons do not reflect a political reality or an aspiration, but rather indicate the important population size in a largely mountainous and desert region that only 100 years ago was sparsely populated. In 1900, "only about 36,000 persons lived along the entire border" (Brandon, Crespin, Levy, & Reyna, 1997). Due to recent internal and international immigration, the U.S.-Mexico border states are young and dynamic and have some of the highest economic and population growth rates found in both Mexico and the United States. Approximately 31% of the border population is younger than the age of 19 (La Fe Policy and Advocacy Center, 2006).

Two of the 10 fastest-growing metropolitan areas in the United States—Laredo and McAllen—are located on the Texas-Mexico border. The U.S. border also has some of the safest cities in the United States. Homicide rates in border cities are much lower than in nonborder cities (Castafieda & Heyman, 2012). In 2010 and 2011, El Paso, Texas, was ranked the safest city in the United States with a population of more than 500,000 (CQ Press, 2011). Since 1997, El Paso has been ranked among the top three of the nation’s safest largest cities.

The border area could be seen as a binational, multistate network of cities. Fourteen twin cities are on both sides of the international boundary; and they are where the majority of the population lives. Some of the twin cities (city in the United States/city in Mexico) are San Diego, California/Tijuana, Baja California; El Paso, Texas/Ciudad Juárez, Chihuahua; Laredo, Texas/Nuevo Laredo, Tamaulipas; and Del Rio, Texas/Ciudad Acuña, Coahuila. These international twin-city regions are among the busiest border crossings in the world. More than half a million people move legally in both directions each day in pursuit of activities such as employment, visiting family, commerce, housing, and health care (Flores & Kaplan, 2009).

Ethnicity and Immigration

It would be incorrect to say that the border counties are the main destination for new immigrants or that these areas are overrun by undocumented immigrants. American citizens constitute approximately 78% of the border population, with a significant portion of the population consisting of permanent legal residents or visa holders. Hispanics account for more than 54% of the border population. Yet the Hispanic population in the border areas is a very diverse group. Except in California, the majority of Hispanics in the border states are U.S.-born Americans. Many of them have lived in the area for more than five generations. International immigrants represent only 22% of the border population—a share that, although approximately twice the national immigration rate of 13% (which is obtained by adding the noncitizen and the naturalized citizen
columns in Table 5.1), does not represent the majority of Hispanics. What differentiates the border areas and the Southwest in general from the rest of the United States is the more than 100-year-old history of migration from Mexico into the area (Jiménez, 2010; Massey, Durand, & Malone, 2002), along with the Mexican and Native-American populations already living in the Southwest prior to the coding of the Southwest territory to the United States at the end of the Mexican-American war of 1848. Not surprisingly, the border states and counties show the largest concentrations of Mexican- or Hispanic-origin populations in the nation. For example, El Paso is more than 82% Hispanic (U.S. Census Bureau, 2010b; Washington Valdez, 2011). The highest new-immigrant concentrations are also found in border counties, in agricultural areas, and in California. Southern California has a larger percentage of first-generation migrants than the other border states, which have a majority of people who are second- or later-generation immigrants (U.S. Census Bureau, 2012b).

**GIS Methodology**

California, Arizona, New Mexico, and Texas are the four states that border Mexico. For our analysis, we selected counties along the U.S.-Mexico border states that are contiguous with northern Mexico, as well as a cluster of southwestern border Texas counties. The two border counties in California are Imperial and San Diego. The four Arizona border counties are Cochise, Pima, Santa Cruz, and Yuma. In New Mexico, there are seven border counties: Doña Ana, Eddy, Grant, Hidalgo, Lea, Luna, and Otero. The 22 Texas border counties are Brewster, Brooks, Cameron, Culberson, Dimmit, El Paso, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Kenedy, Kinney, Maverick, Pecos, Presidio, Reeves, Starr, Terrell, Val Verde, Webb, Willacy, and Zapata. Census 2010 data at the county level were used to estimate the total population and to construct the percentage represented by Hispanic populations (self-selected ethnicity or Latin American or Spanish origin). American Community Survey (ACS) five-year estimates (2006–2010) at the county level were used to construct the percentage of the population below the poverty line, the percentage of the population represented by naturalized citizens, and the percentage of the population who are not U.S. citizens. Census and ACS sociodemographics variables were mapped using the ArcMap10 geographic information system (GIS) software and are shown as quantities in Table 5.1.

As Table 5.1 shows, the percentage of the population below the poverty level in U.S. border counties (20.12%) is much higher than the national average (13.82%), particularly for New Mexico (21.37%) and Texas (30.91%) (U.S. Census Bureau, 2012a). The GIS map included in Figure 5.1 provides a more nuanced and graphical display of the population below the poverty level in the counties in the border states. Texas shows the strongest spatial correlations of poverty and large Hispanic populations at the county level (see Figures 5.1 and 5.2).

**Access to Health Care**

In Mexico, more than 34% of the population has no health care coverage. Of those people who do have some form of coverage, approximately 65% have health coverage through government programs, and only 2.8% through private insurance (INEGI, 2010). Access to health care is an ongoing issue on many parts of the U.S.-Mexico border. In the northern Mexican border states, 37.3% of all individuals have no health insurance, 58.7% are insured by the state social security system, and 4% are considered unspecified. The situation was much worse before 2002, when the so-called Seguro Popular was implemented. As of April 2012, 52.6 million people were enrolled in this Mexican government-run program (Secretaria de Salud, 2012). Seguro Popular was designed to provide medical help to low-income families. Anyone enrolled in this program has medical coverage for 284 medical interventions and more than 500,000 illnesses as described in the program's catalogue (Catalogo Universal de Servicios de Salud). To qualify for the program, a family should not have an annual income higher than 11,378.86 pesos. Seguro Popular is funded by the
federal government and the states, and the percentage every family or individual pays as their share is determined by their annual income. In 2012, the federal government paid $800,19 pesos per individual enrolled in the program; the states paid $440,10 per individual enrolled in the program; and the rest of the funding came from the percentage each individual enrolled in Seguro Popular has to pay (Seguro Popular, 2012). In 2009, more than 9 million families were enrolled in the program, yet the states next to the U.S. border have some of the lowest enrollment numbers, leaving many Mexican citizens uninsured (INEGI, 2010).

The border region of Texas has a 30% rate of uninsured people, and approximately 14% of California county populations along the U.S.-Mexico border are uninsured (United States-Mexico Border Health Commission, 2010). Some border residents from Mexico and the United States (insured and uninsured) access both traditional and alternative forms of medicine, such as herbs or massages, more frequently than the national rate (Rivera, Ortiz, Lawson, & Verma, 2002).

Although populations in border communities along the U.S.-Mexico border region have some of the highest uninsured rates in the United States, the proximity to medical care in neighboring Mexican border cities may offer more alternative forms of health care to the uninsured than communities farther away from the border. It is important to note that the number of people seeking medical care in Mexico has dropped significantly since the “drug war” violence began in Ciudad Juárez. In a recent study of 1,091 border residents surveyed in El Paso, Castañeda and Lachica found that 55.6% of respondents did not have medical insurance. Among the uninsured, 31% cross the border into Ciudad Juárez for health care. Reflecting the toll taken by the ongoing violence, 40% of the sample surveyed reported going to Mexico for medical care before 2008; today 26% still go to Mexico for medical care, but 14% no longer seek affordable care in that country due to safety concerns.

Some border residents living alone or in relative poverty do not have access to convenient and extensive public transportation systems that might enable them to seek health services. Preliminary research by Castañeda and Lachica revealed that more than 12% of their respondents were kept from seeking health care because of transportation issues, while more than 34% reported that financial problems kept them from seeking health care.

**Health on the U.S.-Mexico Border: Transnational Approaches**

Traditional approaches to understanding disease and health care as either local, regional, or national problems are particularly inadequate to describe disease and health in this binational border region. Social sciences research specifically related to border health can be divided into two equally substantive research and intervention approaches and bodies
of literature (Collins-Dogru, 2006). The first deals with the transnational approaches of people, patients, pathogens, and diseases crossing borders (Collins-Dogru, 2006). For example, research by Grizeski (2011) describes how parents of children with asthma navigate transnational medical fields to take advantage of the best health care practices and prices on each side of the border. Parents on both sides of the U.S.-Mexico border cross the border for their children's health care, unless constrained by a lack of documentation or various other barriers, such as lack of transportation (Heyman, Núñez, & Talavera, 2009). The second body of literature addresses collaboration across geopolitical borders (Collins-Dogru, 2006), as seen with ongoing research by the Pan American Health Organization (PAHO) and the Border Health Commission, which are binational collaborations designed to address health and environmental issues in border regions shared by the United States and Mexico. Diseases and environmental degradation are blind to geopolitical boundaries—hence the need for increased collaborative partnership between countries.

Noncommunicable Diseases

The predominant diseases among the U.S.-Mexico border region population include cardiovascular disease, diabetes mellitus, and cancer—more specifically, prostate, breast, cervical, and uterine cancers (United States-Mexico Border Health Commission, 2010). The United States and Mexico share similar health concerns. In the United States in 2009 and 2010, heart disease was the leading cause of death, with lesser causes including malignant neoplasms (second), cerebrovascular diseases (fourth), and diabetes mellitus (seventh) (Kochanek, Xu, Murphy, Minnifoe, & Kung, 2011; Murphy, Xu, & Kochanek, 2012). For Mexico in 2008, the leading cause of death was diabetes mellitus, followed by ischemic diseases of the heart, cerebrovascular diseases, and hypertension (SINAIS, 2011). Not surprisingly, then, type 2 diabetes is one of the priority objectives in the Healthy Border 2010 Program (United States-Mexico Border Health Commission, 2010). According to the literature, the high rates of diabetes among Hispanics and the high percentage of Hispanics living along the U.S.-Mexico border region have collectively resulted in a disproportionate number of cases of diabetes occurring in the border states compared to the rest of the United States (Díaz-Kennery et al., 2010).

According to the Latino Coalition for Healthy Californians (2006), the relationship between diabetes and obesity in Latinos is rooted in communities that may both unknowingly and knowingly encourage unhealthy food choices. Some theories that limited choices within communities regarding where one can eat and the availability and pricing of healthy food (such as fresh produce) can impact one's caloric intake and influence the probability of a person being obese. Predominantly poor communities may also be "healthy food deserts," which are defined by the United States Department of Agriculture (USDA) as follows:

Urban neighborhoods and rural towns without ready access to fresh, healthy, and affordable food. Instead of supermarkets and grocery stores, these communities may have no food access or are served only by fast food restaurants and convenience stores that offer low healthy, affordable food options. The lack of access contributes to a poor diet and can lead to higher levels of obesity and other diet-related diseases, such as diabetes and heart disease. (USDA, 2012)

The landscape of food deserts can be seen as going hand in hand with communities that are predominantly poor, like many of those found in the U.S.-Mexico border regions. Yet due to the proximity to Mexico, to agricultural lands, and to large chain stores and small ethnic businesses catering to Hispanics, this does not seem to be the case in the border (Anchondo, 2013).

The Pan American Health Organization (2005) reported that among the 7.5 million adults living on the U.S.-Mexico border, approximately 1.2 million adults have diabetes, with approximately 500,000 living on the Mexican side of the border and 700,000 living on the U.S. side. The diabetes border study also showed that the level of obesity on both sides of the U.S.-Mexico border is between 33% and 41%. The report estimated that 5.3 million adults in these areas are overweight or obese. Obese individuals are at increased risk of diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, among other conditions. The study also indicated that people on the U.S. side of the border who are obese have a 2.8 times greater risk of having diabetes than people of normal weight (PAHO, 2005).

Interestingly, a study by CDC researchers found that most obese adults are not classified as "low income," warranting questions as to reasons for obesity among poor border residents (Ogden et al., 2010). Yet other researchers point directly at poverty being an indicator of obesity (Foreyt, 2003). The difference may not be so much the incidence of diabetes among Hispanics as the higher mortality rates among Hispanics at the border (La Fe Policy and Advocacy Center, 2006). The increasing size of the Hispanic population in the southwestern United States as well as throughout all parts of the United States calls for more research to begin to understand and prevent the growing issues of obesity and diabetes among all Hispanic populations, including those who live on the border.

Communicable Diseases

From an epidemiological perspective, twin cities such as El Paso and Ciudad Juárez should be seen as one metropolitan area. Although the
two entities are separated by the U.S.-Mexico border, the "sister cities" (as they are often called) should be recognized as one region insofar as pathogens do not recognize geopolitical boundaries. Preliminary results of an analysis commissioned by PAHO show that HIV/AIDS on the border is a critical issue, with rates ranging from 10 to 15 per 100,000 population in the U.S. border states and from 2 to 5 per 100,000 population in the Mexico border states. According to the Texas Department of State Health Services (2011), tuberculosis rates are higher in border regions than in interior parts of Texas. This may be due in part to the higher numbers of foreign-born individuals passing through border regions (Texas Department of State Health Services, 2011). It is important to note that although transmission of tuberculosis (TB) across the U.S.-Mexico border is widespread, a similar phenomenon can be seen in many borders and ports of entry around the world (Salas-Blythe, 2008). The Texas border with Mexico has one of the highest incidences of TB in the United States, estimated at 9.9 per 100,000 (2011). Tuberculosis disproportionately affects poor communities. The national TB rate for Mexico in 2007 was 21%, while the Mexican border states were home to 31% of the total cases in Mexico in 2007 (Moya & Lusk, 2009). The Texas Department of State and Health Services (2010b) also reported a higher prevalence rate of hepatitis C concentrated around the U.S.-Mexico border, with the upper level near- ing 2.6% in 2010.

Violence and Mental Health

Along with tuberculosis, cancer, and diabetes, "violence, mental illness, psychosocial problems, suicide, depression and substance abuse . . . are major contributors to the burden of disease and disability for the U.S.-Mexico Border communities" (PAHO, 2012). An increasing body of literature describes violence as a public health issue (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Since 2008, northern Mexico has seen an unprecedented deployment of the Mexican Federal Police and Mexican military. Campbell (2009) describes the northern Mexican border as a "drug war zone," indicating the warlike, violent atmosphere found there. With a current count of 47,515 murders (Cave, 2012) and an ongoing fear of federal, military, and local police officers and cartel members alike, citizens on the Mexican side of the border increasingly have to deal with stress and trauma. Some of the residents of northern Mexico who have American citizenship or visas, or the few who have been given asylum, come to the United States and may suffer from different levels of post-traumatic stress disorder (PTSD).

Although research on the effects of the ongoing violence in northern Mexico is limited (in part due to the continuous nature of the violence, which makes for a lack of long-term analysis on the outcomes of such

violence), one can deduce that the widespread murder, kidnapping, and extortion found on the Mexico side of the U.S.-Mexico border have ongoing implications for the mental health of both Mexican and United States residents of the border. Despite the low levels of violence and crime on the U.S. side, the effects of violence in Mexico are felt: if the local culture can be binational, so, too, can the mental health effects of violence, even for those persons who do not cross into Mexican border cities. Ongoing research will allow us to better understand the effects of increased violence on people's health.

Upper-middle-class immigrants—including asylum seekers, U.S. citizens previously living in Mexican border cities, and, to a much smaller extent, undocumented Mexican citizens fleeing the violence in Mexican border cities—face a lack of mental health professionals trained to deal with this type of trauma once they arrive in the United States. According to a local clinical social worker, another barrier to seeking care for health care treatment is the paranoia observed among people escaping extortion attempts in Ciudad Juárez; patients even fear that the organized crime elements there may find out that they are talking about them to their therapists. Although border cities such as El Paso have always maintained services for migrants (such as the Annunciation House migrant shelter), the mental health infrastructure in cities such as El Paso is not set up to assist the increased wave of trauma-stricken migrants fleeing the violence experienced since 2007. Amid the rise of this violence, the Greater El Paso Chamber of Commerce Community Mental Health Survey in 2008 found that a number of factors make service delivery difficult in El Paso, including stigma regarding mental health within the community culture, a lack of funding, a large number of indigent or uninsured patients, and limited licensed mental health professionals (Tomnka, Caire, & Soden, 2008). Despite the immigrant reality of the area, mental health services cannot adequately deal with the stressors brought about by migration itself (Castañeda & Buck, 2011).

Drug and Alcohol Use

Drug and alcohol smuggling have played a significant role in the culture and economy of many regions along the U.S.-Mexico border. Since the days of alcohol prohibition in the 1920s, through the growth of the Mexican heroin trade, and now due to the U.S. countercultural demand for marijuana, the border has been a major port of entry of illegal substances (Campbell, 2009). According to Moya and Shedlin (2008), "While new immigrants are less likely to engage in drug use than the U.S.-born population, those living in the United States for 10 years or longer report drug use that does not differ statistically from that of native born populations." (p. 1748).
The constant availability of drugs along the U.S.-Mexico border has increasingly become a public health issue. The increased prevalence of smoking and injecting methamphetamine and crack, plus the continued preferred method of injecting Mexican tar heroin, leads to high-risk, drug-influenced behaviors including shared syringes (Maxwell et al., 2000). Clean syringes can help reduce the spread of blood-borne diseases such as HIV and hepatitis C. Scott Comar’s (2010) memoir illustrates the common practice of Ciudad Juárez law enforcement regularly rounding up injection drug users and anyone else who might look transient, confiscating their needles and drug paraphernalia, and then putting them in prison when the suspects do not have enough money to pay off the arresting officers. Drug addicts go through terrible withdrawal symptoms in prison and are desperate for a fix when they come out after 48 hours. After leaving detention, because of the chemical need to “get well,” they may use other people’s syringes. This behavior poses a high risk for spreading HIV and hepatitis C.

Health Disparities Survey Findings

Here we present the results from a survey of a purposive sample of 1,091 residents of El Paso, Texas, of whom 233 were homeless people of any race or ethnicity. The survey focused on Hispanics and mobile populations. It oversampled the undocumented and homeless subpopulations, but also included housed people and citizens. The survey included information on Hispanics of different generations and legal statuses.

The following figures are from a subsample of 884 Hispanics. Fifty-three percent of respondents had no medical insurance. Seventy-three percent said they needed general health care services in the last 12 months but could not get them. Fifteen percent said they needed help but could not access, dental care. Ten percent said they needed, but could not access, eye care. Another 34% said they needed mental care but could not access it. 25% said they needed substance abuse counseling but could not access it. As a point of comparison, 14% said they needed help finding a job. Out of those who were declined health care in the last 12 months, 25% reported having been victims of discrimination in the past 5 years. In turn, of those who were declined health care in the last 12 months, 35% had at one point been convicted of a crime. Of the 17% who said they lacked access to health care in the United States, 34% of those denied health care in the United States were able to obtain it in Ciudad Juárez. The question remains as to what happens to the other 66% of those without access to health care.

Conclusion

The proximity to Mexico and the relatively low cost of living in the U.S.-Mexico border region can make poverty and disease more bearable in some ways, yet poverty on the border presents particular challenges to some of the area’s inhabitants—especially those disenfranchised without citizenship, those without residency papers or visas, and those living in colonias. What can be stated without hesitation is that there is a need for more culturally sensitive (i.e., Mexican-American), linguistically appropriate, class-sensitive, and place-informed (i.e., U.S.-Mexico border region) research and analysis. Although the communities along the U.S.-Mexico border do share demographic, cultural, and socioeconomic similarities, further studies taking into consideration the many variables that distinguish the border communities are needed. The increasing population of Hispanics in the southwestern United States as well as throughout all parts of the United States calls for more research to better understand and prevent the growing issues of obesity, diabetes, mental health, and poverty among all Hispanic populations, including those who live on the border.

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Chapter 6

Neighborhood Effects on Obesity among Racial-Ethnic Minorities: A Lifespan Approach

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While the etiology of racial-ethnic disparities in obesity is complex, the scientific evidence clearly supports a link between neighborhood context and obesity among racial-ethnic minority groups. Although overweight and obesity prevalence have increased for all racial-ethnic groups, the rate of overweight and obesity among racial-ethnic minorities is disproportionately larger than that among non-Hispanic Whites (Ogden, Carroll, Kuc, & Flegal, 2012; Schell & Gallo, 2012). This disparity may be due in part to the neighborhood contexts in which racial-ethnic minorities reside (Frank, Kerr, Sallis, Miles, & Chapman, 2008).

There are several plausible mechanisms through which neighborhood context contributes to the disproportionate prevalence of obesity among racial ethnic minorities. Prominent among them are neighborhood economic viability, built environment barriers, and social contexts. Often, racial-ethnic minorities are concentrated in racially segregated urban areas characterized by a large percentage of residents living below the poverty line (Subramanian, Chen, Rehkopf, Waterman, & Krieger, 2005; Williams & Collins, 2001; Wilson, 1987, 1996). This concentration of urban...