The **Health of Immigrants** in New York City

NYC Health

Contents

Key Findings

New York City's over 3 million immigrants — more than one-third of the city's population — represent a broad spectrum of global communities, cultures and languages and have a variety of health needs. While four out of five immigrants have been in the U.S. for 10 years or longer, over 229,000 have arrived from the U.S.-Mexico border between spring 2022 and January 2025. This influx of new arrivals has made attention to the health needs of immigrants ever more urgent.

No report can touch on all of the health experiences of immigrant New Yorkers nor delineate all of the structural conditions that influenced them. We have tried to fairly portray and interpret the data while noting the numerous limitations. For example, the NYC Department of Health and Mental Hygiene (NYC Health Department) does not ask about immigration status in providing services or conducting surveys, as a matter of policy and inclusion, so we cannot report on immigration status; and data on some new immigrant populations, especially communities with a smaller number of immigrants, and immigrant experiences with discrimination or anti-Black racism, are limited. We acknowledge these and other factors as affecting the well-being of our city's immigrants particularly and of all New Yorkers.

Some noted strengths of NYC's immigrant population and their support to the city as relates to health:

- Immigrants in NYC are estimated to live longer from birth than U.S.-born New Yorkers (83.5 vs. 79.9 years).
- Immigrants overall are less likely than U.S.-born New Yorkers to be currently smoking (7% vs. 11%), and the rate among female immigrants is lower (4%).
- Heart disease and cancer are the number one and number two causes of death for both immigrant and U.S.-born New Yorkers. Compared with U.S.-born New Yorkers, however, immigrants have death rates that are 28% lower for heart disease and 19% lower for cancer.
- Immigrants are more likely than U.S.-born New Yorkers to work in service professions (30% vs. 18%), which includes many social service and health care support roles and other positions that sustain New Yorkers' well-being.
- Immigrants comprise 47% of NYC's workforce of health care practitioners and technical occupations.

Immigrants may experience health challenges stemming from structural issues such as exclusion from programs based on immigration status, race and ethnicity, employment that doesn't offer health insurance, and language barriers. Some key indicators of structural and health issues among NYC's immigrants are:

- Immigrant adults (15%) are nearly twice as likely as U.S.-born adults (8%) to not have health insurance. Immigrants who are Latino (26%) or born in Mexico (46%) are most likely to lack insurance.
- Immigrants with depression are less likely to receive mental health treatment (34%) than U.S.-born New Yorkers with depression (48%).
- Immigrant New Yorkers (14%) are more likely than U.S.-born New Yorkers (10%) to have diabetes. Diabetes prevalence is particularly high among immigrants from Bangladesh (31%).
- The prevalence of hypertension, a major risk factor for heart disease and stroke, is higher among Caribbean-born New Yorkers (36%) than immigrants as a whole and U.S.-born New Yorkers (both 29%).
- Infant death is rarer when the birthing parent is an immigrant than U.S.-born (3.3 vs. 4.2 per 1,000 live births). However, relative to other babies of immigrant parents, infant mortality is elevated among those born to birthing parents from Jamaica and Haiti, which is likely due to related systems of oppression including racism and their multilevel impact on social and health conditions.

- Among adults ages 18 to 64, high rates of COVID-19 mortality by occupation type were observed among immigrants working essential jobs such as food preparation and serving (234.2 deaths per 100,000 people), transportation (185.6 deaths per 100,000 people), and construction and extraction (178.7 deaths per 100,000 people). This compared with 48.8, 55.4 and 43.1 deaths per 100,000 people among U.S.-born New Yorkers in the same respective occupation types.

As of June 2024, NYC emergency housing was sheltering 65,000 of the 206,000 immigrants who newly arrived since spring 2022. Seventy-eight percent of these shelter residents were members of families with children under the age of 19. Local government, health care and community organizations are attempting to address the immediate needs of our new arrivals and connect them to primary care services.

To protect the health of immigrants, NYC needs to take measures to affect policy in health and other domains. Efforts must be made to broaden health insurance coverage and safeguard health service access for all New Yorkers. Broader structural issues will need to be addressed as well. We must ensure immigrant populations have access to affordable housing and a right to seek employment. A comprehensive leave-taking policy must protect immigrant New Yorkers' rights to take time off for sickness, caregiving and family formation.

"Immigrant New Yorkers exhibit notable strengths that contribute to their resilience and acceptance, including a collective work ethic and strong cultural bonds [that foster] community and mutual support."

— Korean Community Services

Letter From the Commissioners of Health and Immigrant Affairs

Dear New Yorker,

We are excited to present "The Health of Immigrants in New York City," the first comprehensive report about immigrant health from the New York City Health Department in almost 20 years. Today, over 3 million immigrants contribute to every aspect of life in New York, from democracy and the economy to health care, education and culture. For generations, immigrants have helped shape NYC into the vibrant, world-renowned city it is today.

This report provides a broad picture of immigrant health, including measures that describe social, economic, housing and neighborhood conditions, as well as behaviors, access to care and health outcomes that impact the physical and mental health of our communities. Immigrants in NYC are a diverse group, coming over time from hundreds of places with varying social, political and economic experiences. Differences among immigrants from the largest countries or regions of origin highlight the diversity of immigrant New Yorkers' strengths and needs. Since many of our data sources may not capture the experiences of the newest New Yorkers, a separate section on new arrivals to NYC is included.

Communities across New York see firsthand how social and economic drivers and access to care here and abroad affect immigrants' health. I (Commissioner Morse) have witnessed the challenges faced by many immigrant families, including during my work caring for immigrants at Kings County Hospital in Brooklyn and while living in Haiti, Rwanda and Botswana. These experiences have fueled my passion for advocating for global health equity, as I believe that everyone deserves access to quality care regardless of their immigration status or any other factor.

I (Commissioner Castro) know that the health of immigrant communities constitutes the health of New York City. As a New Yorker who immigrated to the U.S. with my family at a young age, I am proud to see how far the City has come in supporting immigrant New Yorkers in health care access and services. Our office will continue to work closely with other agencies and partners to address all determinants of health — social, physical and economic — including City partners such as the NYC Health Department to help immigrant New Yorkers get connected to critical health services.

The topic of immigrant health is particularly important given that, as of January 2025, our city has welcomed over 229,000 new arrivals from the U.S.-Mexico border since spring 2022, many of whose initial needs for health care, housing, employment and legal services are being supported by the City. We hope that this report enriches our understanding of the health of NYC's immigrants, prompts reflection on inequities and the resources needed to support well-being, and spurs further collaboration between City agencies, communities, policymakers and other partners to promote equitable conditions and good health outcomes.

Michelle Morse, MD, MPH, Acting Commissioner, NYC Health Department
Manuel Castro, MPA, Commissioner, NYC Mayor's Office of Immigrant Affairs

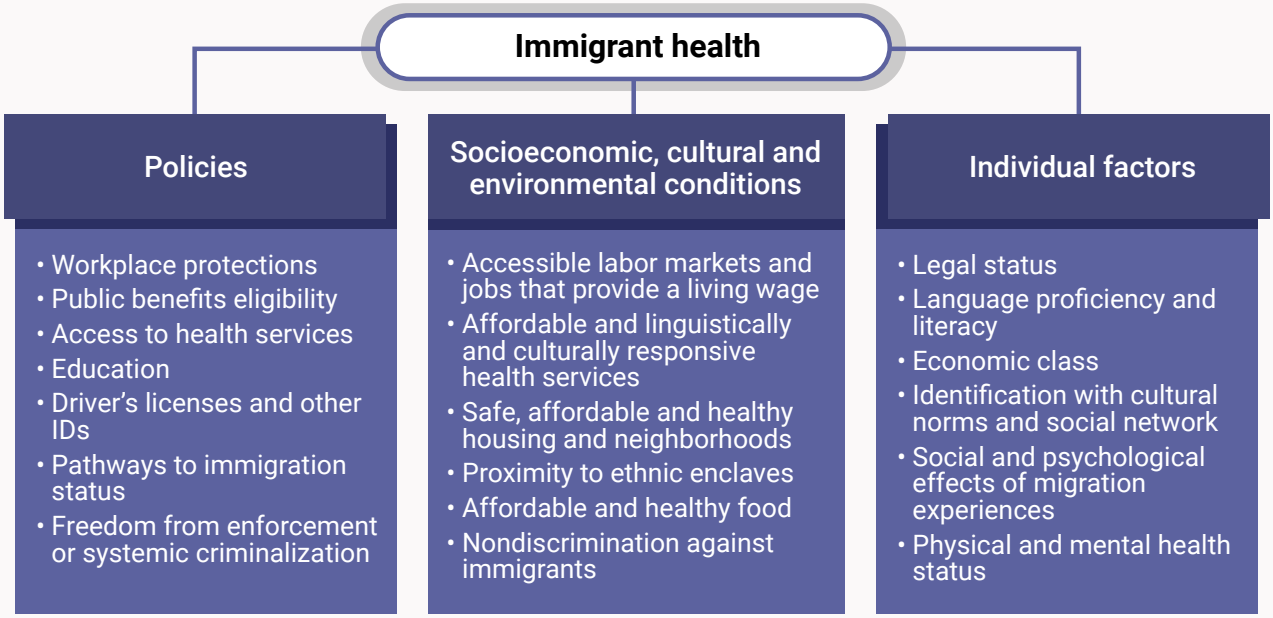
Introduction

New York City has been a destination for immigrants since its establishment. The city is currently home to 3 million immigrants who make up 36% of the population. Immigrants have contributed to every aspect of New York life, including supporting the economy; championing democracy as voters and elected officials; playing vital roles in health care, education and government; bringing a diversity of food, music and art; and leading area sports teams.

Immigrants are a diverse group and may have differences in health outcomes by place of origin, immigration status, race, ethnicity and length of time in the U.S. Their health may be better than that of U.S.-born people for many reasons: the foods they eat may be healthier; they may have more financial resources or social connections; or those who are able to travel to the U.S. to work may be relatively healthy to begin with, a phenomenon referred to as the "healthy immigrant effect."[1] At the same time, some immigrants face distinct health challenges. These may arise in part from systemic racism, xenophobia and long-standing restrictive and discriminatory U.S. policies that have limited access to health services. Immigrants' well-being may also be affected by separation from their families as U.S. immigration policy has promoted immigration of laborers and often constrained family immigration.

The graphic below depicts numerous structural and social factors, including policies, systems and communities, that influence immigrant health. We must understand these multiple factors to best characterize and promote the health of immigrants.

Factors in multiple realms influence the health of immigrants in New York City



This report describes the health of NYC's immigrants as completely as possible, in a short space, based on existing data collected at the population level. It discusses health inequities and structural barriers affecting immigrants. The report primarily compares demographics and health measurements between immigrants and non-immigrants and also makes comparisons among immigrants from different places and regions. It incorporates data showing the broad impacts of the COVID-19 pandemic. Where possible, immigrants' multiple, intersecting identities were considered, including their race and ethnicity and their gender and sexuality. These identities contribute to a population's health and well-being in addition to nativity and immigration. Quotes from community partners are featured to provide personal and organizational anecdotes, convey factors affecting immigrants' health and cast attention across the lifespan. The report also highlights resources and key partners for supporting immigrant health in NYC.

Although these population-based data have limitations and are only part of the whole picture, attention to immigrant health is urgent. The arrival since spring 2022 of more than 229,000 people from the U.S.-Mexico border, many of whom are settling long-term in NYC, shows how important creating a detailed picture of the health of immigrant New Yorkers is. This report aims to inform service delivery and policies that affect our city's growing and changing immigrant landscape.

"[Immigrants have] resilience, resourcefulness and willingness to ask for help. Most have been very responsive to connecting with us and following through. ... They also tend to call to ask questions and for more assistance if they run into obstacles."

— Institute for Family Health

About This Report

This report provides a broad picture of the health of immigrants living in NYC. It begins with a description of NYC's immigrant population including where they are from and other demographic information. It continues with data on the social determinants of health — the social and environmental conditions in which people are born, grow, work, live and age. It then moves on to describe health behaviors that can impact health. The section on family health focuses on pregnancy- and birth-related data, while the mental health section includes data related to children, teens and adults. It then moves to data about access to health care and health outcomes. This is followed by information about new arrivals to NYC. It ends with a reflection on NYC's progress on immigrant health in the past decade and draws some broader conclusions. The report presents data from numerous sources, including Health Department surveys such as the Community Health Survey, Heath Department disease surveillance systems and records of births and deaths, and external sources such as the U.S. Census Bureau's American Community Survey.

To determine which available measures might best convey the health of immigrant New Yorkers, the NYC Health Department collaborated with a group of 18 external partners who bring the expertise of health and service providers, academics and community-based organizers. Population-level data for many of these measures don't typically change dramatically from year to year, partly because of the persistence of structural inequities and their influence on health outcomes. The information about new arrivals and indicators about COVID-19, among others, are changing rapidly.

Adult immigrant New Yorkers are identified by place of birth information. Teenage New Yorkers are represented by data on public high school students, for which "language other than English spoken at home most of the time or all of the time" is used as a proxy for teens who may live in an immigrant household. Statistical analysis shows that a language other than English being spoken at home tracks closely with there being one or more immigrant adults in the household.

Information about a person's place of birth is complex. We classified as "born outside the U.S." anyone born outside the U.S. and U.S. territories. From the American Community Survey, this group includes people born abroad to American parents, who comprised 4% of the foreign-born population or about 135,000 people. The most common places of birth for people born abroad to American parents were the Dominican Republic, Jamaica

"Maybe it shouldn't be surprising that children and families who have traveled thousands of miles for safety are among the most resourceful and resilient patients I have ever met."

— Terra Firma

and China. Other reports that use the same source of data do not always include those born abroad to American parents among the "foreign-born" population. Another complication is that some foreign places of birth are territories or special administrative regions, such as Hong Kong, or a country whose boundaries and names have changed since New Yorkers were born there, such as the U.S.S.R. becoming the Russian Federation. We therefore use the term "place of origin" in this report rather than "country of origin."

It is worth noting that people from Puerto Rico, a U.S. territory, represent 9% of the NYC population and are U.S. citizens whether they were born in the 50 U.S. states or in Puerto Rico. Although they are considered U.S.-born in this report, Puerto Ricans may share some experiences similar to those of immigrants, including a history of colonization, challenges with language access at times, and the stress of being away from one's place of origin.

Where possible, data are reported by place or region of origin to characterize differences among immigrant groups. Groupings varied for each data source used in this report. Measures of health are analyzed and presented among as many as nine global regions and 20 places of origin that represent the largest immigrant populations in NYC. Throughout the report, presentations of some or all of these top 20 places of origin are referred to by "top places of origin/immigration," or data may be shown by regions. When data on place or region of origin are not available or reliable, data are shown only among immigrant New Yorkers overall.

In this report, some of the survey results compare estimates between two groups using a statistical method known as a t-test. For some data where a t-test has not been conducted, instead 95% confidence intervals are used to compare. A confidence interval is a range of values in which we are 95% sure the true value lies. In these cases, if the confidence intervals of two measures did not overlap, a significant difference is inferred. This is a conservative measure of statistical difference. For both t-test and confidence interval comparisons between measures, the reference groups are usually specified in the body of the text. The report text highlights statistically significant findings but does not include all significant results.

Most estimates are evaluated for reliability. Estimates with a relative standard error greater than 30%, or with a small sample size or number of events, are noted as follows: "Interpret estimate with caution due to small sample size." Survey estimates from the Community Health Survey are age-adjusted. All survey estimates are weighted to represent the NYC population and compensate for unequal probability of selection and nonresponse bias.

Online supplemental tables provide numbers, rates, t-test results, confidence intervals, technical notes and additional analyses by places and regions where available for each data source: See the online appendix at nyc.gov/assets/doh/downloads/excel/episrv/ihr-appendix-2025.xlsx. Some characteristics, such as legal immigration status or whether someone is a new arrival to the U.S., are largely unavailable in the sources we present.

The report includes quotes and vignettes from several NYC community-based organizations that partner with the NYC Health Department to serve immigrant communities across the city. While these organizations serve all New Yorkers, they focus on decreasing health inequities among foreign-born New Yorkers by improving access to health care, addressing cultural and language barriers, and targeting resources and interventions. Their quotes reflect their specialties and expertise and do not represent all NYC community-based organizations, all providers for NYC immigrants or the experiences of all immigrant New Yorkers.

Terminology

Immigrant, migrant, foreign-born, born outside the United States: The experience of immigration is complex and may vary based on immigrants' identities. People who come to the U.S. from around the world may have very different journeys, experiences and motivations. We strive to both use appropriate terminology and acknowledge that not everyone may identify with the same terminology. We therefore use these terms interchangeably in this report, and all are generally referring to people born outside the U.S.

New New Yorkers, new arrivals, asylum seekers: These terms are used to describe people born outside the U.S. and entering NYC since April 2022. Although the term "asylum seeker" is widely used to refer to this population, not all people who have recently arrived in the U.S. and New York have applied for asylum, and some do not intend to or may not be eligible to.

Birthing people, mothers: In acknowledgment of the potential experience of oppression and health inequities for a person holding multiple marginalized identities, we take an inclusive approach and use words like "mothers" and "pregnant or birthing people" in this report.

Sex: "Male" and "female" are terms used to represent sex, separate from gender identity. Sex is identified in the American Community Survey by the question "What is [person's] sex?", in the Community Health Survey by the question "What was your sex assigned at birth?"; and in the Youth Risk Behavior Survey by the question "What is your sex?" Everyone has a gender identity — for example, man or woman — and a sex assigned at birth. Sex and gender may correspond or, for people such as transgender and nonbinary people, they may not. See page 19 for data on gender identity.

Age adjustment: Estimates from the Community Health Survey and mortality rates are age-adjusted to the U.S. 2000 standard population. To compare different populations, age adjustment is a common way to account for different age distributions. For example, when comparing the rate of death, if one population has a larger percentage of older people, they may have a higher rate of death only because older people are more likely to die. Age adjustment standardizes the populations being compared to account for different age distributions.

Poverty/income: High poverty/low income is defined as household income below 200% of the federal poverty level (FPL), medium poverty/medium income as between 200% and less than 400% FPL, and low poverty/high income as 400% FPL or higher.

New York City Immigration History Through the 20th Century

NYC has always been a city of immigrants. The flow of immigrants to NYC has been influenced by social, political and economic conditions around the world; economic opportunities in the U.S.; and the racial and ethnic discrimination embedded in U.S. society and immigration policy. This timeline of the policies and eras that have shaped NYC's immigrant tapestry is far from complete but demonstrates the evolving nature of immigration to the U.S. and NYC. It provides context for interpreting the health and well-being of immigrants in NYC as presented in this report.

Pre-1600s

The Lenape, an Indigenous society, settled in the territory that is now NYC around 3,000 years ago.

Mid-1800s to early 1900s

Irish, Italian, Chinese and Jewish immigration waves — Beginning in 1845, the Irish Potato Famine spurred emigration to the U.S. Beginning around 1860, landless Italian farmers escaping poverty emigrated to NYC. Chinese immigration to NYC began to grow around the 1870s, as employment in the western U.S. became scarcer. Jews fled violent riots aimed at killing or expelling them, called pogroms, in Central and Eastern Europe beginning in the 1880s. All of these groups faced religious, economic and ethnic discrimination once they arrived in the U.S.

1800

1600s

Non-Indigenous settlers and colonization — The first non-Indigenous settler in what is now NYC was Juan Rodriguez, a Black or mixed-race man born in what is now the Dominican Republic, who arrived on a Dutch ship in 1613. In the 1620s, the Dutch forcibly displaced the Lenape, established the colony of New Amsterdam and brought the first enslaved Africans to the colony. In 1664, the Dutch peacefully surrendered New Amsterdam to the English, who renamed the colony New York. Under English rule, Africans continued to be enslaved in NYC.

1892

Ellis Island opened in New York harbor as an immigration processing center. It welcomed over 12 million immigrants to the U.S. over 62 years.

1882

The Chinese Exclusion Act banned Chinese laborers from entering the U.S. and established a precedent for immigration policy discriminating based on country of origin. The legislation was not repealed until 1943.

1924

Fueled by nativist ideals, the **Immigration Act of 1924** instituted a national origins quota system. This halted immigration from Asia and curtailed the number of immigrants from Southern and Eastern Europe.

1965

The **Immigration and Nationality Act of 1965** overturned the discriminatory national origins quota system, prioritized family reunification and emphasized high-skill employment. It ushered in immigrants from Asia, the Caribbean, Africa, and Southern and Eastern Europe and dramatically increased NYC's cultural diversity.

1900

1980

The **Refugee Act** created a standardized process for the admission and resettlement of refugees escaping persecution and created a pathway to permanent residency and citizenship for refugees and asylees.[2]

1960s-1980s

Dominican immigration Dominican migration to NYC accelerated in the 1960s as a result of economic and political turmoil in the Dominican Republic.

1986

The **Immigration Reform and Control Act** created civil and criminal penalties for employers who knowingly employed undocumented workers and allowed undocumented immigrants who entered the U.S. prior to 1982 to become permanent residents. About 3 million immigrants gained legal status.

1987

New York State established the **Prenatal Care Assistance Program** to provide Medicaid coverage to low-income pregnant people regardless of immigration status.

1990s-present

Mexican immigration to the U.S. increased and agricultural labor markets became increasingly competitive. Immigrants from Mexico increasingly moved to NYC and other cities for service-sector and construction jobs.

1990

New York State established **Child Health Plus**, an insurance option for children from low- to middle-income families and available regardless of immigration status. The program served as a model for the later establishment of the national Children's Health Insurance Program.

1996

The **Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA)** — Among other changes to public benefits, PRWORA created a five-year wait period before lawfully present immigrants can enroll in Medicaid, Child Health Plus or other public benefits nationally. Deportations increased significantly in response to IIRIRA.

New York City Immigration Milestones in the 21st Century

2001

Aliessa v. Novello — A group of immigrants subjected to the waiting period for lawfully present immigrants to enroll in public benefits sued New York State, claiming that the policy violated their rights under both the New York State and U.S. Constitutions. In response, New York State established state-funded Medicaid for individuals considered to be Permanently Residing Under Color of Law.

2010

The **Affordable Care Act** was enacted to expand affordable health insurance coverage but largely excluded undocumented immigrants from new programs and coverage expansions.

2017

Executive Order 13768 expanded ICE powers and allowed local law enforcement to, in many cases, deport immigrants, in violation of federal laws.

2001 | 2010 | 2012 | 2017

2001

9/11 attacks — Muslim and Muslim-perceived people in the U.S. experienced increased xenophobia. In 2003, the Immigration and Naturalization Service was abolished and the Department of Homeland Security and Bureau of Immigration and Customs Enforcement (ICE) were formed, shifting immigration policy to focus on border security. Policies targeting Arab, Muslim and South Asian communities in particular were enacted.

2012

Created via executive order, **Deferred Action for Childhood Arrivals (DACA)** protects some undocumented immigrants who came to the U.S. as children from deportation and allows access to work permits. In 2021, following a rescission by President Trump and numerous lawsuits, a U.S. District Court determined that the policy is illegal. Currently, the program is not accepting new applications but still provides protections to recipients pending appeals of the 2021 ruling. In New York State, DACA recipients are eligible for state-funded Medicaid.

2018

A **"zero tolerance" policy** was created with the intention to prosecute all undocumented adult immigrants in federal court. Children accompanying these adults, who would not be prosecuted under this policy, were then separated from their parents and taken into the custody of the U.S. Department of Health and Human Services.

2019-2021; 2022-present

Public charge is a concept that has existed in immigration policy since the 1800s. In 2019, the Trump administration issued regulations expanding the criteria for public charge determinations. This allowed the government to prevent entry into the U.S. or adjustment of status of individuals who "primarily rely on the government for subsistence." The new regulations affected participants in programs such as Medicaid and the Supplemental Nutrition Assistance Program. Following numerous lawsuits, the Biden administration issued updated public charge regulations, which effectively reverted to the previous policy.

April 2022-present

New arrivals — As of January 2025, over 229,000 people had newly arrived in NYC and entered City emergency housing since April 2022. Many of these people arrived after having crossed the U.S.-Mexico border with the intent to pursue an asylum claim. Both policies within the U.S. and political, social, ecological and economic conditions in other countries have contributed to migration. During the same period, war in Ukraine led to a designated humanitarian parole pathway for Ukrainian nationals and the arrival of more than 14,000 Ukrainians to NYC.

2024

New York State expanded its **state-funded Medicaid** program to cover low-income individuals ages 65 or older regardless of their immigration status.

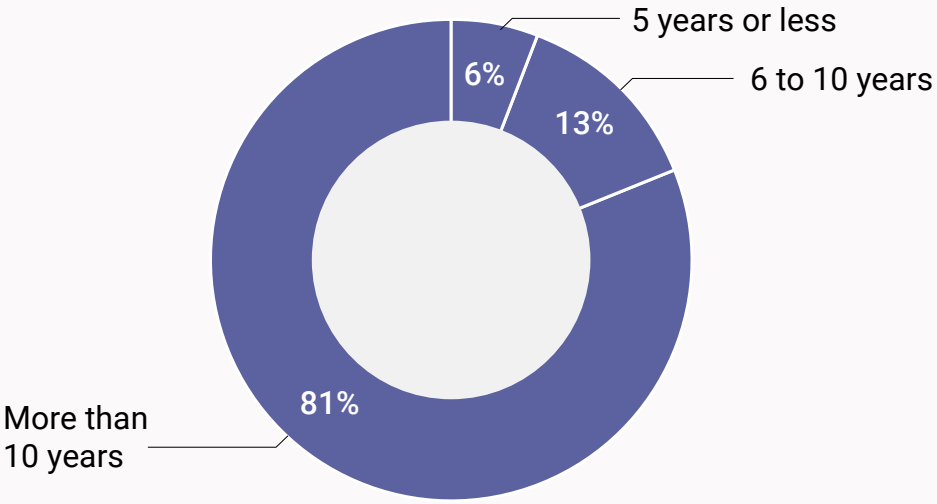
Immigrants in New York City

The immigrant population of NYC hails from more than 150 countries and speaks more than 700 dialects,[3] making NYC the most linguistically diverse city in the world. About a quarter of NYC immigrants speak primarily English, 30% speak Spanish and 12% speak Chinese (including Mandarin and Cantonese) at home. In descending order by number of speakers, after Spanish and Chinese, the other top non-English languages spoken at home are Russian, Bengali, French Creole or Haitian Creole, French, Arabic, Korean, Niger-Congo languages (such as Yoruba and Igbo), Tagalog/Filipino, Polish and Italian.

Of the more than 3 million immigrants that make up the population of NYC, most (81%) have been in the U.S. for more than 10 years and 59% are naturalized citizens. An analysis of 2019 data estimates that 62% of NYC families include at least one immigrant member. Among them, 12% of families are mixed status, which means at least one person in the family is undocumented, while others may be naturalized citizens, legal permanent residents or of other lawful status.[4]

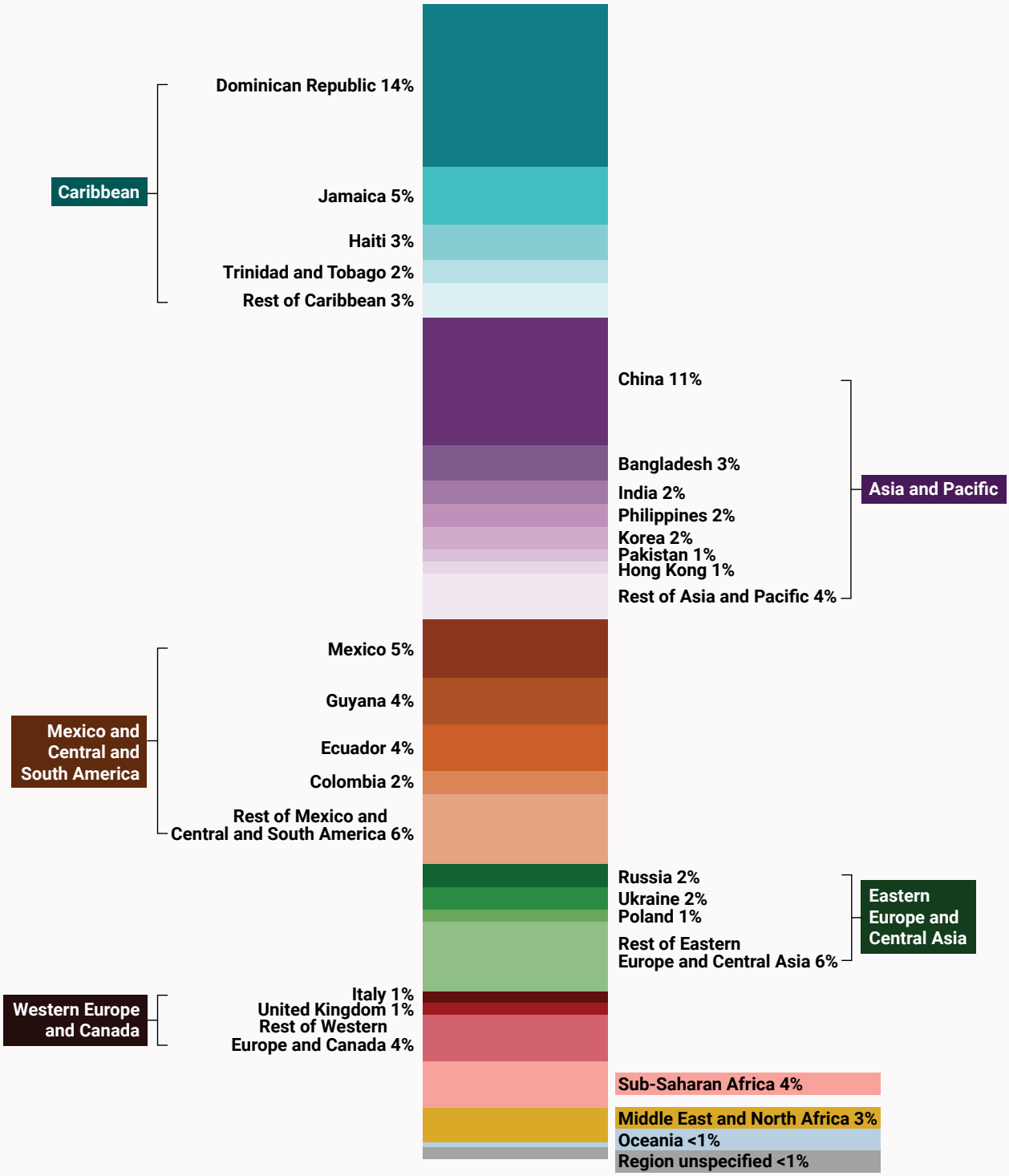
New Yorkers from the Dominican Republic and China make up a quarter of the city's immigrant population. More people move to NYC from the Caribbean than any other region (28%), followed by the Asia and Pacific region (25%). People from the sub-Saharan Africa region comprise 4% of NYC's immigrants, the Middle East and North Africa make up 3%, and Oceania less than 1%. In the decade between 2011 and 2021, there have been small shifts in the proportion of NYC's immigrant population coming from different regions of the world. New Yorkers from the Asia and Pacific region make up one and a half percentage points more of the immigrant population in 2021 (25.3%) than in 2011 (23.7%), while immigrants from Mexico and Central and South America make up 2% less in 2021 (21.9%) than they did in 2011 (23.9%).[5]

Length in time in the U.S. among New York City immigrants



Data source: American Community Survey 2017-2021

Places and regions of origin among New York City immigrants



Note: Places of origin that individually contribute 1% or more proportionally to the NYC population; places that contribute <1% are grouped by region. See the online appendix for list of countries: nyc.gov/assets/doh/downloads/excel/episrv/ihr-appendix-2025.xlsx.

Data source: American Community Survey 2017-2021

Demographic Profile of Immigrant New Yorkers

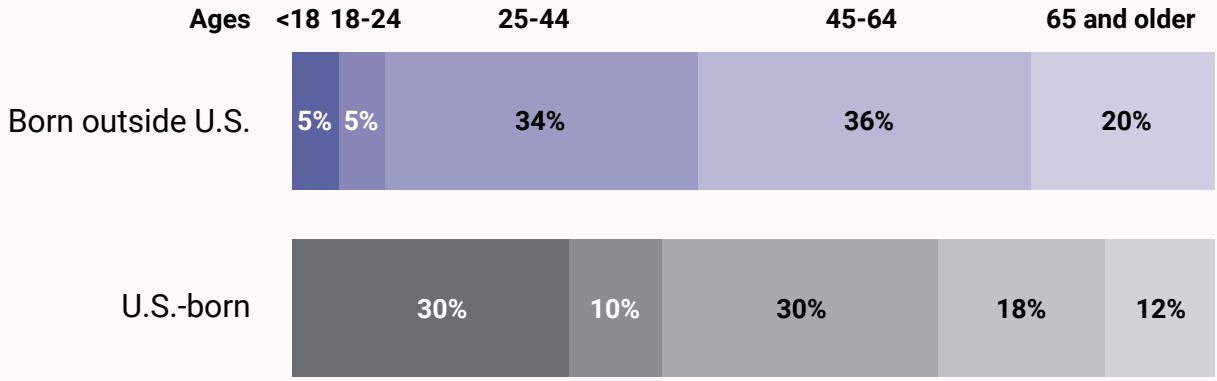
NYC's immigrant population exhibits rich diversity of aspects of their identity, including in areas of race and ethnicity, gender identity, sexual orientation, disability and lived experiences. Immigrants' varied identities, including their identity as immigrants, may intersect to create experiences of privilege and oppression.[6] For example, racial identity is an important component to understand discrepancies in health care access and outcomes across the immigrant population, as a result of historical and present-day systemic racism in the U.S. Even within racial and ethnic groups, experiences may differ depending on ancestry, history of immigration, economic status and other factors.[7,8]

The population of New Yorkers born outside the U.S. is older than U.S.-born New Yorkers. Among U.S.-born New Yorkers, 30% are under 18 years old, compared with only 5% of those born outside the U.S. The proportion of immigrants under 18 years ranges from 2% among those from Korea and Trinidad and Tobago to 11% among immigrants from Bangladesh. Older adults, who are 65 years or older, make up 20% of New Yorkers born outside the U.S. and only 12% of U.S.-born New Yorkers. Italian-born New Yorkers have the highest proportion (54%) of those 65 years or older, among the top places of immigration. Different age distributions between immigrant groups, and between NYC's immigrants and U.S.-born, are explained largely by the timing and magnitude of past waves of immigration and by the ages of those who immigrated.

New Yorkers born outside the U.S. are more likely (14%) than those born in the U.S. (11%) to live in multigenerational households, meaning three or more generations of the same family living in the home. More than one in five Bangladeshi (24%), Chinese (22%) and Guyanese (23%) immigrants live in multigenerational households.

New Yorkers born outside of the U.S. are generally older than U.S.-born New Yorkers

Distribution of population in each age group



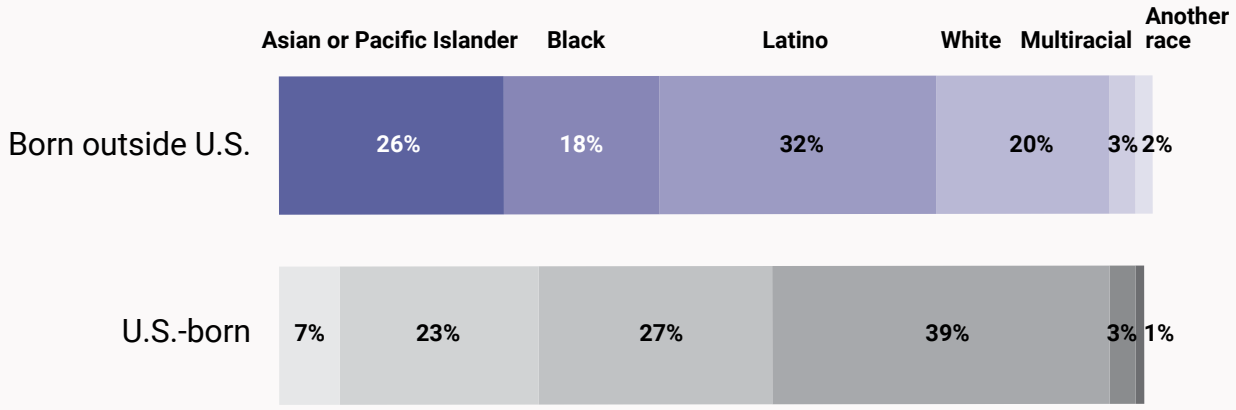
Data source: American Community Survey 2017-2021

In NYC, 26% of immigrants identify as Asian or Pacific Islander (API), nearly four times the proportion of U.S.-born New Yorkers that identify as API (7%). One-tenth of a percent of NYC's immigrants identify as American Indian or Alaska Native, versus two-tenths of a percent of U.S.-born.

Overall, the NYC population is 52% female. Among immigrants, 53% overall are female, ranging among the top places of origin from 42% from Mexico to 59% from Jamaica, 60% from the Philippines and 61% from Trinidad and Tobago. This variation is partly due to policies and practices that encourage immigration by people able to work in certain industries that have unequal gender balances, such as nursing.

A higher proportion of New Yorkers born outside of the U.S. are Asian or Pacific Islander than U.S.-born New Yorkers

Distribution of population in each race and ethnicity group



Note: Asian or Pacific Islander, Black, White, and Multiracial and Another race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Not shown on figure: American Indian or Alaska Native (non-Latino), 0.1% of the immigrant population and 0.2% of the U.S.-born population.

Data source: American Community Survey 2017-2021

Black Immigrants

The pathway to residency and citizenship in the U.S. has many bureaucratic, physical, mental and societal hurdles. For Black immigrants, there are many specific vulnerabilities. In this section, we use the definition of "Black immigrant" used by the Black Alliance for Just Immigration's report "The State of Black Immigrants," where they define it as any person born outside the U.S. or U.S. territories, whose place of origin is in Africa or the Caribbean.[9]

Black immigrants may disproportionately be subjected to harm from discriminatory laws and practices, regarding immigration or otherwise. At an April 2024 NYC City Council meeting, Black migrants testified to the difficulties they were facing, and the city committed to assessing the well-being of new arrivals, including this population.[10-12]

Between 2000 and 2014, the number of foreign-born naturalized and non-citizen Black individuals living in the U.S. increased 54%.[9] Asylum and refugee applications to the U.S. from migrants originating from African countries increased from 72 applications in 2016 to 1,054 in 2018.[13] By 2023, an even higher proportion, although still a minority, of new arrivals to NYC had come from Africa.[10,14]

Increased coordination between the U.S. Immigration and Customs Enforcement (ICE) and police in some U.S. jurisdictions can compound the vulnerabilities of Black and other immigrants.[15] For example, of the nearly 100,000 legal permanent residents deported from the U.S. from 1996 to 2010, almost 10% of these were Jamaican deportees even though Jamaicans made up less than 2% of all legal permanent residents.[16] There is no evidence that Black immigrants are more likely than other immigrants to commit crimes, yet in the U.S., Black immigrants are overrepresented among people in immigration court on criminal grounds and threatened with deportation. Black immigrants account for 20% of those in court despite making up only 7% of the noncitizen population.[9] In New York State, immigrants from African nations with large Muslim populations experience higher-than-average removal rates. Immigrants from the West African region (Benin, Burkina Faso, Cabo Verde, Gambia, Ghana, Guinea, Guinea-Bissau, Cote d'Ivoire, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo) also experience disproportionate removal rates compared with other groups in New York that were born outside of the U.S.[17]

Even before entering the U.S. immigration system, a combination of restrictive policies implemented in 2018 targeting asylum seekers and anti-Black racism have increased Black immigrant susceptibility to discrimination and violence at the southern border of the U.S. For example, the facial recognition software of a smartphone app required to schedule asylum appointments has reportedly failed to register darker skin tones. The U.S.' "Remain in Mexico" policy, enacted in 2019, and its "metering" approach that restricts the processing volume of migrants, has forced many African migrants to wait in Mexico for months for a U.S. asylum claim appointment. This creates special problems for Black immigrants as many African migrants speak languages such as English or French and not Spanish, which complicates navigation of the Mexican health care and immigration systems.[18] Language barriers can persist in NYC in another form, where interpretation and translation services are less likely to be available in African languages.

It is important to include this lens of anti-Black bias when identifying and addressing barriers to health and equity for Black immigrants.

Sexual Orientation and Gender Identity

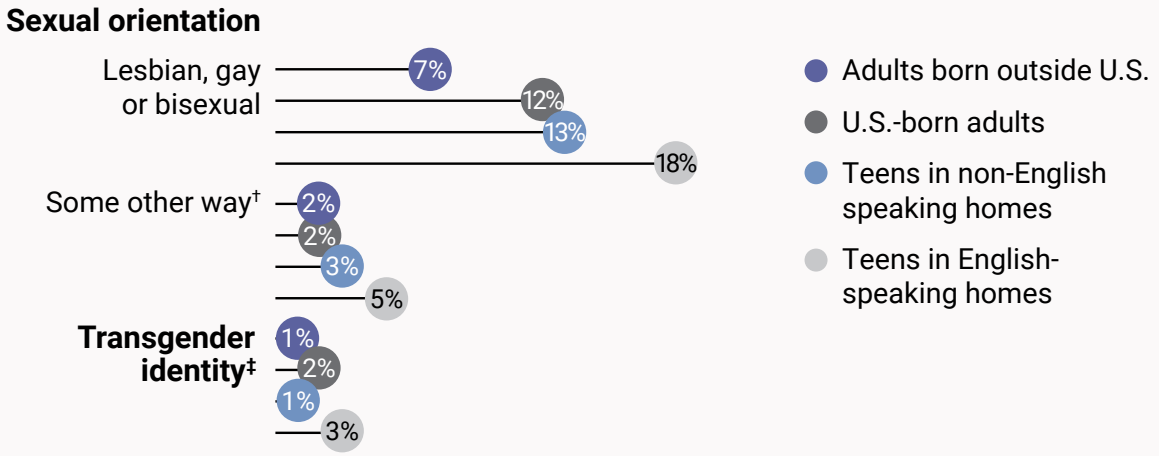
The lived experiences and intersecting identities of NYC's lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) immigrants bring unique and valuable perspectives and contributions. Some historical and present-day policies, practices, beliefs or systems constrain access to health care, presenting challenges for LGBTQ+ people.

Some LGBTQ+ immigrants have fled persecution in their own countries or places of origin and come to the U.S. looking for safety and acceptance. NYC has the nation's largest LGBTQ+ population, with a relatively accepting and celebratory environment, legal protections and numerous LGBTQ-friendly services and organizations. Many LGBTQ+ immigrants may find a home and community here. However, they may still encounter discrimination and trauma, and some may avoid seeking health care services if they are afraid their immigration status, sexuality or gender identity may be revealed — even though it is illegal to discriminate on these bases in health care settings in NYC and New York State.[19]

About 7% of NYC adults born outside the U.S. identify as lesbian, gay or bisexual (LGB), a smaller proportion than U.S.-born NYC adults (12%). Adults from the Philippines were more likely to identify as LGB (25%*) and those from India (2%*) and China (3%) were less likely to identify as LGB, compared with immigrants overall. Among NYC public high school students, teens who live in mostly non-English speaking homes (13%) are less likely than those who live in mostly English-speaking homes to identify as LGB (18%). Note that 5% of teens are unsure of their sexual orientation. The percentage who are unsure does not differ by language spoken at home.

Immigrant New Yorkers are less likely (1%) than U.S.-born NYC adults to identify themselves as transgender, gender-nonconforming, nonbinary or having another gender identity (2%). NYC public high school students who live in mostly non-English speaking homes are less likely (1%) than those who live in mostly English-speaking homes to identify as transgender (3%).

How adult and teen New Yorkers describe their sexual orientation and gender identity



*Interpret estimate with caution due to small sample size.
"Some other way" includes those who describe themselves in some way other than lesbian, gay, bisexual or heterosexual. Among teens, 5% are unsure of their sexual orientation.
‡Among adults, "transgender" includes those who describe themselves as transgender, gender-nonconforming, nonbinary or another gender identity other than man or woman. Among high school students (teens), it includes those who describe themselves as "transgender."

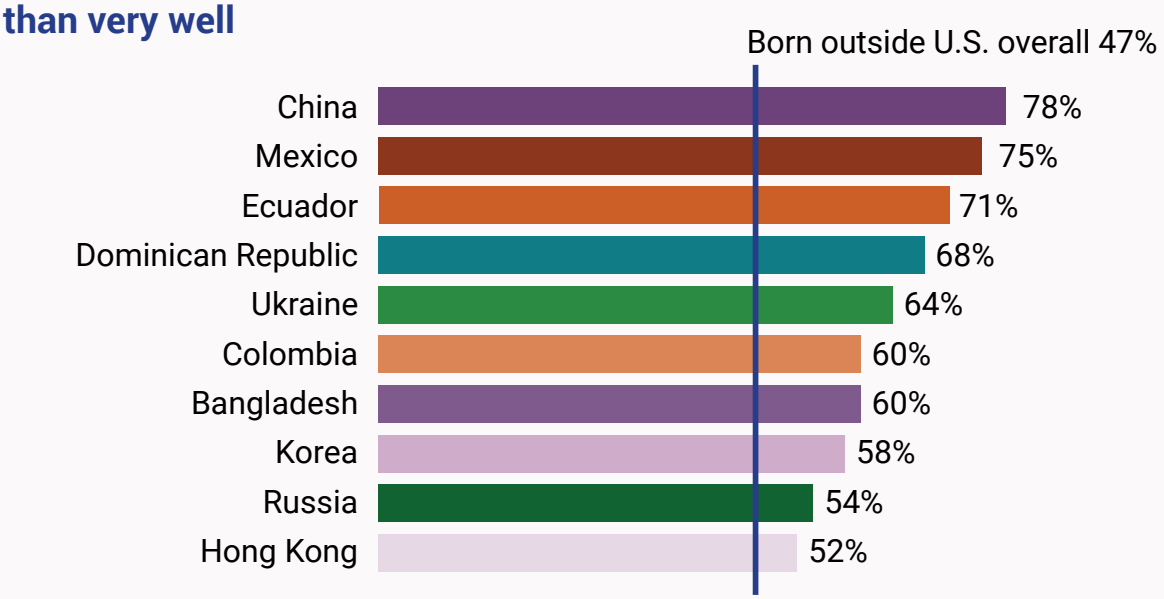
Data sources: (Sexual orientation and gender identity, adults) NYC Health Department Community Health Survey 2021-2022; NYC Health Department Youth Risk Behavior Survey 2021 (sexual orientation — teens) and 2019-2021 (gender identity — teens)

English Proficiency

English language proficiency can contribute to increased employment and educational opportunities, as well as reduce barriers to getting care and understanding health information. People who are less proficient in English may experience barriers to accessing spoken or written information about their health, be more likely to experience discrimination, and be less likely to seek out social services.

Many immigrants are multilingual, but some may not feel comfortable communicating in English. Overall, 47% of New Yorkers born outside the U.S. estimate that they do not speak English very well. Estimated lack of English proficiency varies among the top places of origin. Immigrants from China, Mexico, Ecuador, the Dominican Republic, Ukraine, Colombia, Bangladesh, Korea, Russia and Hong Kong all report higher rates of speaking English less than very well, compared with the average for all immigrants. The Health Department and other NYC agencies have guidelines for providing services to, or interacting with, New Yorkers with limited English proficiency, such as routinely translating materials into the most-spoken languages and providing interpretation services.

Percentage of immigrant New Yorkers who report they speak English less than very well



Note: Among the top places of origin.

"Immigrant New Yorkers we work with face prevalent health challenges rooted in language and cultural barriers, hindering access to vital health care information and services due to limited English proficiency. Mental health issues arising from migration experiences compound these challenges, alongside a lack of preventive care and education regarding chronic diseases, and Alzheimer's disease [and] dementia with aging population."

— Korean Community Services

Data source: American Community Survey 2017-2021

Disability

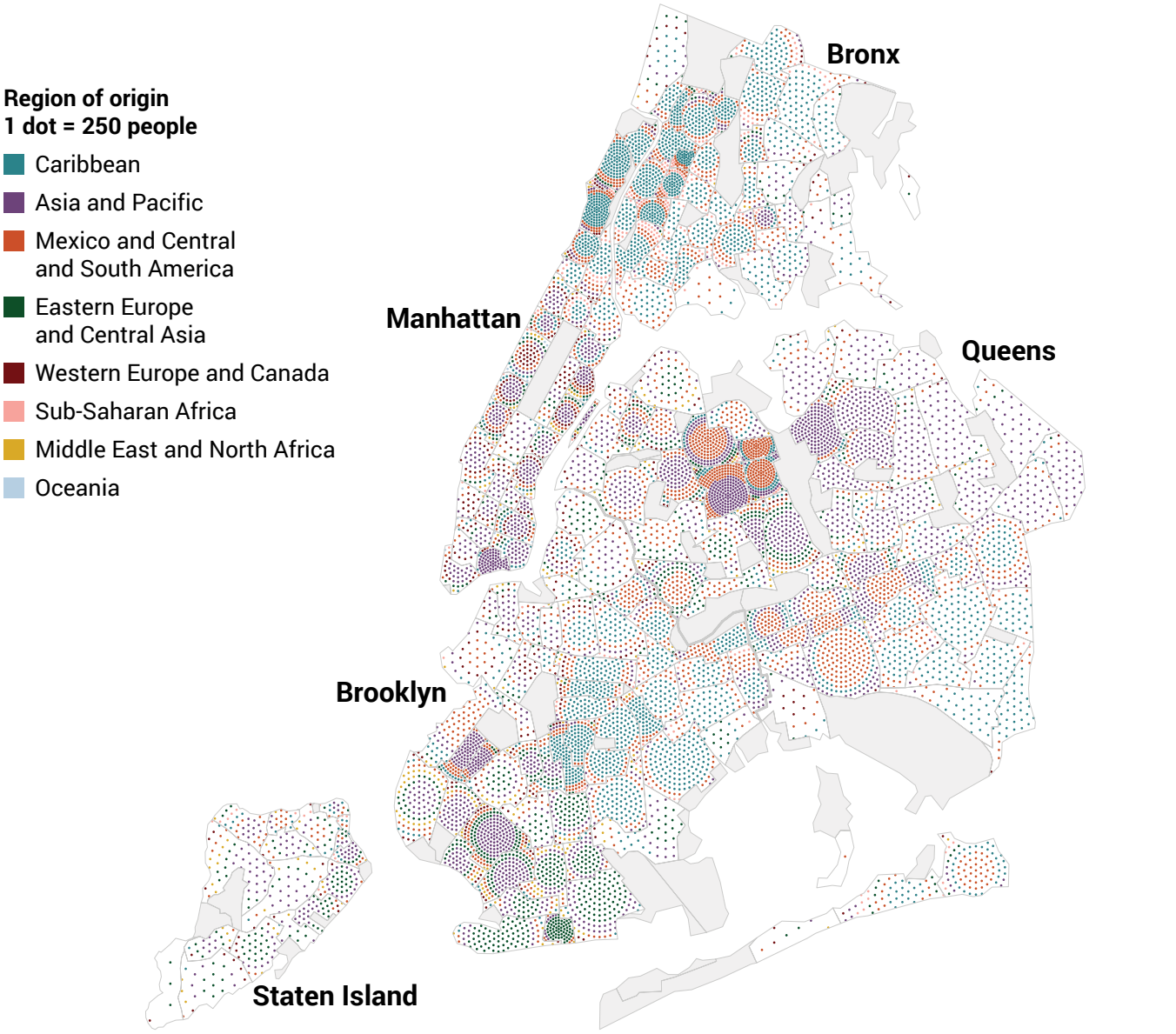
Disabilities can include both physical and mental conditions that limit or restrict participation in some activities. Overall, adults 15 and older born outside the U.S. are less likely (12%) than those born in the U.S. to report any disability (14%). Among immigrant adults 55 and older, 24% of those born outside the U.S. report any disability, compared with 30% of U.S.-born New Yorkers. Among New Yorkers born outside the U.S.:

- 2% of any age have hearing difficulty (deaf or serious difficulty hearing)
- 2% of any age have vision difficulty (blind or serious difficulty seeing, even with glasses)
- 4% of those 5 years and older have a cognitive difficulty (difficulty remembering, concentrating or making decisions)
- 8% of those 5 years and older have an ambulatory difficulty (serious difficulty walking or climbing stairs)
- 4% of those 5 years and older have self-care difficulty (difficulty with bathing or dressing)
- 6% of those 15 years and older have independent living difficulty (difficulty doing errands alone such as visiting a doctor's office or shopping)

Data source: American Community Survey 2017-2021

Immigrants in New York City by Neighborhood

New Yorkers born outside the U.S. live in all parts of the city; some neighborhoods are home to a large proportion of immigrant New Yorkers, including in Queens, Brooklyn, Manhattan and the Bronx. Ethnic enclaves, neighborhoods where immigrants may cluster, have come to define our city and our communities. While living in an ethnic enclave does not appear to confer a health advantage for immigrants overall,[20] it has also been hypothesized that immigrants living in ethnic enclaves may have more community support and assistance with finding culturally and linguistically accessible health care.

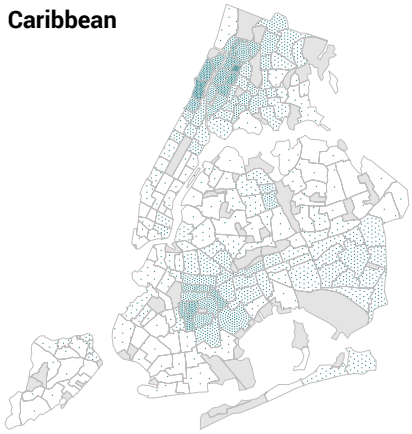


Note: Neighborhood tabulation areas (NTAs) are aggregations of census tracts that represent a minimum population of 15,000 residents and were created to project populations at a small area level for PlaNYC. For more information, visit nyc.gov/planning and search for **neighborhood tabulation areas**. One dot represents 250 people. Dots are arranged in a bull's-eye formation in the center of each NTA and represent a measure of density within each NTA, not an exact location. The largest region of origin for that neighborhood is located at the center.

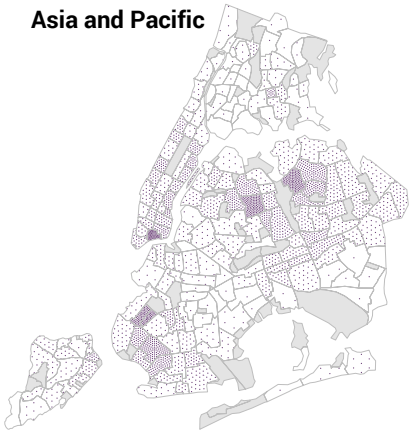
Data source: American Community Survey 2018-2022

Immigrants in New York City by Region of Origin

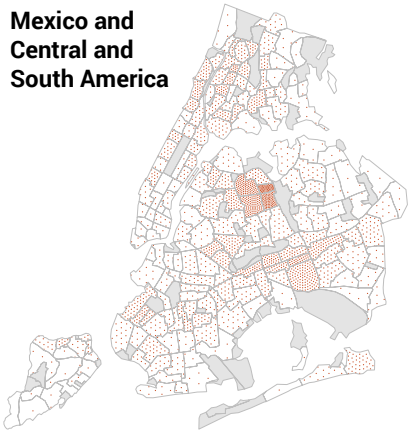
Caribbean



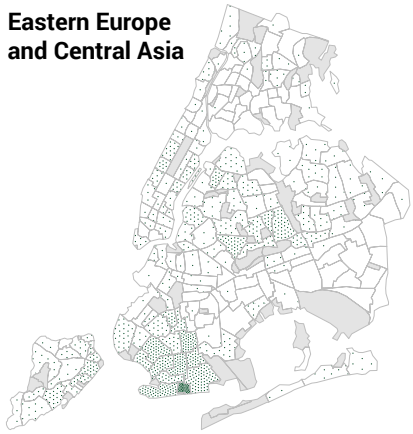
Asia and Pacific



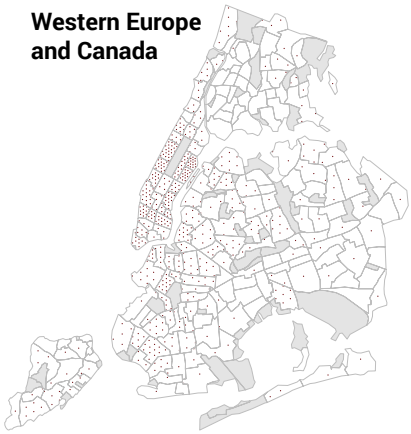
Mexico and Central and South America



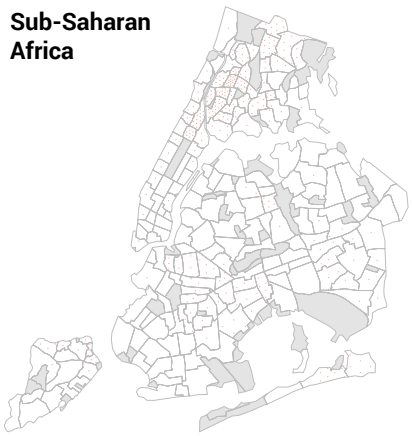
Eastern Europe and Central Asia



Western Europe and Canada

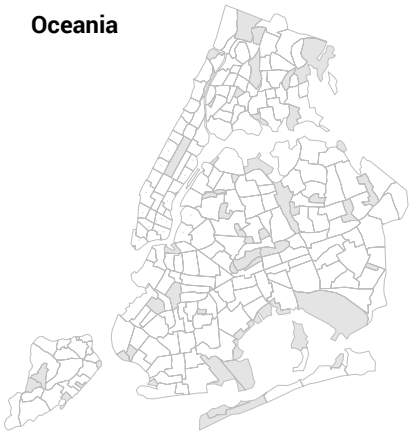


Sub-Saharan Africa



Middle East and North Africa

Oceania



Note: Neighborhood tabulation areas (NTAs) are aggregations of census tracts that represent a minimum population of 15,000 residents and were created to project populations at a small area level for PlaNYC. For more information, visit nyc.gov/planning and search for **neighborhood tabulation areas**. One dot represents 250 people. Dots are arranged in a bull's-eye formation in the center of each NTA and represent a measure of density within each NTA, not an exact location.

Data source: American Community Survey 2018-2022

Social, Economic and Environmental Conditions

Education, income and employment are interrelated factors that have a fundamental impact on health. In our society, secure employment, at a living wage and with other fair labor conditions, is necessary to meet basic needs for housing and nutrition and to access health care. In NYC, immigrant New Yorkers are workers and entrepreneurs who contribute to the economy and provide essential services. More than 50% of people considered frontline workers — nurses, janitors, bus drivers, grocery clerks and others who work in jobs essential to the people of NYC — are born outside the U.S.[21] Immigrants, both documented and undocumented, pay taxes as part of their employment and contribute to the economy of NYC.[22] Structural barriers such as racism and xenophobia, language limitations and lack of access to employment that provides fair wages and benefits affect the economic security of immigrant New Yorkers.

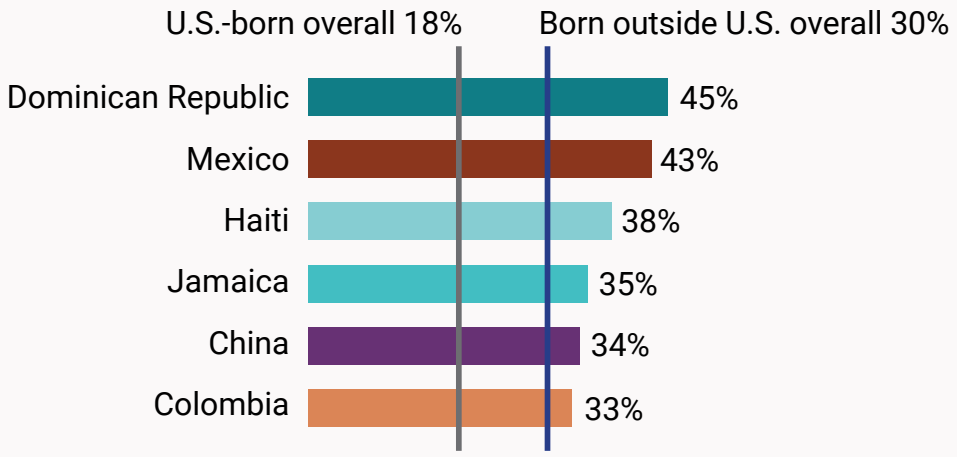
Employment

Overall, New Yorkers 16 and older who were born outside the U.S. are more likely (93%) than U.S.-born adults (91%) to be employed in the past five years. Employment among immigrants is influenced by factors such as when they arrived in the U.S., education level, profession and eligibility for work visas. Among immigrants from the top places of origin, 97% of immigrants from India are employed.

Among employed New Yorkers, immigrants are more likely (30%) than those born in the U.S. (18%) to work in the second-most prevalent occupational category in NYC, the essential "service occupations." Among

Immigrants from the Dominican Republic and Mexico most commonly work in service occupations

Among the top places of origin, those with the largest percentage of employment in service occupations among New Yorkers born outside the U.S.



Data source: American Community Survey 2017-2021

employed immigrant New Yorkers, those originally from the Dominican Republic (45%) and Mexico (43%) are most likely to work in service occupations. Conversely, immigrants are less likely (33%) than those born in the U.S. (49%) to be employed in the most prevalent occupational category in NYC, "management, business, science and arts occupations." Although they are less likely to be employed in this group at large, this category includes the subcategory "health care practitioners and technical occupations," and nearly half (47%) of workers with these jobs are New Yorkers born outside the U.S. even though immigrants make up about 36% of the population.

Compared with U.S.-born workers, those born outside the U.S. have more exposure to occupational health hazards and poor working conditions.[23,24] Immigrants, particularly undocumented immigrants, are heavily employed in the relatively low-wage construction industry. Workers 16 and older born outside the U.S. are twice as likely (8%) as U.S.-born workers (4%) in NYC to work in natural resource/construction/maintenance occupations. This is a category of jobs that often use informal work agreements that can leave workers vulnerable to exploitation and dangerous work environments.

"Our immigrant patients are hard workers — even willing to put up with poor working conditions, long hours and low pay in order to get ahead. Many times, they are working to help families back home to put food on tables or send their children, siblings or relatives to school, or send money for medical care."

— Terra Firma

In 2021, adults in NYC who were born outside the U.S. were more likely (63%) than U.S.-born adults (47%) to report they worked outside the home during the COVID-19 outbreak.

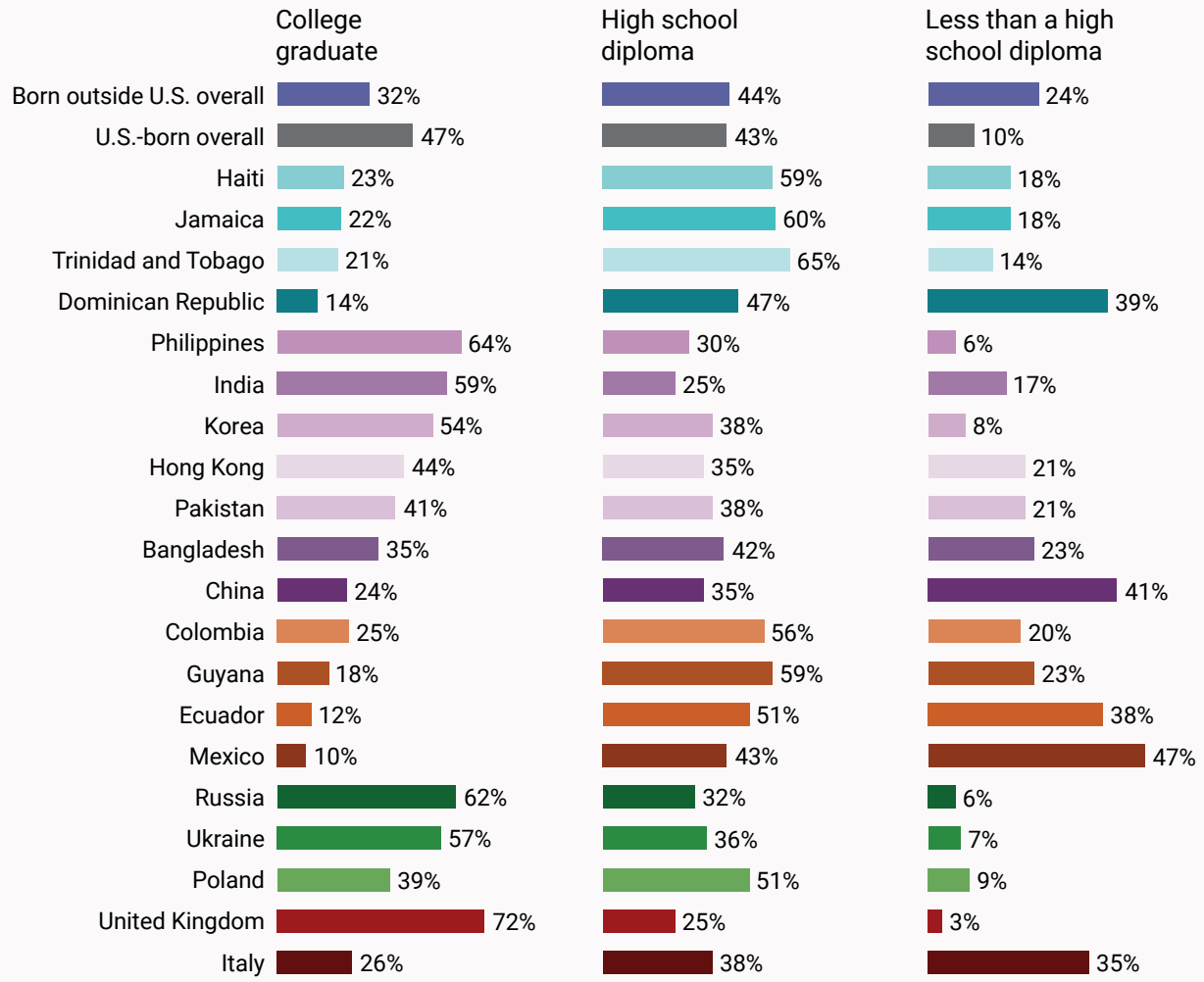
Data sources: (Occupation data) American Community Survey 2017-2021; (worked outside home during COVID) NYC Health Department Community Health Survey 2021

Education

Differences in educational attainment may be attributed to a range of factors including that certain places of origin are overrepresented in visa categories that require higher education. New Yorkers 25 years and older born outside the U.S. are as likely (44%) as those born in the U.S. to have a high school diploma (43%).

Immigrants 25 years and older are more likely (24%) to not have a high school education and less likely (32%) to have a college degree than those born in the U.S. (10% and 47%, respectively). Among immigrant New Yorkers from the top places of origin, the proportion with a college degree varies from 10% among adults from Mexico to 72% among adults from the United Kingdom.

Educational attainment among New Yorkers born outside the U.S. by top places of origin



Note: Percentages among the top places of origin; among adults 25 years and older.

Data source: American Community Survey 2017-2021

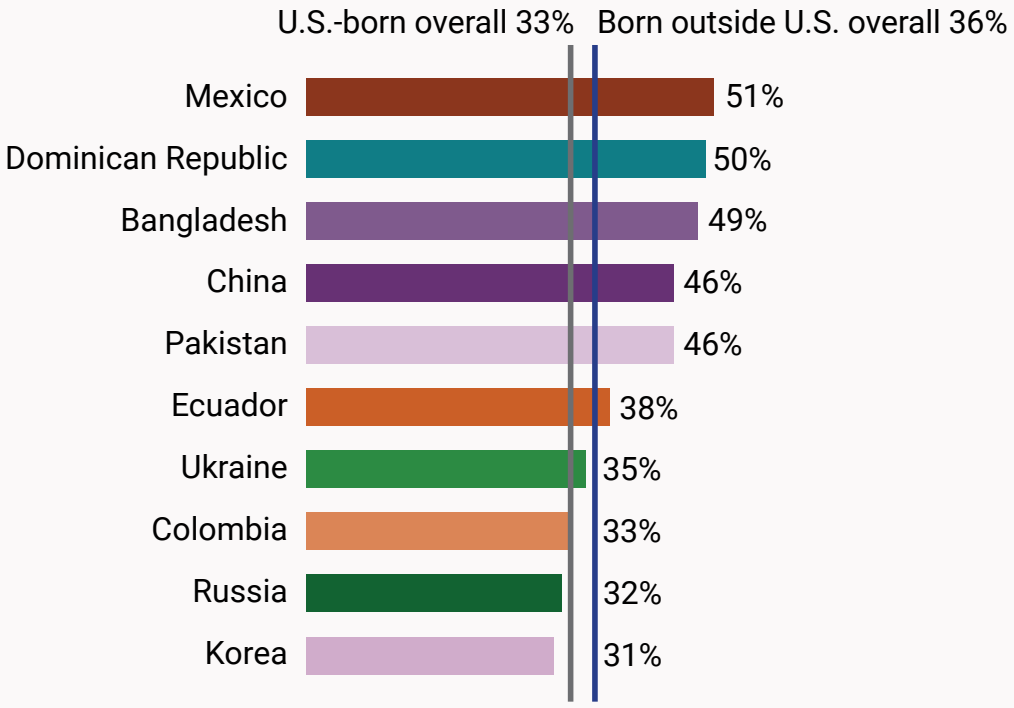
Economic Stress

More than one-third of New Yorkers (34%) report having low total income, which we define as income below 200% of FPL and also refer to as "high poverty."[25] Bangladeshi, Pakistani, Chinese, Mexican, Dominican and Ecuadorian immigrant New Yorkers have higher rates of high poverty compared with the citywide average.

Income is needed to cover basic needs including housing, food, transportation, child care, health care and other expenses. A household that does not have enough income to meet basic needs experiences income insecurity. An analysis that took into account the minimum cost of basic needs finds that households that are headed by immigrants who are not U.S. citizens experience a greater share of income insecurity relative to their representation in the NYC population.[12]

Not being able to afford basic necessities may particularly influence the health and well-being of children. A higher proportion of children who are not U.S. citizens (27%) than children who are U.S. citizens (20%) live in households whose income is below 100% of the poverty threshold defined by the NYC Government Poverty Measure.[26] This measure takes into account the effect of taxes, nutrition and housing assistance, costs for basic needs, and the high cost of living in NYC to determine the poverty threshold.

New Yorkers born outside the U.S. with individual income below 200% of the federal poverty level



Note: Among top places of origin.

Data source: American Community Survey 2017-2021

Food Security

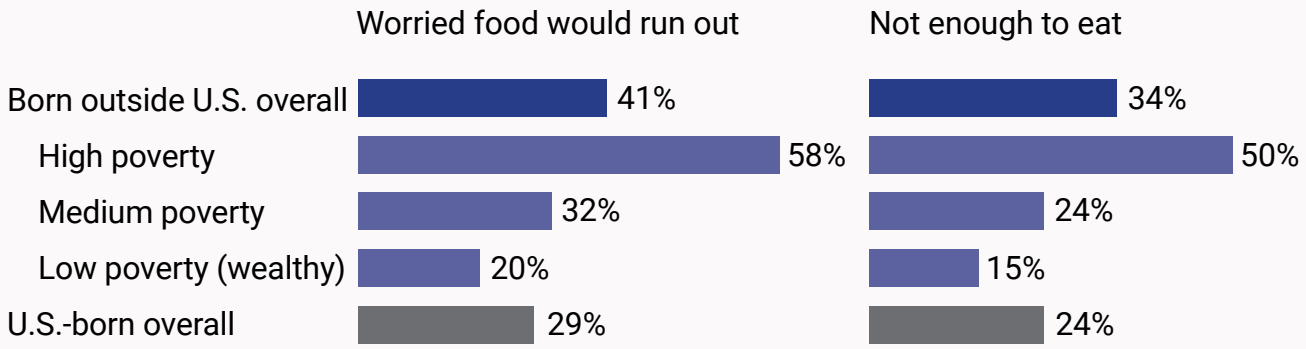
Food security for a household means access by all members, at all times, to enough food for an active and healthy life. Access to nutritious food is limited by poverty, economic opportunities and neighborhood divestment, all of which stem from centuries of structural racism. Some immigrants may also not be eligible for programs that provide food assistance, depending on their immigration status.[27]

Immigrant New Yorkers are more likely (41%) than U.S.-born New Yorkers (29%) to report they sometimes or often worried food would run out before their household gets money to buy more. Among immigrants, 58% of those living in households with high poverty have this concern, almost three times the rate of those in households with low poverty. API, Black and Latino immigrant New Yorkers are more likely than white immigrants to be concerned about running out of money to buy food.

New Yorkers born outside the U.S. are similarly more likely (34%) than those born in the U.S. (24%) to report that sometimes or often there is not enough to eat. Half of immigrants in households with high poverty report sometimes or often not having enough to eat, compared with one in seven immigrant New Yorkers with low poverty. API, Black and Latino immigrants are more likely to say there sometimes or often was not enough to eat than white immigrants. New Yorkers from the Dominican Republic and Mexico most commonly reported not having enough to eat compared with immigrants overall.

Among New Yorkers born outside the U.S., those in high-poverty households are most likely to experience food insecurity

Percentage of immigrants worried food would run out or that there was not enough to eat, overall and by household poverty



Note: High poverty defined as household income below 200% FPL, medium poverty between 200% and less than 400% FPL, low poverty 400% FPL or higher.

Data source: NYC Health Department Community Health Survey 2021-2022

Where we live plays a critical role in our health throughout our life. The financial burden of housing can contribute to stress that negatively impacts our health. Stable housing and the social support from neighbors and friends we rely on can bolster health.

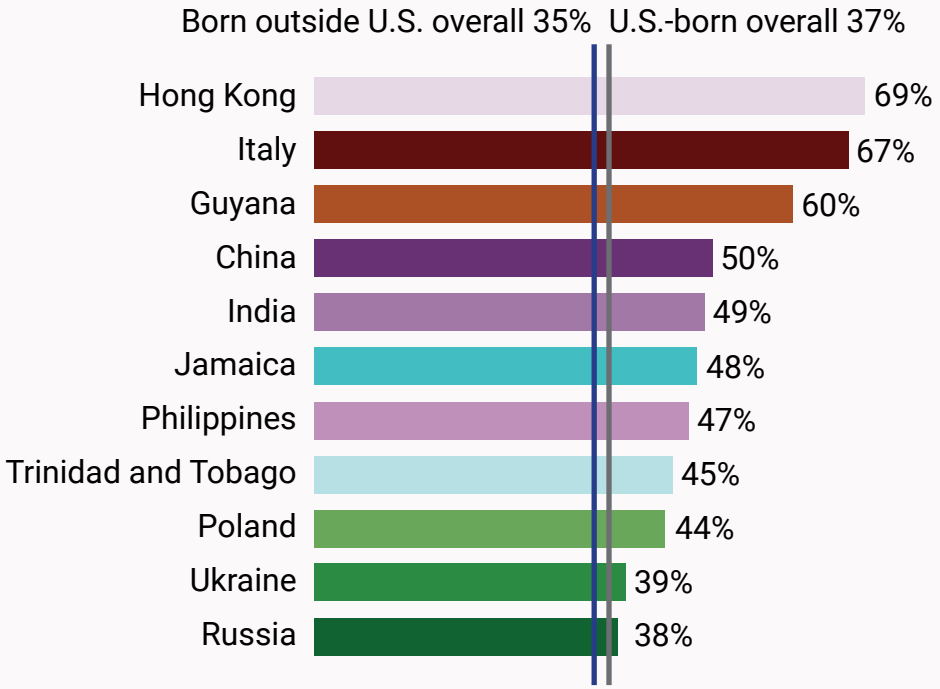
Helpful Neighbors

Community social cohesion, meaning the connectedness between people, has been linked to positive mental and overall health.[28,29] Immigrant New Yorkers are less likely (55%) than those born in the U.S. (61%) to strongly or somewhat agree that people in their neighborhood are willing to help their neighbors. Among NYC immigrants, a greater sense of neighbors' willingness to help is reported by immigrant New Yorkers who were born in Jamaica (66%) or Bangladesh (66%*), and a lower sense of neighbors' willingness to help is reported by those born in the Philippines (43%*), compared with all immigrants.

Homeownership

Historical and contemporary disinvestment and racial housing discrimination has made it hard for many New Yorkers to own homes, which contributes to racial disparities in intergenerational wealth. Homeownership is also associated with better health.[30] Homeownership can, however, present a financial burden, especially for buyers who are low income. These homeowners may receive subprime or predatory loans that put them at risk of foreclosure. In NYC, immigrant New Yorkers (35%) are less likely than those born in the U.S. to be homeowners (37%). Among the top places of origin for immigrants, the highest homeownership is among those born in Hong Kong (69%), Italy (67%) and Guyana (60%) while the lowest homeownership is among those born in the Dominican Republic (11%) and Mexico (9%).

Homeownership among New York City immigrants



Note: Highest percentages among the top places of origin; own home free and clear or with a mortgage or loan.

*Interpret estimate with caution due to small sample size.

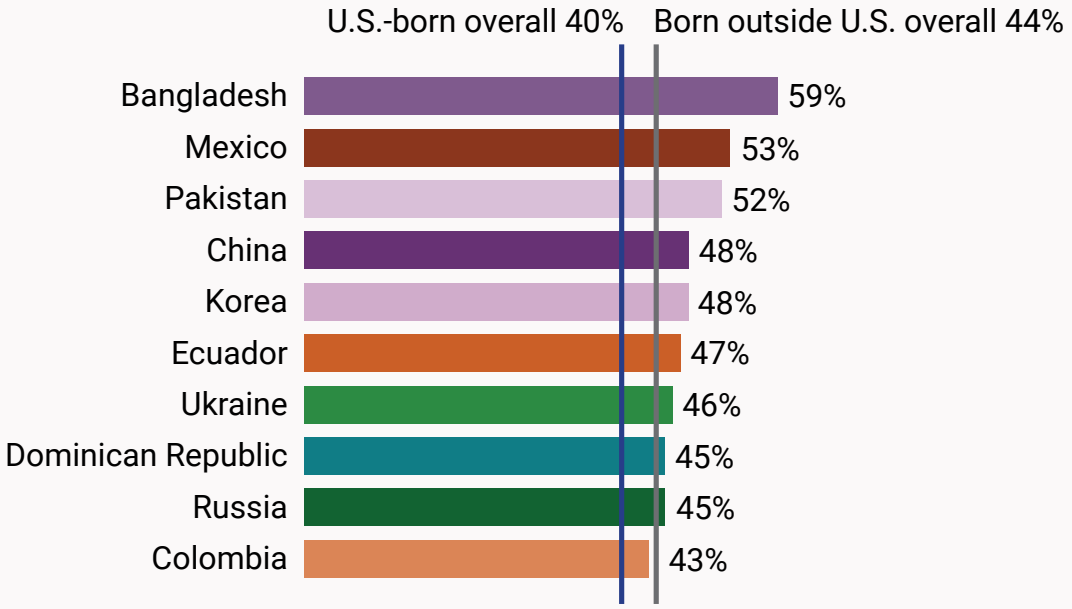
Data sources: (Helpful neighbors) NYC Health Department Community Health Survey 2021-2022; (homeownership) American Community Survey 2017-2021

Rent Burden

More than four in 10 NYC immigrants (44%) pay rent and utilities that are over 30% of their income, which is considered rent burdened. This is a greater proportion of rent burden than among U.S.-born New Yorkers (40%). This burden is highest among those who were born in Bangladesh (59%), Mexico (53%), Pakistan (52%), China (48%) and Korea (48%). These data may not account for the receipt of rental assistance among renters who have low incomes, although some immigrants are not eligible for some forms of housing assistance depending on their status. Ten percent of NYC renters born outside the U.S. report receiving housing assistance, compared with 18% of U.S.-born renters. Immigrants from regions in Asia, Europe, the Caribbean and Latin America are less likely (ranging from 2%* to 14%) to receive housing assistance than U.S. born renters (18%). NYC programs like CityFHEPS do serve immigrant communities.

Immigrants from many places experience high rent burden in New York City

Percentage who pay rent and utilities over 30% of their income



Note: Highest percentages among the top places of origin.

Crowded housing, which is more than two people per bedroom or in a studio, has been associated with greater transmission of infectious disease, mental health stress and sleep-related problems.[31] Immigrant New Yorkers (17%) are more likely to live in crowded housing than those born in the U.S. (13%). In NYC, 27% of immigrants from the region of West Africa, 25% from South Asia and 23% from Latin America live in crowded housing.

Poorly maintained housing can lead to worsened asthma and other respiratory illnesses. Immigrants from the regions of West Africa (23%), other parts of Africa (34%*) and Latin America (21%) report three or more of the following housing problems: heating problems, leaks, rodents, nonworking toilet, holes in walls or floors, or large sections of peeling paint or broken plaster.

*Interpret estimate with caution due to small sample size.

Data sources: (Rent burden) American Community Survey 2017-2021; (receipt of rental assistance, crowded housing, housing problems) NYC Housing and Vacancy Survey 2023

Climate Resilience

Global climate change, including dangerous air pollution from wildfires and storm-related flooding and mudslides, will continue to both challenge individuals' health and drive migration.[32] NYC will continue to experience extreme heat events, increased flooding and other environmental impacts that may increase the risk of illness, injury or death.[33] Increases in climate-related migration add to the moral imperative to create robust policies and social safety nets for immigrants. Although many immigrants may be unaware of this right, Federal Emergency Management Administration (FEMA) Disaster Assistance, which can be used for post-disaster needs such as temporary rental assistance, home repairs and medical losses, is available without regard to immigration status.

Working Air Conditioning

Access to working air conditioning (AC) can prevent heat-related illnesses and save lives during peak temperatures.[34] Immigrant New Yorkers are less likely (86%) to have working AC in their home compared with those born in the U.S. (89%). NYC immigrants from the Caribbean are less likely to have working AC (82%), compared with all others born outside the U.S.

Flooding

The lack of affordable and safe housing in NYC intersects with climate change to put many immigrant New Yorkers at risk.[35] Ten out of the 14 deaths caused by the remnants of Hurricane Ida in 2021 were among Asian and Latino immigrants, many of whom lived in unregulated basement apartments.[36]

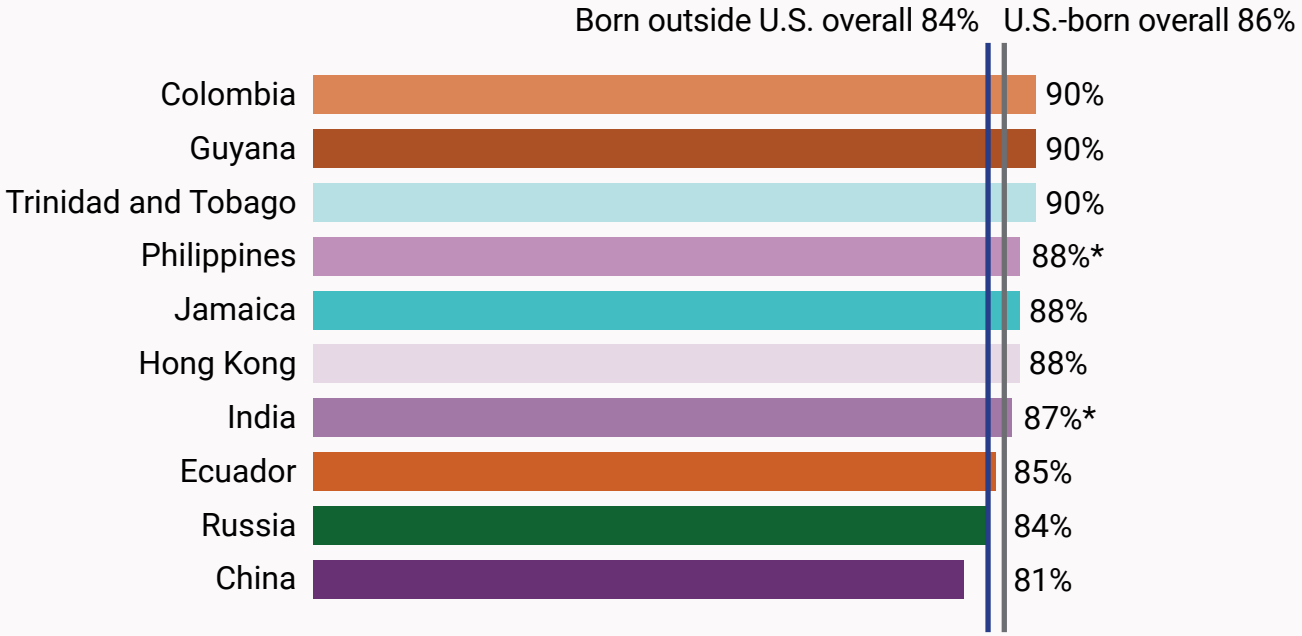
Data source: (Working air conditioning) NYC Health Department Community Health Survey 2021-2022

Healthy Living

Self-Reported Health

How people feel about their own health can be a good measure of overall mental and physical health. A lower proportion of New Yorkers born outside the U.S. (84%) report "excellent," "very good" or "good" general health, compared with U.S.-born New Yorkers (86%). A higher proportion of immigrant New Yorkers from Guyana and Colombia (both 90%) report "excellent," "very good" or "good" general health compared with immigrants overall, while those born in the Dominican Republic (75%) are less likely to report "excellent," "very good" or "good" general health.

Self-reported "excellent," "very good," or "good" health among immigrant New Yorkers



Notes: Highest percentages among the top places of origin.

*Interpret estimate with caution due to small sample size.

What models of care provision and accompaniment have you found most successful in working with immigrant New Yorkers? "Providing culturally responsive care, for example, nutritional advice that incorporates food commonly eaten by a patient."

— Coalition for Asian American Children and Families

Data source: NYC Health Department Community Health Survey 2021-2022

Fruits and Vegetables

The proportion of adults who consume at least one serving of fruits or vegetables daily is about the same when we compare immigrants (88%) and U.S.-born New Yorkers (87%). By specific place of birth, adults born in China (96%) and Russia (96%) have a higher consumption of fruits and vegetables than other immigrant adults, while adults born in the Dominican Republic have a lower daily consumption (79%). Public high school students who live in mostly non-English speaking homes are more likely to report consuming one or more servings of fruits or vegetables on average per day (59%) when compared with teens who live in homes where mostly English is spoken (53%).

Physical Activity

Participation in regular physical activity reduces stress and assists in boosting overall health. Adult immigrant New Yorkers are less likely (67%) to participate in any physical activity compared with U.S.-born adult New Yorkers (73%). Among adult immigrant New Yorkers, the proportion who are physically active is higher among those born in Mexico (78%), and lower among those born in China (59%) and the Dominican Republic (60%), compared with adult immigrants overall. The proportion of NYC public high schoolers who meet daily physical activity guidelines is similar among teens who live in mostly English-speaking homes and those who live in non-English speaking homes (both 14%).

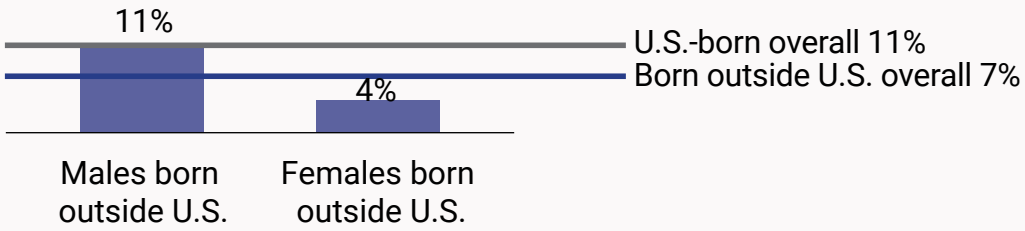
Data sources: (Fruit and vegetable consumption, physical activity — adults) NYC Health Department Community Health Survey 2021-2022; (fruit and vegetable consumption, physical activity — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Smoking, Vaping and Smokeless Tobacco Use

Smoking is a risk factor for heart disease, stroke and over 10 types of cancer, including lung cancer. Adult immigrant New Yorkers are less likely to be currently smoking (7%) compared with U.S.-born New Yorkers (11%). Adult New Yorkers born in Guyana (3%*), Jamaica (4%*) and Hong Kong (4%*) are the least likely to be currently smoking, compared with the rest of the adult immigrant population. Adult male immigrants (11%) are more likely than female immigrant adults to smoke (4%). About 3% of NYC high schoolers currently smoke cigarettes; the proportion is similar among teens who live in mostly non-English speaking homes and those in mostly English-speaking homes. Current use of electronic vapor products such as e-cigarettes is more prevalent (13%) among teens than smoking cigarettes and is similar among those in mostly non-English and mostly English-speaking homes.

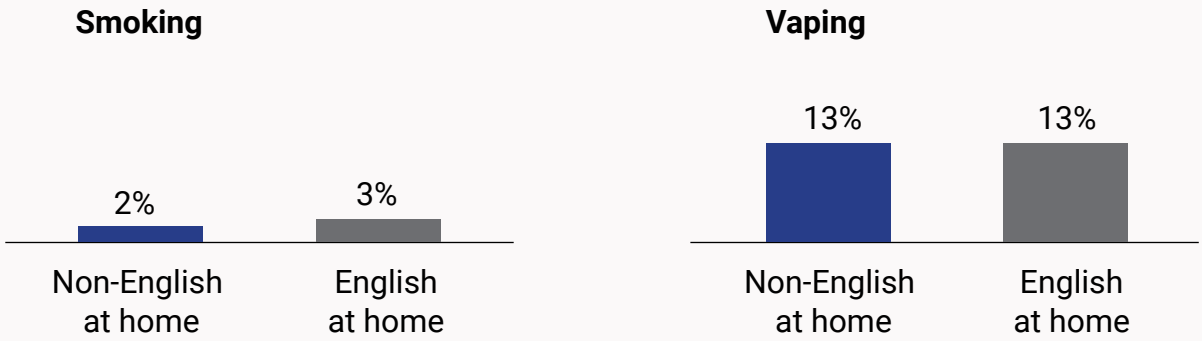
Male immigrants in New York City are more likely to smoke cigarettes than female immigrants

Percentage of adults who smoked cigarettes in the past 30 days



New York City public high school students, whether from English or non-English speaking homes, are more than four times as likely to use electronic vapor products as to smoke cigarettes

Percentage of students who smoked or vaped at least one day in the past 30 days by language spoken at home



*Interpret estimate with caution due to small sample size.

Data sources: (Smoking — adults) NYC Health Department Community Health Survey 2021-2022; (smoking, e-vapor product use — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Alcohol Use

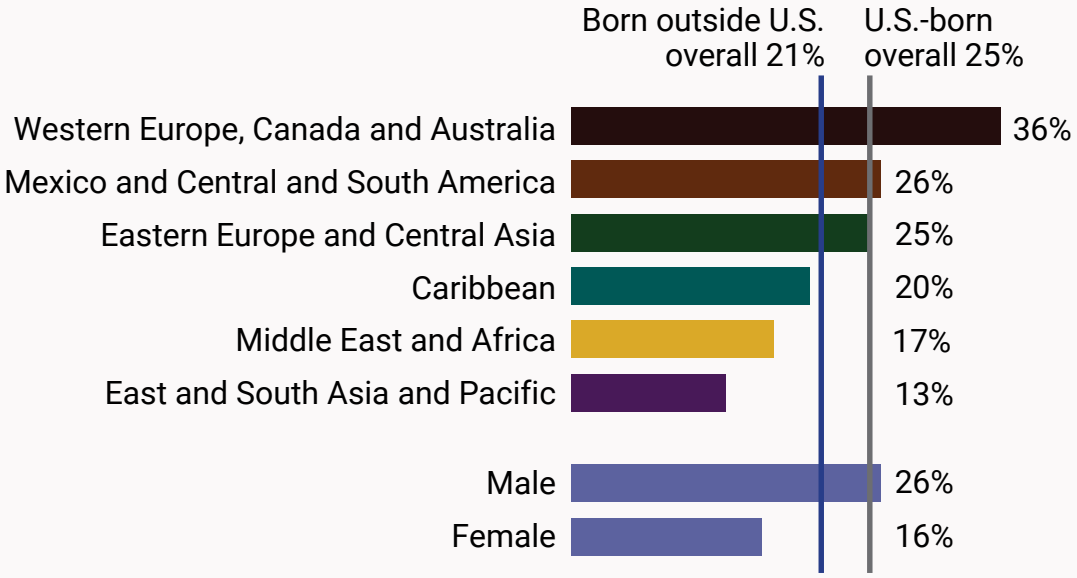
Excessive alcohol consumption is defined as heavy drinking, binge drinking or both. Heavy drinking is consuming an average of more than two drinks per day for males and more than one drink per day for females. Binge drinking is consuming five or more drinks on one occasion for males and four or more drinks on one occasion for females. Both are associated with negative health outcomes such as accidents, injuries, cancer and depression. Even lower levels of drinking can raise the risk of health problems. Adults born outside the U.S. have a lower rate of excessive alcohol use (21%) compared with U.S.-born adults (25%). Among immigrants, excessive alcohol use is highest among those from Western Europe, Canada, and Australia (36%) and Mexico and Central and South America regions (26%) and lowest among those from the East and South Asia and Pacific region (13%).

Among adults born outside the U.S., one out of four males drinks alcohol excessively, compared with one out of six females. Among public high school students, binge drinking does not differ by language spoken at home (both English and non-English 7%).

"Standardized mental health screenings can be revised to be more culturally relevant and appropriate. ... When asking questions about alcohol and substance abuse, for instance among members of the Muslim community, it is important to adjust questions so they will not offend clients and will encourage clients to answer more accurately."[37]

— Coalition for Asian American Children and Families

Excessive alcohol use among New York City adults born outside the U.S., by region of origin and by sex



Note: Excessive alcohol use is consuming an average of more than two drinks per day for males and more than one drink per day for females, and/or five or more drinks on one occasion for males and four or more drinks on one occasion for females in the last 30 days.

Data sources: (Excessive drinking — adults) NYC Health Department Community Health Survey 2021-2022; (binge drinking — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Condom Use

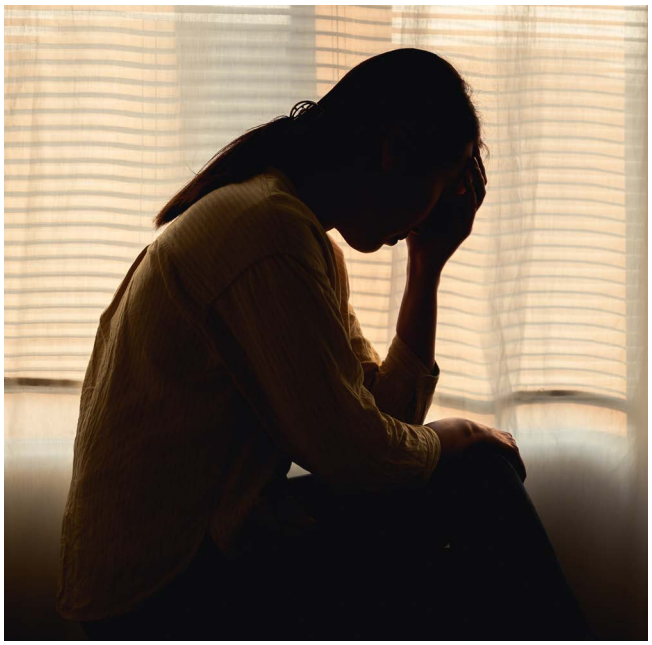
Consistent condom use is highly effective in reducing the risk of becoming pregnant and acquiring sexually transmitted infections, including HIV infection. Immigrant adult New Yorkers who are sexually active are more likely (27%) than U.S.-born New Yorkers (23%) to use a condom. Among immigrants, those from China are more likely to use condoms (38%), and those from Guyana are less likely (16%), compared with immigrants overall. Condom use among sexually active NYC public high schoolers who live in mostly non-English speaking homes (56%) is similar compared with teens who live in English-speaking homes (57%).

Data sources: (Condom use — adults) NYC Health Department Community Health Survey 2021-2022; (condom use — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Intimate Partner Violence

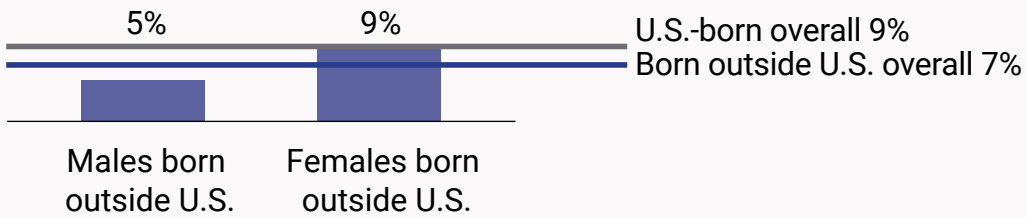
Intimate partner violence (IPV) is real or threatened aggression committed by a current or former partner. People who are oppressed or marginalized, including immigrants, may face elevated risk of IPV.[38] Women immigrants may be more vulnerable to IPV as immigration may make them leave behind their social networks and face language or cultural barriers to accessing information and services.[39]

Physical IPV includes hitting, slapping, shoving, choking, kicking, shaking or otherwise physically harming someone. Among adult New Yorkers born outside the U.S., the prevalence of ever experiencing physical IPV is higher among females (9%) than males (5%). A similar difference is seen among U.S.-born females (12%) and U.S.-born males (6%). Among public high school students who dated someone in the past 12 months, a similar percentage of females and males report recent physical dating violence within the past month: 8% among both male and female teens who speak a language other than English at home and 9% among both male and female teens who do speak English at home.



Sexual dating violence is being forced to do sexual things such as kissing, touching or having sex. Among students who speak a language other than English at home, females are more likely (9%) to report experiencing recent sexual partner violence than their male counterparts (4%). The pattern is similar among male and female students who speak mostly English at home (8% female vs. 5% male).

Experience of physical intimate partner violence among adult immigrant female and male New Yorkers



Data sources: (Physical intimate partner violence - adults) NYC Health Department Community Health Survey 2021-2022; (physical and sexual intimate partner violence – teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Family Health

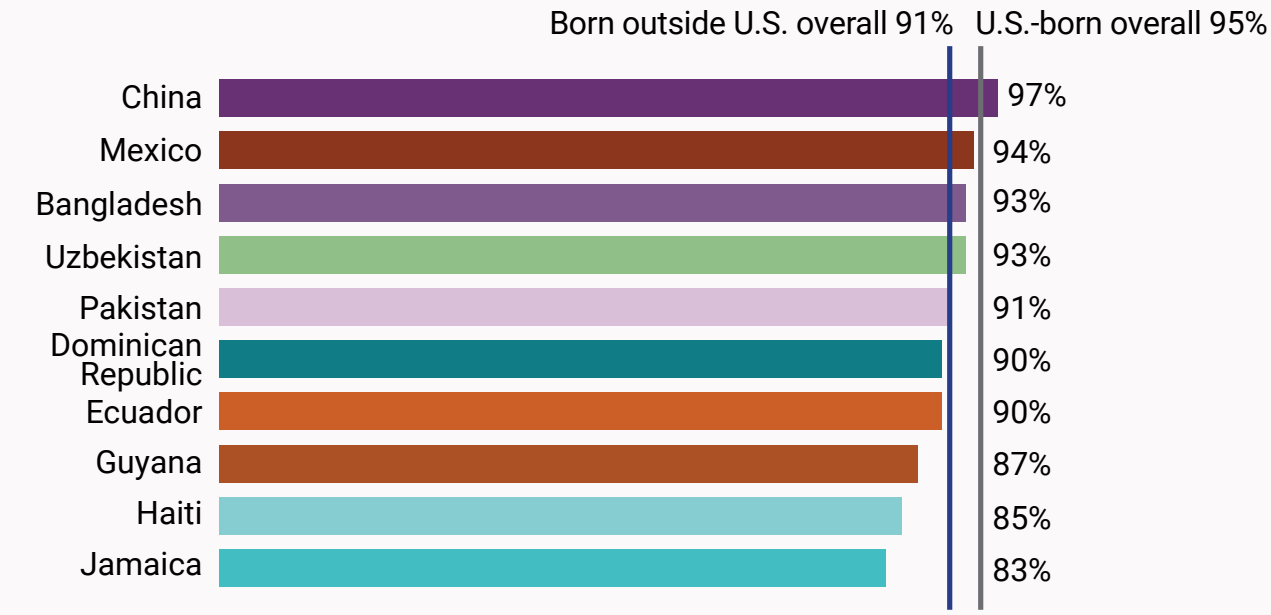
Prenatal Care

Access to quality health care is critical to the health of people who are pregnant and their babies. Prenatal care can improve pregnancy outcomes by monitoring medical conditions such as diabetes, high blood pressure and depression. Immigrants may experience barriers to receiving prenatal care due to language hurdles, immigration status, health insurance status and lower educational attainment.[40]

Pregnant people in NYC who are born outside the U.S. are less likely (91%) than those born in the U.S. (95%) to get timely prenatal care within the first two trimesters of pregnancy. Among immigrants, birthing parents who have lived in the U.S. for 10 years or more are more likely (96%) to get timely prenatal care than those mothers who have been in the U.S. less than 10 years (89%). The proportion of people who immigrated from the top 10 places of origin who received timely prenatal care varied from 83% among people from Jamaica to 97% among those from China.

Many immigrant mothers are less likely to receive timely prenatal care than U.S.-born birthing people

Percentage among New York City mothers born outside the U.S. by place of origin



Notes: Timely prenatal care is within the first two trimesters of pregnancy. Highest percentages among the top places of origin.

Data source: NYC Health Department Office of Vital Statistics, 2017-2021

Diabetes During Pregnancy

Diabetes during pregnancy can be dangerous to both the pregnant person and the baby if left untreated. A person may have diabetes before becoming pregnant, referred to as pregestational diabetes, or can develop gestational diabetes. This happens when pregnancy hormones cause cells to stop responding as well to insulin, a hormone needed to bring sugar from the blood into the body's cells for energy. When that happens, the body is not able to make enough insulin to keep the sugar levels in the normal range. Gestational diabetes usually goes away after the baby is born; however, people with gestational diabetes are at greater risk for developing diabetes later in life. Pregnant people born outside the U.S. are one and a half times more likely (20%) to have diabetes during pregnancy than those born in the U.S. (12%). The prevalence of diabetes during pregnancy is greatest among mothers from South Asia (30%) followed by those from the East Asia and Pacific region (27%). Pregnant people from the Europe and Central Asia region were least likely to have diabetes during pregnancy (11%) compared with immigrant mothers overall.

Hypertension During Pregnancy

Hypertension (high blood pressure) during pregnancy is a serious but treatable condition. Pregnant people with a previously normal blood pressure may develop high blood pressure during pregnancy.

Preeclampsia is a blood pressure condition that can occur during pregnancy or after childbirth in which there is high blood pressure and other signs of organ injury. Eclampsia is the presence of seizures in someone pregnant or immediately after giving birth, usually when the person had previously high blood pressure or preeclampsia. In NYC, pregnant people who were born outside the U.S. (13%) are less likely to report any of these conditions — high blood pressure that started before or during pregnancy, preeclampsia during pregnancy, or eclampsia during pregnancy — than U.S.-born pregnant people (18%). Compared with immigrant mothers overall, pregnant people in NYC from the sub-Saharan Africa region and the Caribbean region are more likely to have any of these conditions (both 20%).

"Educating and encouraging follow-through is critical in helping immigrants to engage in ongoing preventative health care. Many immigrants are unfamiliar with our health care system and have never had a comprehensive physical exam, which would be important to identify any ongoing health issues. Women need gynecological exams and many who are pregnant need to engage in prenatal care. Most need women's health care and also birth control options."

"There have been many [immigrant] prenatal patients that have not received care in the past, and often aren't sure how far along their pregnancy is."

— Institute for Family Health

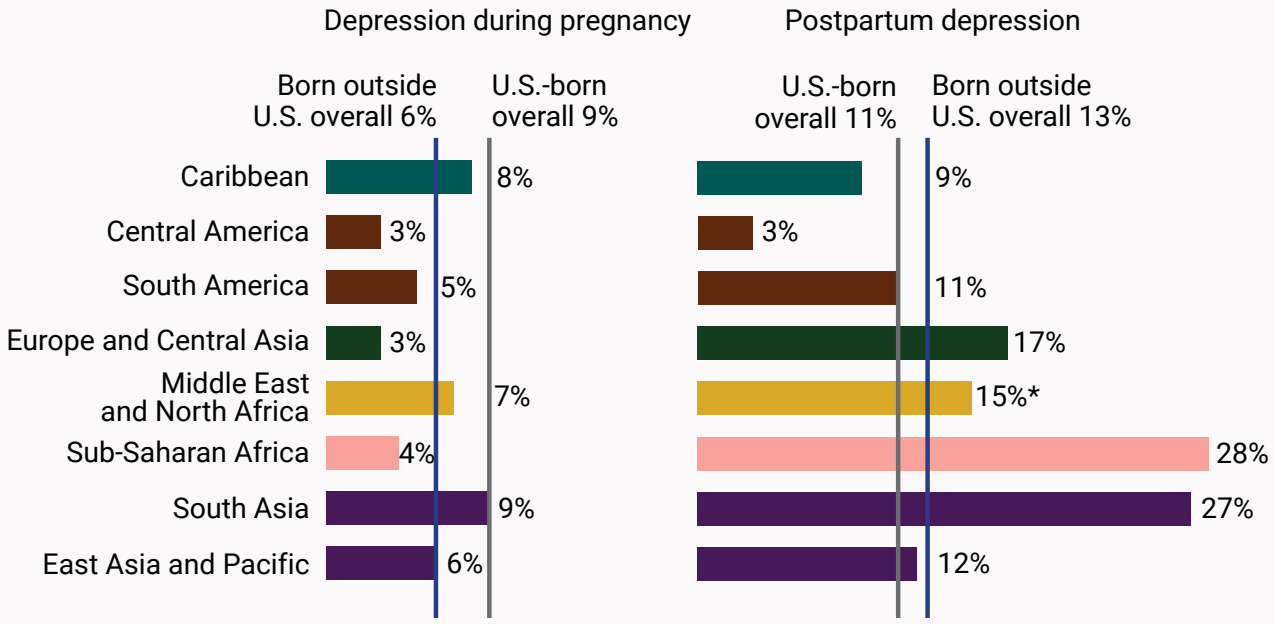
Data source: NYC Health Department Pregnancy Risk Assessment Monitoring System 2019-2021

Depression During and After Pregnancy

Depression during or after pregnancy is common and can be treated. Pregnant people born outside the U.S. are less likely (6%) to have depression during pregnancy than pregnant people who were born in the U.S. (9%). Interestingly, immigrants are more likely (13%) to have depression after pregnancy, also known as postpartum depression, than those born in the U.S. (11%). NYC mothers from sub-Saharan Africa (28%) and South Asia (27%) are twice as likely as all immigrant mothers to have postpartum depression. Immigrant mothers who have been in the U.S. less than 10 years are more likely (15%) than those here 10 years or more (11%) to have postpartum depression, but the rate of depression during pregnancy does not differ by length of time in the U.S.

Mothers in New York City born outside the U.S. are less likely to have depression during pregnancy but more likely to have postpartum depression, compared with U.S.-born mothers

Prevalence by region of origin



*Interpret estimate with caution due to small sample size.

Data source: NYC Health Department Pregnancy Risk Assessment Monitoring System 2019-2021

Preterm Births

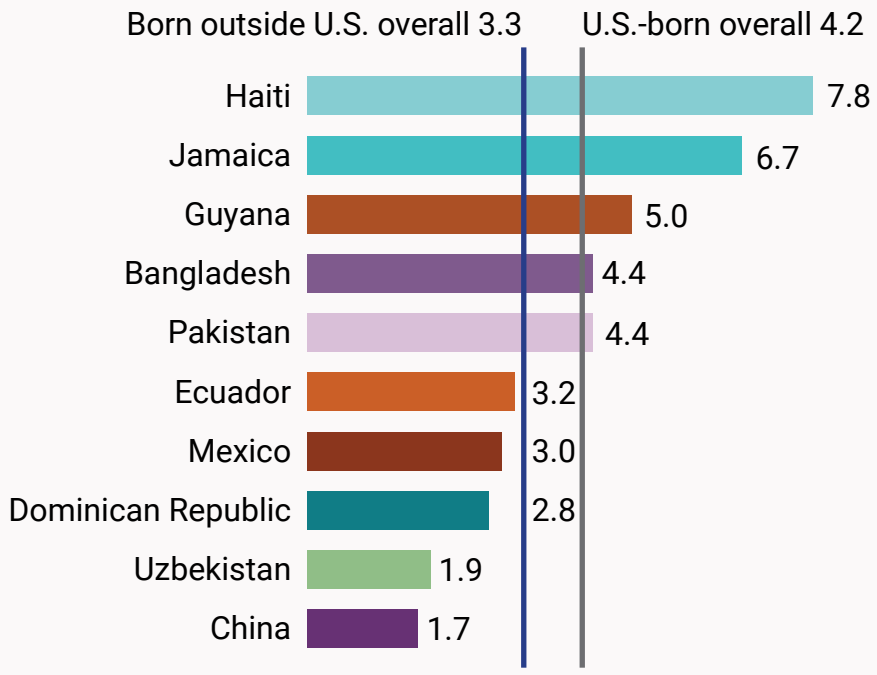
Preterm birth describes babies born before 37 weeks of gestation. Premature babies may be underdeveloped and at risk for medical complications or even death. People born outside the U.S. were less likely (8.7%) than those born in the U.S. (9.5%) to have preterm births. Pregnant people giving birth in NYC from the Dominican Republic, Mexico, Guyana, Jamaica, Haiti, Bangladesh and Pakistan are among those that have higher rates of preterm birth compared with the average among all immigrants giving birth in NYC, ranging from 9.3% to 13.3%.

Infant Mortality

Infant mortality refers to the death of a baby between birth and 1 year of age. The rate of infant death is lower when the birthing parent is an immigrant (3.3 per 1,000 live births) compared with U.S.-born (4.2 per 1,000 live births). Babies born in NYC to immigrants from Jamaica (6.7 per 1,000 live births) and Haiti (7.8 per 1,000 live births) are among those that have a higher-than-average rate of infant mortality compared with other immigrant groups.

The rate of infant mortality is lower among babies born to immigrant mothers in New York City, compared with U.S.-born mothers, although birthing people from some non-U.S. places of origin have higher rates

Rate per 1,000 live births in New York City



Note: Highest rates among the top places of origin of birthing people born outside the U.S.

Data source: NYC Health Department Office of Vital Statistics, 2017-2021

Maternal Mortality

Extreme racial disparities persist in the rate of maternal mortality in NYC. In 2016-2020, among all New Yorkers, Black people were four times more likely than white people to die from pregnancy-associated causes (death during pregnancy or within one year of the end of the pregnancy due to any cause) and six times more likely to die from pregnancy-related causes (death during pregnancy or within one year from the end of pregnancy that is due to a pregnancy complication or other pregnancy-related cause). The NYC Health Department is working to decrease maternal mortality in the city, especially among Black people. Visit nyc.gov/healthynyc for more information about HealthyNYC, the City's campaign for healthier, longer lives.

The pregnancy-associated mortality ratio (PAMR) is a measurement of the number of pregnancy-associated deaths per 100,000 live births. In 2016-2020, the PAMR was lower among immigrants (26.3 deaths per 100,000 live births) than among people born in the U.S. (58.2 deaths per 1,000 live births). Among NYC immigrant groups with four or more pregnancy-associated deaths, the PAMR was highest among those born in Haiti (93.7 deaths per 1,000 live births), followed by Jamaica (87.7 deaths per 1,000 live births), Guyana (47.9 deaths per 1,000 live births), the Dominican Republic (26.9 deaths per 1,000 live births) and China (20.9 deaths per 1,000 live births). Note that due to data limitations, it is not possible to describe the racial or ethnic characteristics of New Yorkers who give birth who are from places of origin outside the U.S.

Data source: NYC Health Department Bureau of Maternal, Infant and Reproductive Health, 2016-2020

Mental Health

The detrimental mental health effects of the COVID-19 pandemic have put a spotlight on communities that may have already been struggling, including many immigrant communities. Immigration can be a stressful life event with lasting consequences such as reduced resources and social support.[41] The process of adaptation and adjustment to a new cultural environment, as well as linguistic and cultural barriers, also plays a significant role in the mental health of immigrants and may especially challenge older adults. Additionally, the recent, ongoing rise in violent and dehumanizing anti-immigrant rhetoric and policies has tremendous impacts on mental health. Experiences of discrimination, physically demanding jobs, different health behaviors from place of origin, and cultural and linguistic barriers to accessible health care are additional stressors. Due to cultural and linguistic differences, diagnosing, treating and understanding the scope of the mental health needs among NYC's immigrants is challenging. It remains critically important that mental health services are designed to identify and meet these needs, which may include providing culturally appropriate and accessible services for all ages and exploring alternative and non-Western forms of mental health treatment.

"PTSD, depression, anxiety and adjustment disorders are among the most prevalent problems seen among unaccompanied migrant children in our program and are normative responses to distressing experiences [such as the] loss of family and friends when fleeing their countries of origin, making a perilous journey to the U.S. with sleep and food deprivation, exposure to the elements and victimization, going through the oftentimes inhumane immigration detention system and then resettling in new communities with new family structures. ... Fear of deportation also adds to fear and emotional stress."

— Terra Firma

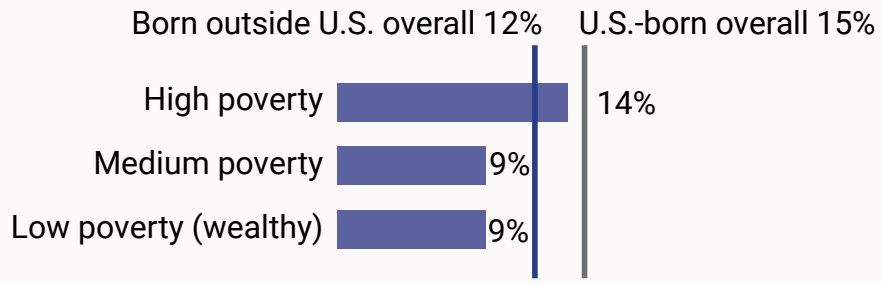
"Mental health professionals [from Terra Firma] support unaccompanied migrant children, and members of asylum-seeking families, by managing acculturative stress, adjusting adaptively to life here, resuming developmental trajectory, and importantly preparing them to testify in court."

— Terra Firma

Depression

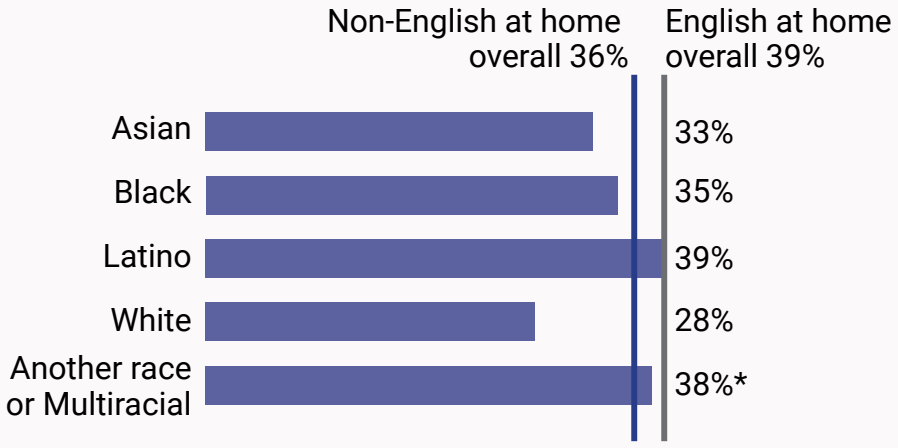
Depression influences both how one feels and how one manages daily activities. The percentage of children ages 3 to 13 who have depression (as told to a parent by a health care provider) is similar between those who have an immigrant parent or parents (2%) and those with only U.S.-born parents (3%). A smaller proportion of public high school students who primarily do not speak English at home (36%) report feeling persistently sad or hopeless, a symptom of depression, compared with students who speak mostly English at home (39%). Among public high school students who primarily do not speak English at home, Latino (39%) students are more likely to report persistent sadness compared with white students (28%). Among adults, those born outside the U.S. (12%) are less likely to report depression compared with U.S.-born adults (15%). Among immigrant adults, those living in high-poverty households are more likely (14%) to report depression compared with those in low- and medium-poverty households (9% for both).

Among New Yorkers born outside the U.S., adults in high poverty households are more likely to report depression in the past two weeks



Note: High poverty defined as household income below 200% FPL, medium poverty between 200% and less than 400% FPL, low poverty 400% FPL or higher.

Feeling persistently sad or hopeless among high school students who speak a language other than English at home, by race and ethnicity



Notes: Percentage who felt sad or hopeless almost every day for two weeks or more in the past 12 months.
Asian, Black, White, and Another race or Multiracial categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

*Interpret estimate with caution due to small sample size.

Data source: (Depression — adults) NYC Health Department Community Health Survey 2021-2022; (felt sad/hopeless — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

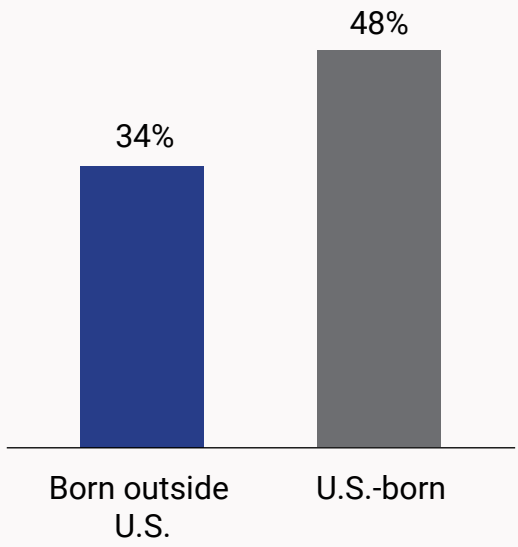
Mental Health Access and Treatment

Mental health treatment includes counseling, therapy or taking prescription medicines. Among adults who have depression, those born outside the U.S. are less likely (22%) than U.S.-born adults (30%) to report needing mental health treatment but not getting it at some point in the past year. Among all NYC adults with depression, 43% get mental health treatment. Immigrant adults with depression are less likely (34%) to receive treatment than U.S.-born adults with depression (48%).

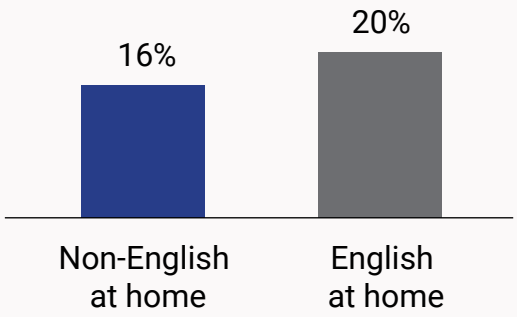
It is possible that immigrant adults may not be fully assessing or acknowledging their mental health needs, due to cultural norms and stigmas which may limit help-seeking behaviors.

Among teens, the percentage of NYC public high school students who seek help from a professional counselor, social worker or therapist is lower among students who primarily do not speak English at home (16%) compared with those who speak mostly English at home (20%).

Adults with depression who got mental health treatment



Public high school students who got help from a counselor



Notes: Adult prevalence of receiving mental health treatment (counseling, therapy or medication) in the past 12 months is among those with depression; prevalence of public high school students who got help from a professional counselor, social worker or therapist for an emotional or personal issue in the past 12 months is among all.

"A parent in need of mental health services [who receives] appropriate care can better mitigate their children's migration-related stress."

— Terra Firma

Data sources: (Unmet mental health need, received mental health treatment — adults) NYC Health Department Community Health Survey 2021-2022; (sought help from a counselor — teens) NYC Health Department Youth Risk Behavior Survey 2021

Health Care Access and Outcomes

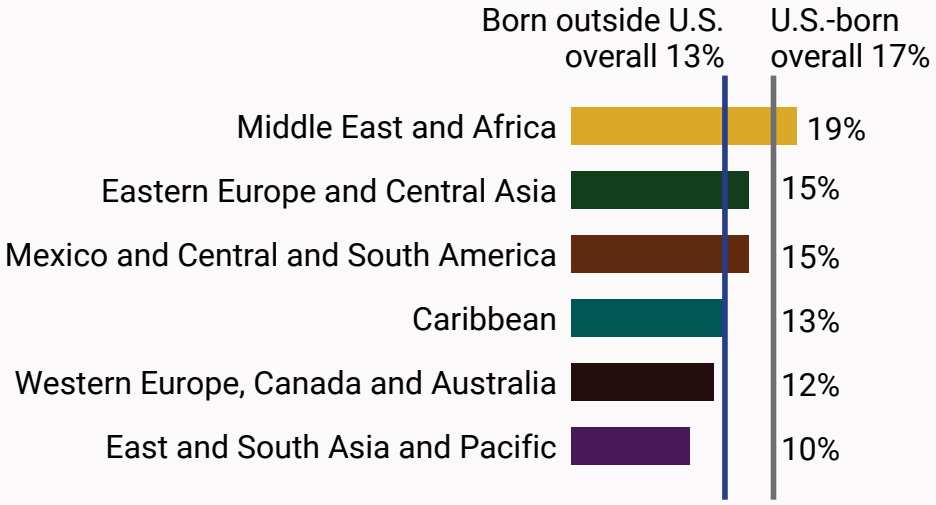
Consistent access to affordable high-quality health care services is crucial to keeping communities healthy. Options for low- or no-cost health care and health insurance for immigrants in New York City are described in the New York City Human Resources Administration's Immigrants webpage; for more information, visit nyc.gov and search for **find what fits: immigrants**. Options include the NYC Care program, which is among the country's largest programs for direct access to health care for uninsured people, accessible at www.nyccare.nyc.

Access to Health Care Services

Immigrant New Yorkers are less likely (13%) than those born in the U.S. (17%) to report that they needed medical care in the past 12 months but did not get it. Rates vary by region, with immigrants from East and South Asia and the Pacific about half as likely (10%) as immigrants from the Middle East and Africa (19%) to forgo needed care. There are many reasons individuals may forgo care, including concerns related to insurance or costs, fear related to immigration status, or distrust of or lack of knowledge about navigating the U.S.' complex health care systems.[42]

New Yorkers who went without needed medical care in the past 12 months

Among adults by region of origin



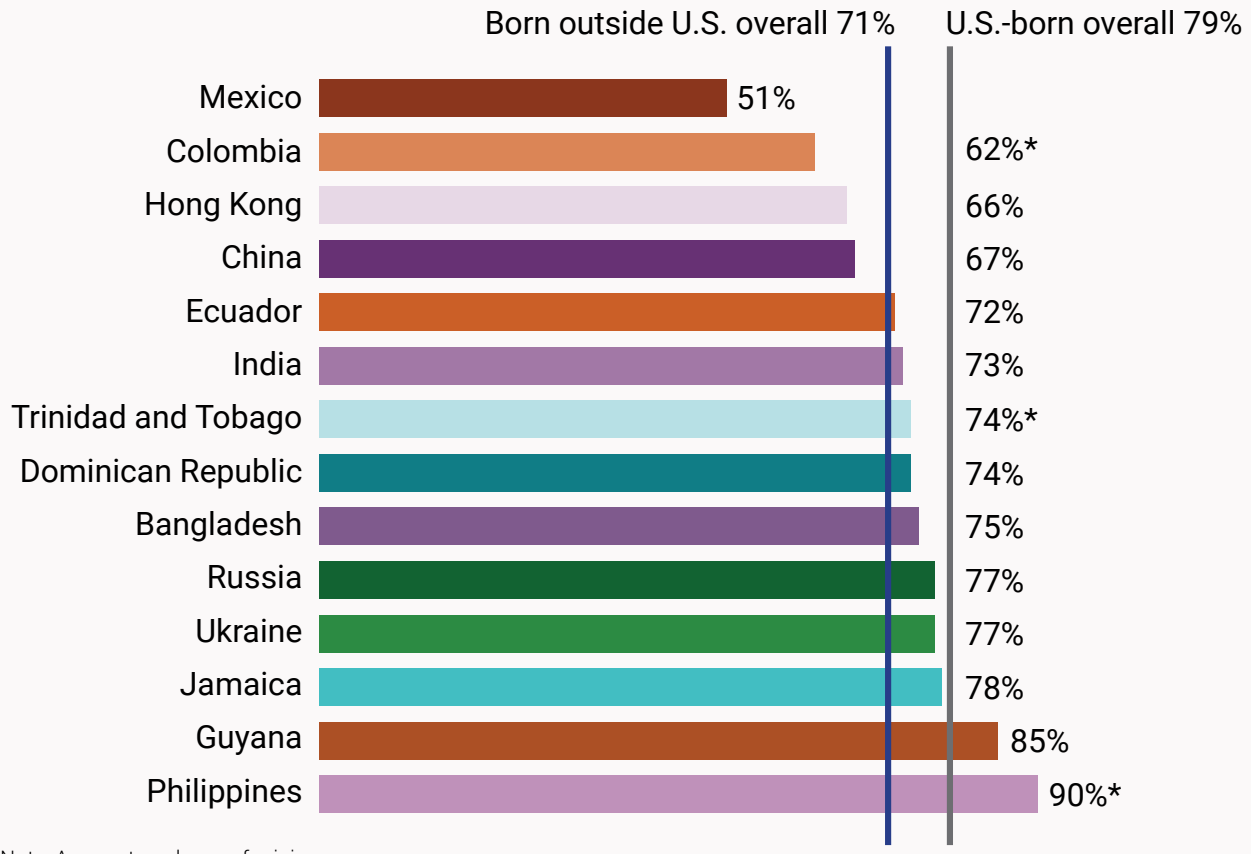
"Many [of our immigrant patients] might use the public hospital system for emergency care or acute care but may forgo important preventative services such as primary care, dental health and mental health."

— Charles B. Wang Community Health Center

Data source: NYC Health Department Community Health Survey 2021-2022

Having a usual source of care can improve health outcomes by increasing access to preventive services and facilitating early detection and treatment of disease.[43] Adult immigrants are less likely (71%) than U.S.-born adults (79%) to have a personal doctor or health care provider, with substantial variation by sex and place of birth. For example, adult immigrants who are female are more likely (74%) than males (69%) to have a personal doctor or health care provider. Mexican-born adults in NYC are less likely (51%) and NYC adults from Guyana are more likely (85%) to report having a personal doctor or health care provider compared with immigrants overall.

Immigrant adults in New York City with a primary care provider



Note: Among top places of origin.

*Interpret estimate with caution due to small sample size.

"The Translatinx community in Queens experiences high rates of violence in general, as well as discrimination in health care settings and difficulty accessing gender-affirming culturally competent care."

— Make the Road New York

Data source: NYC Health Department Community Health Survey 2021-2022

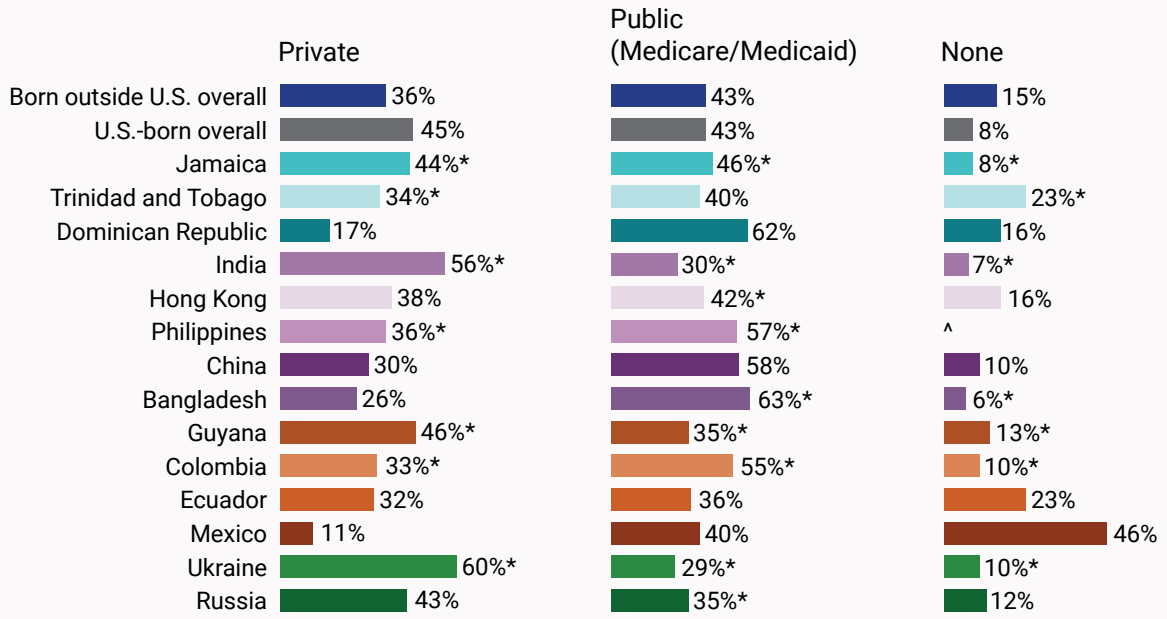
Health Insurance Coverage

Having health insurance improves health care outcomes by facilitating access to necessary services. Immigrant adults are nearly twice as likely (15%) as U.S.-born adults (8%) to be uninsured. Latino immigrant adults are over twice as likely (26%) to be uninsured as API immigrant adults (11%). There are also differences by place of origin even within regions. For example, 23% of Ecuadorian immigrant adults are uninsured whereas 46% of Mexican immigrant adults are uninsured. Immigrant adults living in low- and medium-income households are more likely (18% and 16%, respectively) to be uninsured than those in high-income households (12%).

Immigrant adults are as likely as U.S.-born adults to be enrolled in public health insurance, such as Medicaid. Access and enrollment in public health insurance varies greatly by documentation status, with undocumented people far more likely to be uninsured than those considered lawfully present.[44] While many data sources may have information about whether someone is an immigrant, few record documentation status.

Immigrant adults are less likely (36%) than U.S.-born adults (45%) to have private health insurance. Compared with API immigrant adults, at 35%, white and Black immigrants are more likely (53% and 43%, respectively) and Latino immigrants less likely (22%) to have private insurance. Female immigrant adults are less likely (33%) than their male counterparts (40%) to have private insurance.

Insurance type among adult New Yorkers born outside the U.S.



Notes: Among top places of origin. "Other" insurance category not visualized.

*Interpret estimate with caution due to small sample size.
^Suppressed due to imprecise and unreliable estimate.

Data source: NYC Health Department Community Health Survey 2021-2022

“An undocumented couple sought assistance in need of heart surgery and was overwhelmed and uncertain about how to proceed due to their immigration statuses. With our guidance and support, they were enrolled in NYC Care, which facilitated the crucial surgery that ultimately saved his life.”

— Korean Community Services

“Many [immigrants we work with] come from mixed status families and don’t know what sort of health benefits they’re eligible for and are afraid of interacting with government agencies because of their immigration status.”

— Make the Road New York

“Many immigrants do not understand how insurance works and are frightened when they receive letters that their coverage is ending. They are not adequately informed of the steps to reapply and what is needed for them to have continued coverage or to be eligible.”

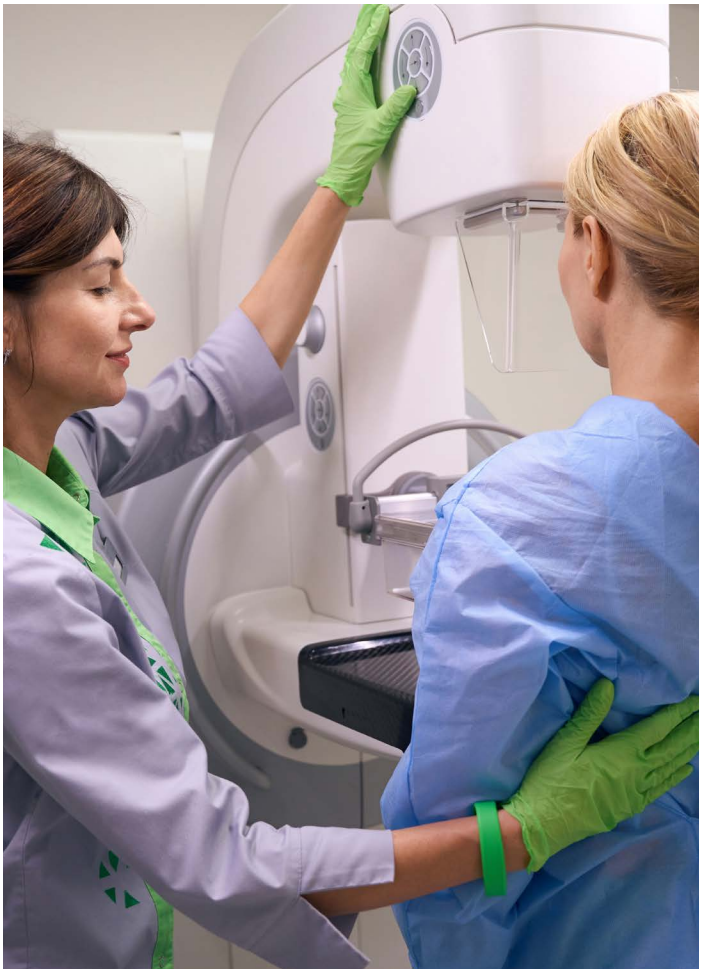
— Institute for Family Health

Preventive Health Care: Breast Cancer, Colon Cancer and Oral Health

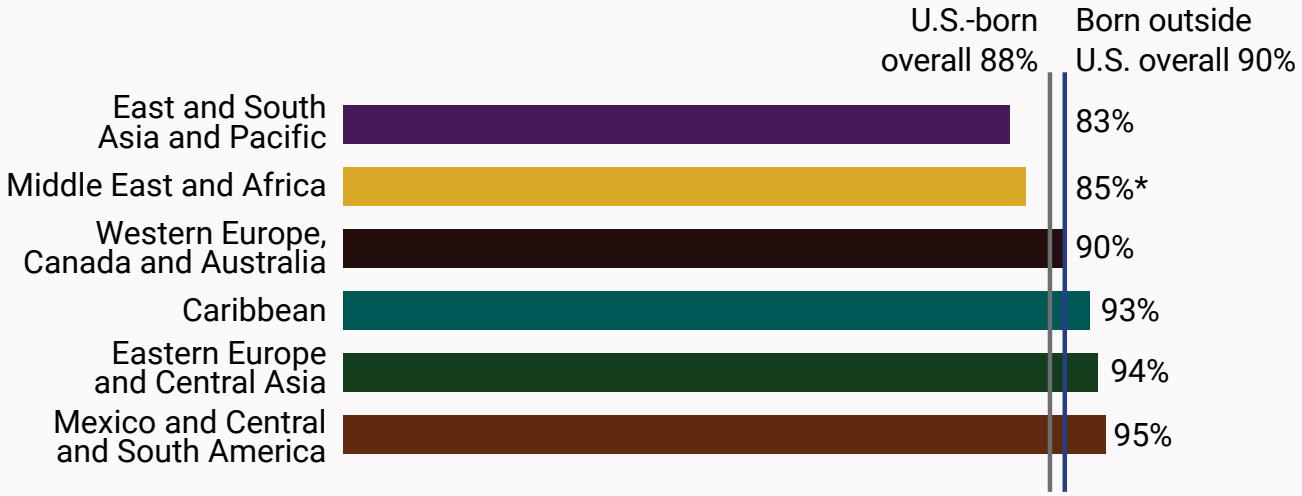
Regular screenings for treatable cancers such as breast and colon (also called colorectal) cancer, along with preventive care such as oral health care, can help prevent disease incidence or progression and improve long-term health outcomes. The NYC Health Department is working to increase screenings to reduce cancer deaths. Visit nyc.gov/healthynyc for more information.

Breast Cancer Screening

It is recommended that women ages 40 and older receive a mammogram every other year. Among female New Yorkers 40 and older, a similar proportion of immigrant (90%) and U.S.-born (88%) have ever had a mammogram. Among immigrant female New Yorkers, those who are Black (94%) or Latina (94%) are more likely than those who are API (83%) to have ever had a mammogram.



Percentage of immigrant female New Yorkers 40 and older who have ever had a mammogram by region of origin



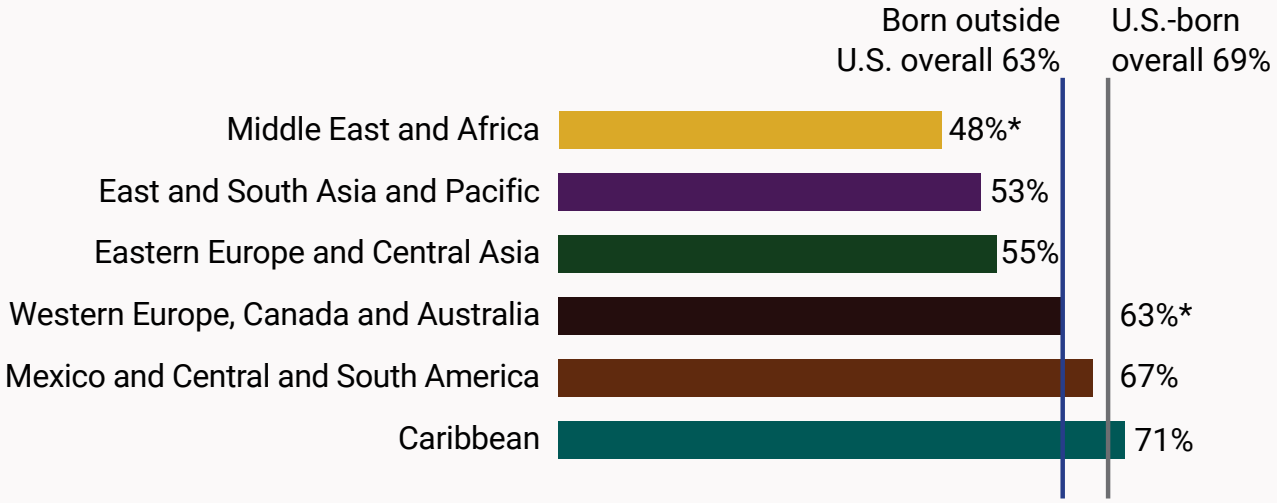
*Interpret estimate with caution due to small sample size.

Data source: NYC Health Department Community Health Survey 2022

Colon Cancer Screening

Colon cancer screening is recommended for adults ages 45 and older. Among New Yorkers 45 to 75 years old, immigrants are less likely (63%) than U.S.-born adults (69%) to receive timely colon cancer screening, which means they got a colonoscopy in the past 10 years or used a home test in the past year. Compared with NYC immigrants overall, immigrants from Jamaica (76%) were more likely to receive a timely colonoscopy and those from China (54%) and Mexico (47%*) less likely.

Timely colon cancer screening among immigrant adult New Yorkers ages 45 to 75, by region of origin



Note: Timely colon cancer screening is colonoscopy in the last 10 years or a home test in the last year.

*Interpret estimate with caution due to small sample size.

Oral Health Care

Regular visits to the dentist from an early age are important to maintaining healthy teeth and gums and overall well-being. Dental treatment can be especially costly for people without insurance. These barriers to oral health may disproportionately affect immigrants.

About 8% of NYC children ages 2 to 13 do not get needed dental care, regardless of their parents' immigration status. About two-thirds of public high school students have seen a dentist within the past 12 months, and this is similar among teens who speak mostly English at home (65%) and those who speak mostly a language other than English at home (67%).

Nearly all adult New Yorkers have received a preventive dental cleaning. However, immigrant adults (3%) are more likely than U.S.-born adults (less than 1%) to have never received a preventive dental cleaning. Chinese immigrants are more likely to have never received a cleaning (7%) compared with immigrants overall.

Data sources: (Colon cancer screening, dental cleaning — adults) NYC Health Department Community Health Survey 2021-2022; (did not get dental care — children) NYC Health Department KIDS Survey 2021; (dental visits — teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

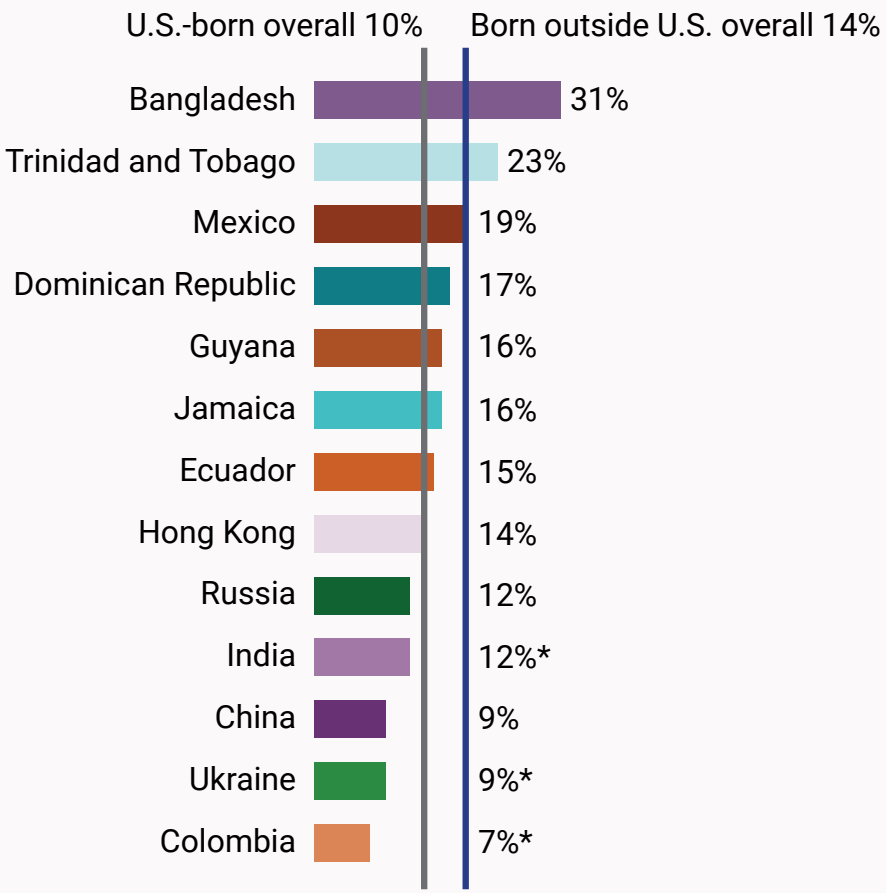
Chronic Diseases: Diabetes, Hypertension and Asthma

Heart and diabetes-related diseases continue to be leading causes of death across all racial and ethnic groups in NYC, though Black New Yorkers have higher rates of death related to heart disease and diabetes compared with other racial groups. The NYC Health Department is working to reduce racial inequities in deaths due to these causes. Visit nyc.gov/healthynyc for more information.

Diabetes

Nearly 1 million New Yorkers have diabetes, a chronic condition that was the eighth-leading cause of death in NYC in 2021. Adult immigrant New Yorkers have a higher diabetes prevalence (14%) compared with U.S.-born New Yorkers (10%). Among the top places of origin, immigrants from Bangladesh have a higher prevalence of diabetes (31%) and those from Colombia (7%*) and China (9%) have lower prevalence of diabetes than overall immigrants. Immigrants in the highest-poverty households are more likely (16%) to have diabetes than those in medium- (12%) or low-poverty households (10%).

Among New Yorkers born outside the U.S, the prevalence of diabetes differs by place of origin



Notes: Among top places of origin. Data for the Philippines are suppressed due to an imprecise and unreliable estimate.

*Interpret estimate with caution due to small sample size.

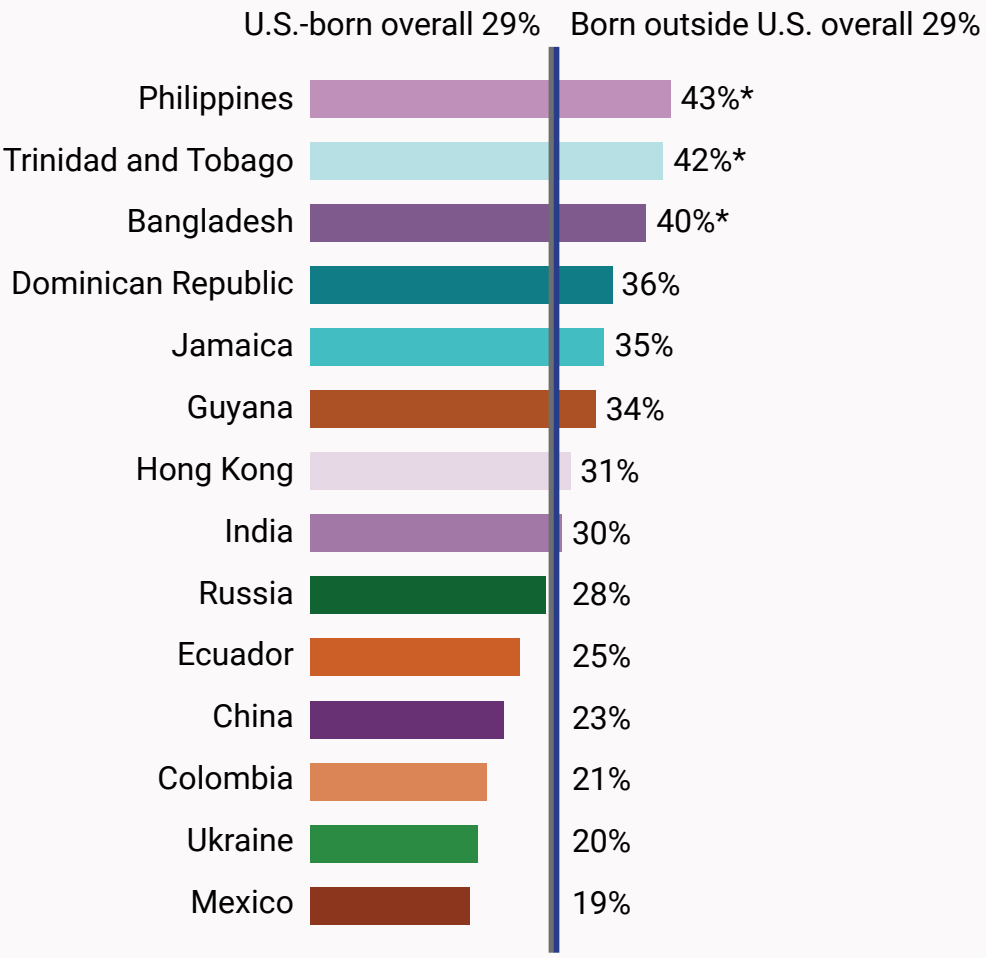
Data source: NYC Health Department Community Health Survey 2021-2022

Hypertension

Hypertension, or high blood pressure, is a major risk factor for heart disease and stroke. Diseases of the heart are a leading cause of death in NYC and nationally. In NYC, 29% of adults have been diagnosed with high blood pressure. This rate is the same for immigrant and U.S.-born New Yorkers. Among the top places of origin, higher rates of hypertension are seen among immigrants from the Philippines (43%*), Trinidad and Tobago (42%*), Bangladesh (40%*) and the Dominican Republic (36%) compared with immigrants overall and lower rates are seen among immigrants from Mexico (19%), Ukraine (20%) and China (23%) compared with immigrants overall.

Immigrants who are Black (36%) are more likely to have hypertension than API (27%), Latino (28%) and white immigrants (25%).

The prevalence of hypertension (high blood pressure) among adults in New York City differs by place of origin



Note: Among top places of origin.

*Interpret estimate with caution due to small sample size.

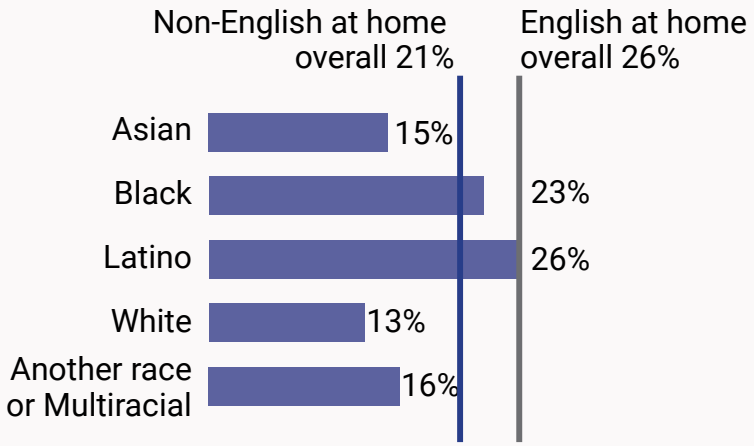
Data source: NYC Health Department Community Health Survey 2021-2022

Asthma

In NYC, asthma disproportionately affects Black and Latino children as well as those residing in high-poverty neighborhoods.[45] About 11% of NYC children ages 1 to 13 years have ever been diagnosed with asthma. Children with at least one parent born outside the U.S. (8%) have a lower prevalence than children who do not have a parent born outside the U.S. (15%). Of those children with at least one immigrant parent and who have been diagnosed with asthma, 28% report they have had an episode of asthma or an asthma attack in the past year, about the same as children with two U.S.-born parents.

Public high school students who live in primarily non-English speaking households are less likely to have ever been diagnosed with asthma (21%) than those who live in mostly English-speaking households (26%). Among those diagnosed, public school students who live in mostly non-English language households are also less likely (24%) to report they have had an episode of asthma or an asthma attack in the past 12 months compared with those who live in primarily English-speaking households (29%). Among teens who live in households where mostly languages other than English are spoken, white teens have a lower rate of ever being diagnosed with asthma (13%) compared with Black (23%) and Latino (26%) students.

Prevalence of ever being diagnosed with asthma among high school students who speak a language other than English at home, by race and ethnicity



Note: Asian, Black, White, and Another race or Multiracial categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

"We work in neighborhoods with extremely high rates of asthma, and many of our members live in poorly maintained housing with conditions that exacerbate respiratory illness and other chronic conditions."

— Make the Road New York

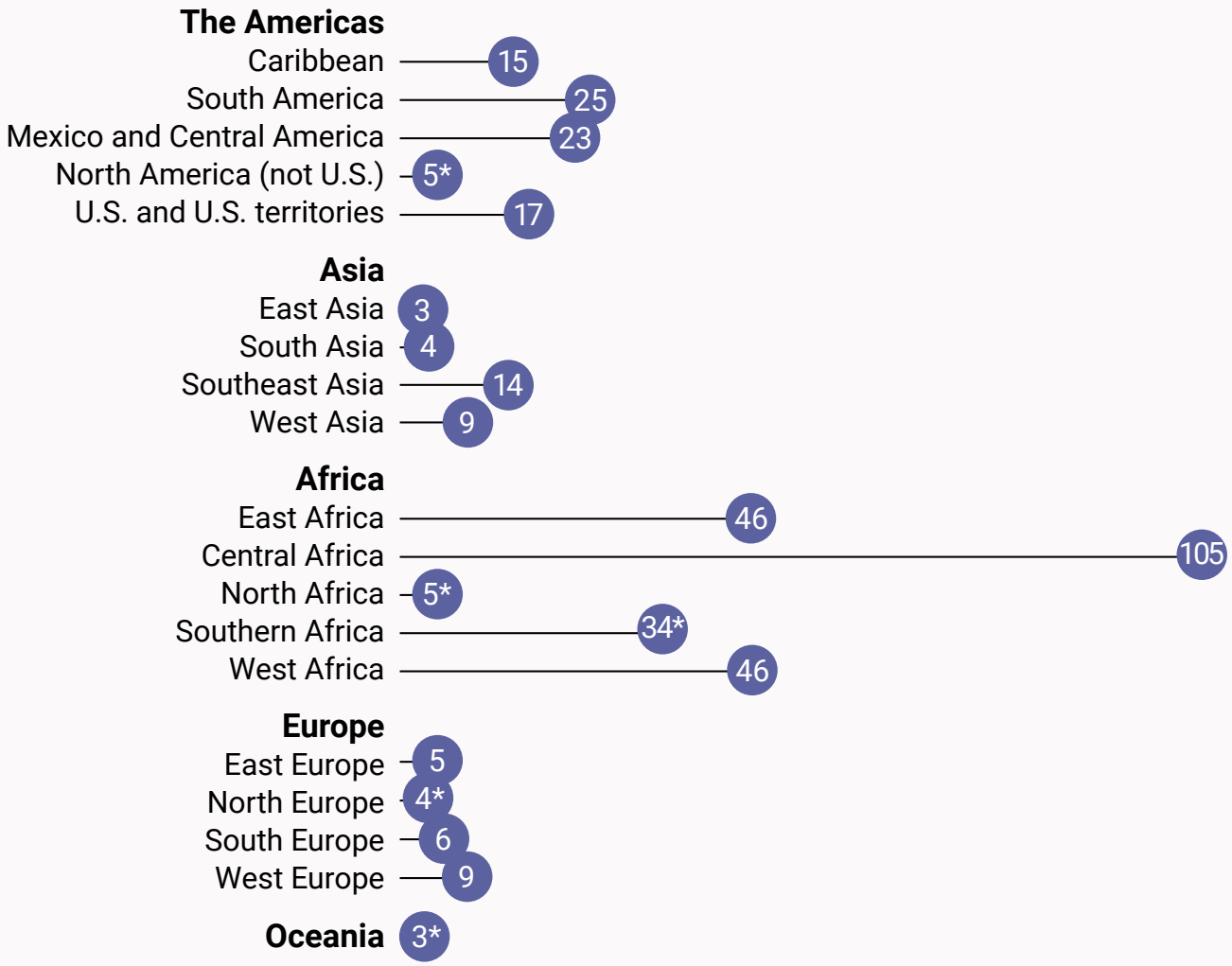
Data sources: (Asthma in children) NYC Health Department KIDS Survey 2021; (asthma in teens) NYC Health Department Youth Risk Behavior Survey 2019-2021

Infectious Disease Prevention, Care and Outcomes

HIV

Immigrants in NYC are less likely than U.S.-born people to be diagnosed or living with HIV. As of 2022, immigrants comprise 25% of the 1,624 New Yorkers newly diagnosed with HIV and 24% of the estimated 82,000 people living with HIV. Immigrants from Central, West and East Africa comprise a relatively small number but experience the highest annual rates of new HIV diagnoses, while immigrants from East and South Asia experience the lowest rates of new diagnoses. Comparable proportions of immigrants and U.S.-born New Yorkers link to timely HIV care after diagnosis, which facilitates longer-term engagement in HIV care. Among people with diagnosed HIV, a higher proportion of immigrants (88%) than U.S.-born people (82%) are virally suppressed, meaning they cannot transmit HIV to others through sex.

Average annual HIV diagnosis rates per 100,000 New York City residents by region of origin



Notes: Rates 2018-2022.
HIV diagnoses include both diagnoses of HIV without AIDS and HIV concurrent with AIDS.
Data exclude people newly diagnosed with HIV in NYC with an unknown region of origin (19.7% of people newly diagnosed).

*Rate should be interpreted with caution due to small population size.

Data sources: (New diagnoses, people living with HIV/AIDS, timely care, viral suppression) NYC Health Department HIV/AIDS Surveillance Registry, 2022

Tools employed in NYC to prevent HIV include condom distribution, sexual health education, harm reduction services, pre-exposure prophylaxis (PrEP, a medicine that prevents HIV), emergency post-exposure prophylaxis (PEP), and equitable policies supporting health, employment and housing. Immigrants are less likely (21%) than U.S.-born New Yorkers (44%) to be aware of PrEP. Immigrants who are white or have higher incomes are more likely than other immigrants to be aware of PrEP.

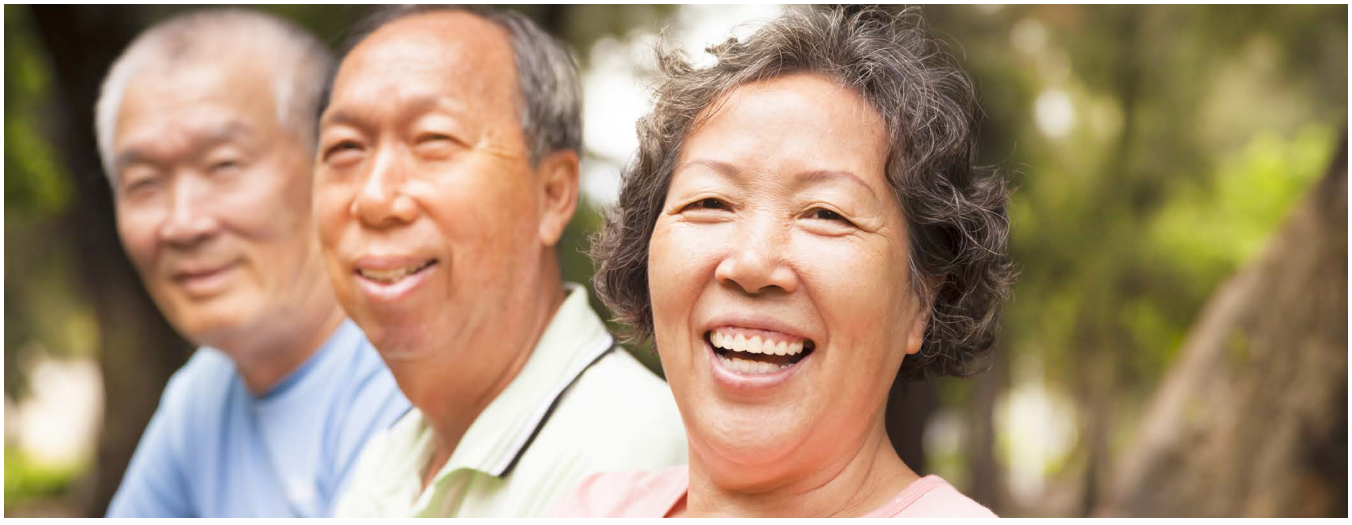
New Yorkers have access to an array of HIV and sexual health services, regardless of insurance or immigration status. The NYC Health Department's Sexual Health Clinics and the PlaySure Network provide comprehensive sexual health services. The Ryan White Part A program provides medical and supportive services, such as care coordination, food and nutrition services, legal services, and housing to income-eligible New Yorkers with HIV. Health insurance, many drug manufacturers, and New York State's Uninsured Care Programs may provide access to HIV prevention, treatment medications or care, in some cases including for undocumented people.

For information and services, visit nyc.gov/health and search for **hiv**, **prep**, **sexual health clinics**, **playsure** or **ryan white**, or visit health.ny.gov and search for **uninsured care programs**.

Hepatitis B

As of 2019, the Health Department estimates that 243,000 people are living with chronic hepatitis B in NYC, accounting for 2.9% of all NYC residents.[46] In 2022, 5,534 people in NYC were newly reported with chronic hepatitis B. Without care and treatment, a quarter of people with hepatitis B may progress to serious liver disease, liver cancer or premature death.[47] Most people with chronic hepatitis B were infected during childbirth, in regions of the world where hepatitis B is common. Organizations participating in the NYC Health Department's Check Hep B Patient Navigation Program connect NYC residents living with hepatitis B to low- or no-cost medical care. Visit nyc.gov/health/map and hepfree.nyc for more information on services.

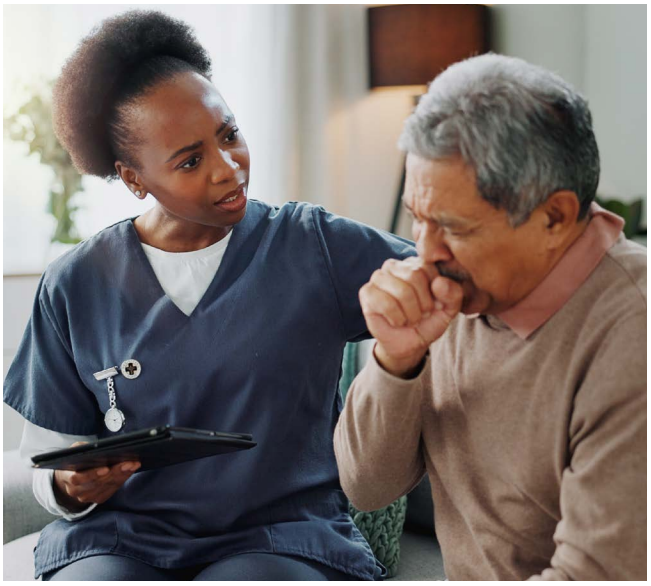
The Health Department's Perinatal Hepatitis B Prevention Program offers case management services to pregnant and postpartum people with hepatitis B infection.[48] Of the 651 New Yorkers with hepatitis B who delivered a live infant in 2022, 620 (95%) were born outside the U.S., including 264 (41%) born in East Asia (primarily China), 151 (23%) born in West Africa (primarily in Guinea, Ghana, Nigeria and Senegal) and 205 (31%) born in other non-U.S. regions.



Data sources: (Awareness of PrEP, adults) NYC Health Department Community Health Survey 2021-2022; (Chronic hepatitis B) NYC Health Department Communicable Disease Surveillance Registry, 2022

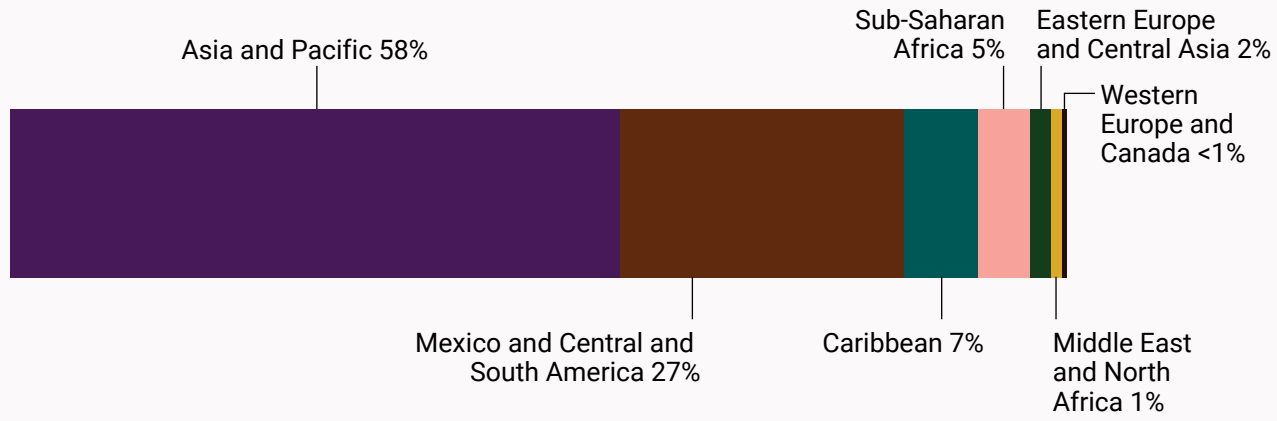
Tuberculosis

Tuberculosis (TB) is one of the leading infectious killers in the world and remains a significant global health problem. In NYC in 2022, 88% of all confirmed TB diagnoses occurred among patients born outside the U.S. The rate of TB among New Yorkers born outside the U.S. is more than 13 times the rate among U.S.-born New Yorkers (14.7 cases vs. 1.1 per 100,000 people). While the largest number of TB cases among New Yorkers born outside the U.S. occur among individuals born in China, Ecuador, Philippines, Bangladesh and India, NYC has TB cases from almost all world regions. Over half of all non-U.S.-born NYC TB patients are born in the Asia and Pacific region. A quarter of these patients are born in the Mexico and Central and South America region. Immigrants diagnosed with TB in 2022 had been in the U.S. for a median of 13 years. TB is also seen across all age groups, with 65% of non-U.S.-born patients in NYC between the ages of 18 and 64. Approximately two-thirds of immigrant TB patients in 2022 were male.[49]



The Health Department performs a variety of integrated activities to support effective, patient-centered TB care, control and prevention in NYC. The NYC Health Department Chest Centers provide free and confidential TB testing, treatment and care for those at high risk for TB, regardless of immigration or health insurance status; for clinic services and hours, visit nyc.gov/health and search for **chest centers**.

Proportion of immigrants diagnosed with tuberculosis by region of origin



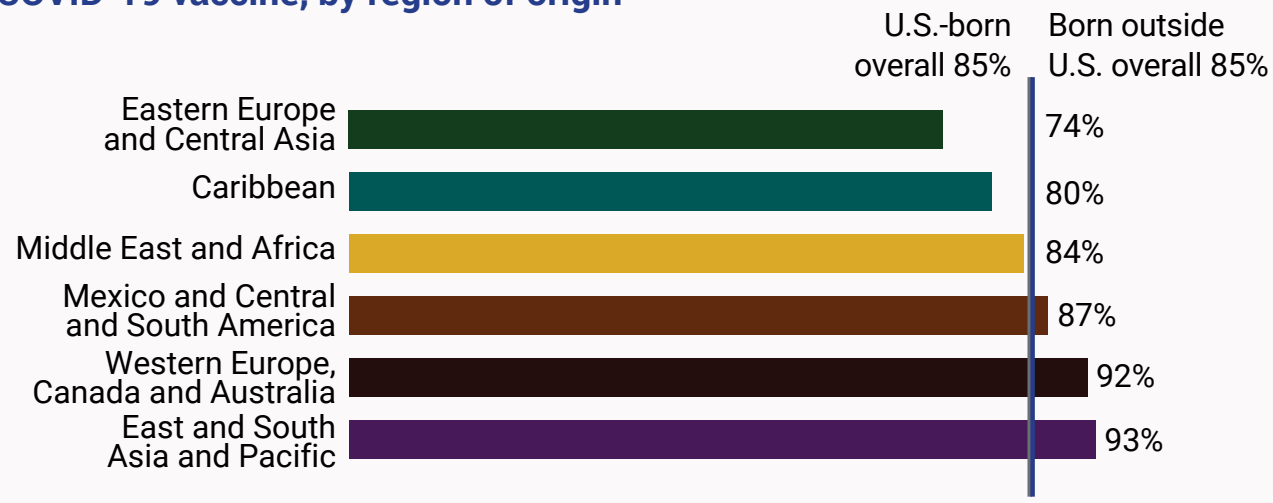
Note: There were no cases from Oceania.

Data source: NYC Health Department Bureau of Tuberculosis Control 2022

COVID-19 Prevention and Outcomes

In March 2020, NYC became the epicenter of the COVID-19 pandemic. COVID-19 continues to circulate, with hundreds of cases reported every day throughout 2024. The NYC Health Department encourages vaccination, as it can reduce the severity of infection. About 85% of both immigrant and U.S.-born New Yorkers have received at least one dose of the COVID-19 vaccine. Among immigrants, vaccination rates are highest among those from the regions of East and South Asia and the Pacific (93%), and Western Europe, Canada and Australia (92%), and lowest among those from Eastern Europe and Central Asia (74%) and the Caribbean (80%). The NYC Health Department is working to increase COVID-19 vaccination to protect New Yorkers — visit nyc.gov/healthynyc for more information about the work. You can also visit nyc.gov/coronavirus and select "Vaccine" in the left-hand menu or call **311** for vaccination information.

Adult immigrants in New York City who received at least one dose of the COVID-19 vaccine, by region of origin



*Interpret estimate with caution due to small sample size.

Immigrants living in households with incomes equal to or greater than 400% FPL have higher COVID-19 vaccination rates (88%) than those with incomes below 200% FPL (83%). Vaccination rates within the immigrant population vary by race and ethnicity, with lower vaccination rates occurring among Black (80%), white (81%) and Latino (85%) immigrants compared with API immigrants (93%).

"Due to fears of accessing health care services during the Trump administration, many [immigrants] did not seek care for COVID-related symptoms and either arrived late to care or died not getting the care they needed."

— Terra Firma

Data source: NYC Health Department Community Health Survey 2022

Millions of people infected with COVID-19 have experienced symptoms that persist for months or years after acute illness. This is generally known as long COVID, and these long-term physical and mental health symptoms can result in disability and socioeconomic hardship. Among adults who reported experiencing any long-term physical health effects that they think might be related to having had COVID-19, 21% of all New Yorkers strongly or somewhat agree that they still feel long-term physical health effects of COVID-19. Female immigrants are more likely (28%) than male immigrant New Yorkers to still feel long-term physical health effects of COVID-19 (16%). Immigrants in high-poverty households are more likely (30%) to still feel long-term physical health effects of COVID-19 than those in medium- (19%) or low-poverty households (13%).

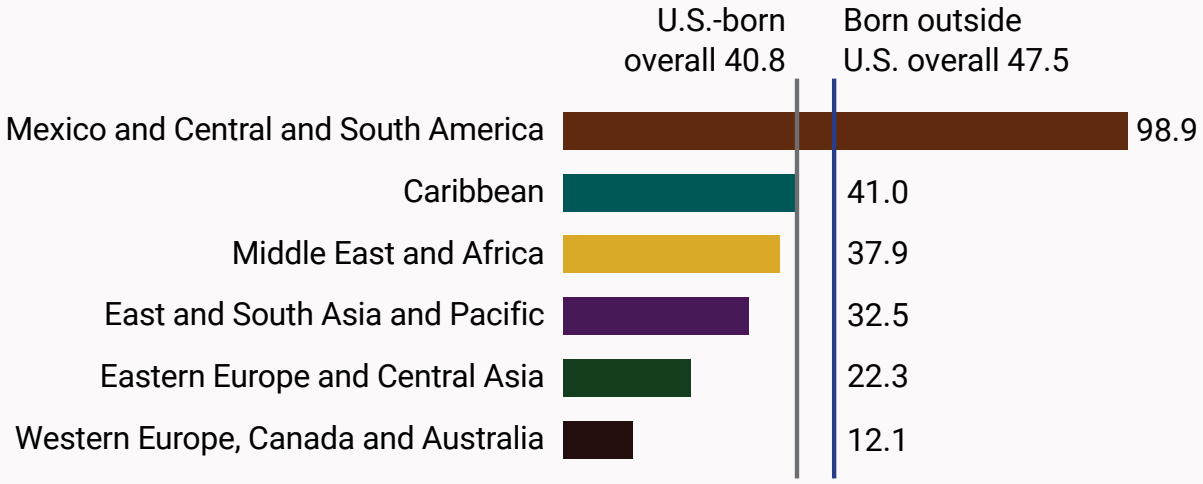
Deaths in NYC increased sharply from March to May 2020 due to COVID-19. Death rates were higher among Latino and Black New Yorkers than white New Yorkers, and COVID-19 death rates were highest in very-high-poverty neighborhoods (30% or more of the population living below FPL), compared with low-poverty neighborhoods (less than 10% of the population living below FPL). NYC life expectancy also dropped substantially from recent pre-pandemic years.[50]

During 2020-2021, immigrant New Yorkers had a higher mortality rate due to COVID-19 than U.S.-born New Yorkers (age-adjusted rate of 149.6 vs. 124.4 per 100,000 people). They also had a higher premature mortality rate (death before age 65) from COVID-19 (age-adjusted rate of 47.5 versus 40.8 deaths per 100,000).

Premature mortality rates from COVID-19 differed depending on the region or place of birth of immigrant New Yorkers. Rates were highest among immigrants from the region of Mexico and Central and South America (98.9 per 100,000 people) and lowest among immigrants from the region of Western Europe, Canada and Australia (12.1 per 100,000 people). Looking at place of birth, premature mortality rates from COVID-19 were highest among people from Mexico (187.3 per 100,000 people) and lowest among people from China (18.2 per 100,000 people).

Premature death in New York City due to COVID-19 was highest among immigrants from the region of Mexico and Central and South America

Rate per 100,000 people less than 65 years, 2020-2021



Data sources: (Long-term COVID-19 effects) NYC Health Department Community Health Survey 2021-2022; (mortality) NYC Health Department Office of Vital Statistics, 2020-2021

Mortality by Occupation During COVID

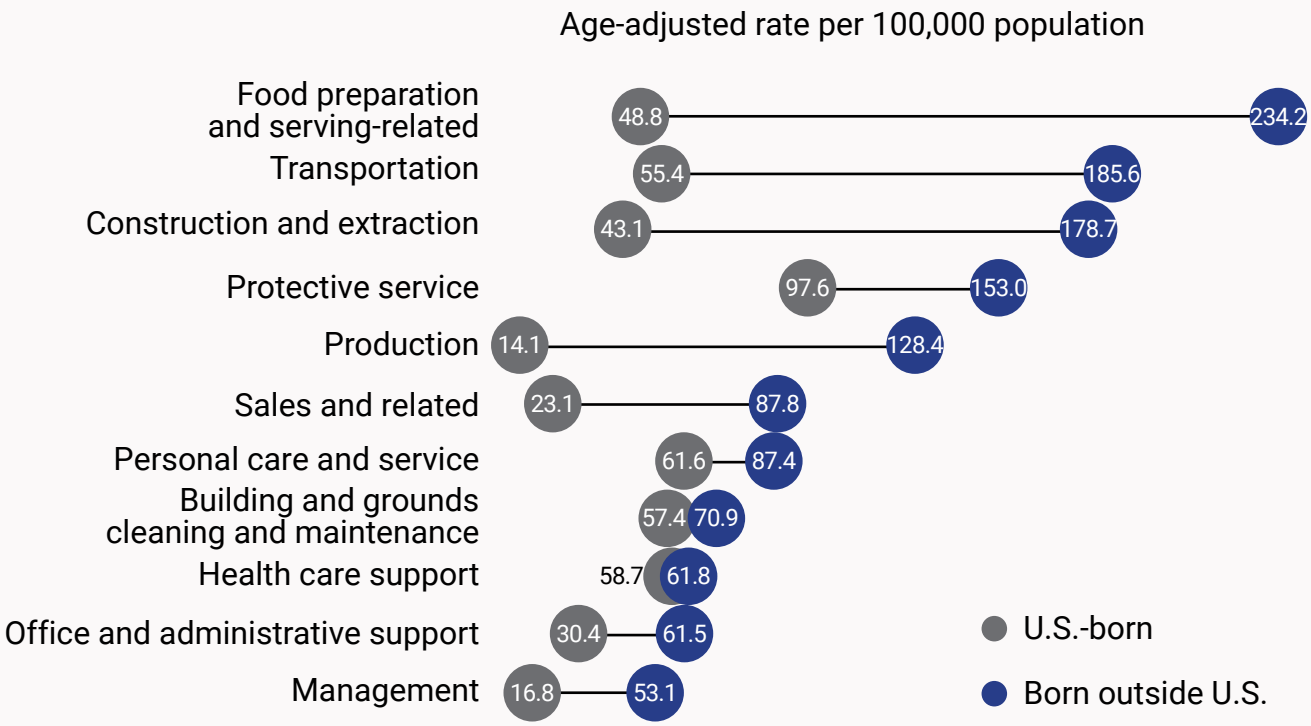
During the COVID-19 pandemic, frontline essential workers continued to work in settings where social distancing was difficult or impossible. In every occupation category, mortality rates for immigrants ages 18 to 64 were higher than those for U.S.-born New Yorkers. Among adults ages 18 to 64 years, the highest rates of mortality among immigrants were observed in those working in food preparation and serving-related (234.2 deaths per 100,000 people), transportation (185.6 deaths per 100,000 people), and construction and extraction occupations (178.7 deaths per 100,000 people). In the occupational categories of Personal Care and Service, Building and Grounds Cleaning and Maintenance, and Health Care Support, the differences in mortality rates between New Yorkers born outside the U.S. and U.S.-born New Yorkers still existed but were less pronounced.

"COVID-19 amplified existing barriers to accessing health care services, particularly for undocumented immigrants who faced fears of deportation when seeking care and experienced financial strain due to loss of employment during lockdowns."

— Korean Community Services

Premature death due to COVID-19 by type of occupation

Rate per 100,000 people ages 18 to 64 years



Data source: NYC Health Department Office of Vital Statistics, 2020-2021

Life Expectancy

Life expectancy — the average number of years a person can expect to live from the time of their birth — has changed dramatically in NYC over the course of the COVID-19 pandemic. The drop from 82.6 years in 2019 to 78.0 years in 2020 represents the biggest and fastest drop in lifespan in a century and reversed years of progress. In 2021, the life expectancy overall was 81.3 years: 83.5 years for immigrants and 79.9 years for U.S.-born New Yorkers.

HealthyNYC, the City's campaign for healthier, longer lives, has established an overall life expectancy goal for NYC to exceed 83 years by 2030, to be achieved by measurable reductions in the primary causes of death and health inequities in the city. Visit nyc.gov/healthynyc for more information.

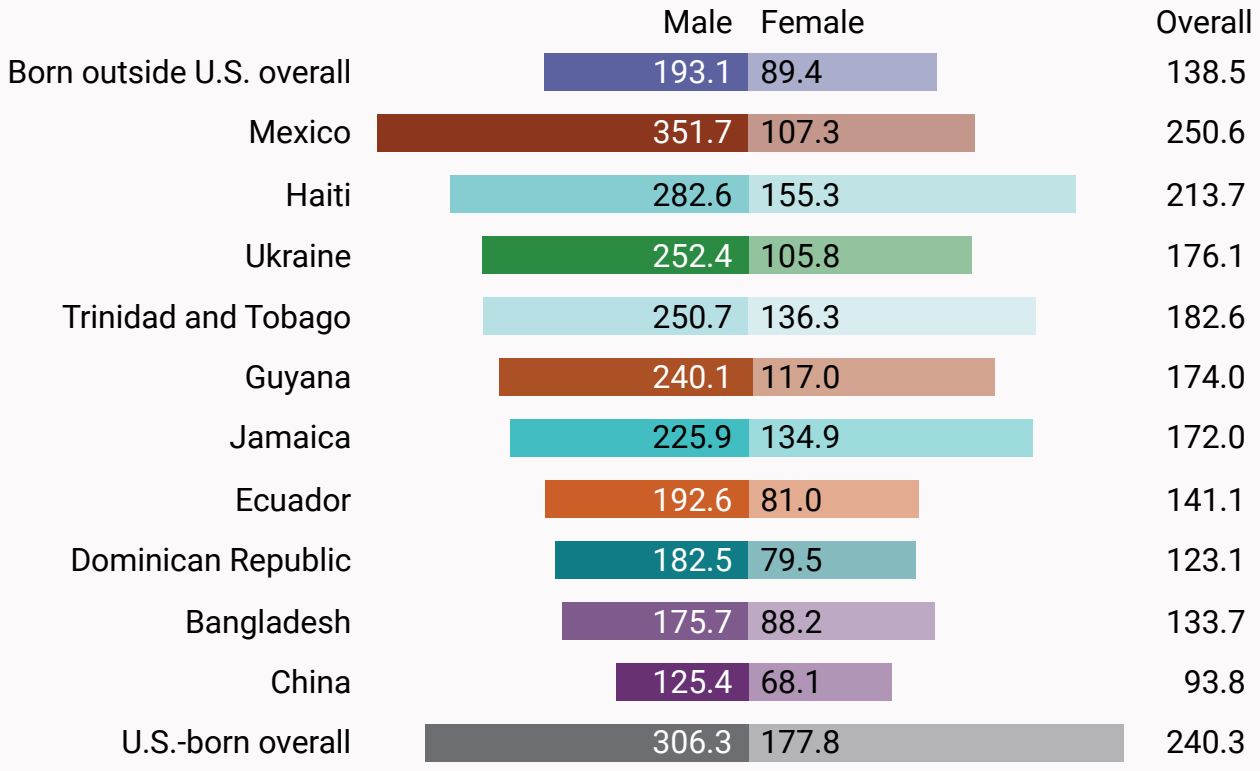
Premature Death

NYC's overall age-adjusted premature death rate (death before age 65) decreased by 9% from 2011 to 2019 but then increased by 49% from 2019 (180.2 per 100,000 people) to 2020 (268.2 per 100,000 people). The sharp increase was primarily due to COVID-19 deaths.[50]

The rate of premature death is lower among immigrant New Yorkers (138.5 per 100,000 people) than among U.S.-born New Yorkers (240.3 per 100,000 people). Rates of premature death are higher for males compared with females among all places and regions of origin.

Rate of premature death by sex and place of origin

Rate per 100,000 people



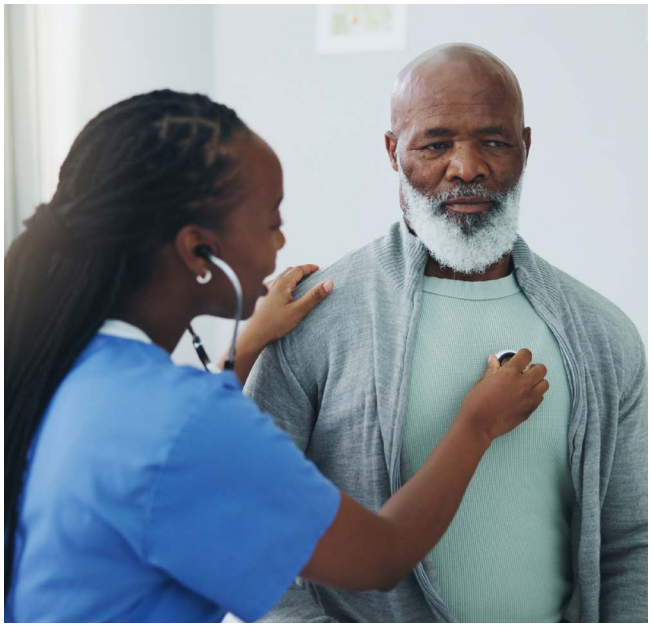
Note: Among top places of origin.

Data source: NYC Health Department Office of Vital Statistics, 2020-2021

Leading Causes of Death

Heart disease is the leading cause of death for all New Yorkers. The rate of death due to heart disease among immigrants is 28% lower than among U.S.-born New Yorkers. The rate of death due to cancer, the second-leading cause of death in both groups, is 19% lower among immigrants than among the U.S.-born. Among New Yorkers born outside the U.S., cerebrovascular disease (such as stroke or brain aneurysm) is the third-leading cause of death (17.6 per 100,000 people). Among U.S.-born New Yorkers, drug-related deaths are the third-leading cause (28.2 per 100,000 people).

Rates of death due to specific causes were analyzed among immigrants from places of origin with the highest number of deaths. The highest rates of death from heart disease are seen in immigrants from Ukraine (259.5 deaths per 100,000 people), Haiti (195.3 per 100,000 people) and Guyana (180.9 per 100,000 people). The highest rates of death from cancer are seen in immigrants from Ukraine (145.3 deaths per 100,000 people), Italy (125.1 per 100,000 people) and Haiti (122.0 per 100,000 people). Among the top places of origin, female immigrants have lower rates of death due to heart disease and cancer than male immigrants.



Top three leading causes of death

Rate per 100,000 people

	Heart disease	Cancer	Third-leading cause
Ukraine	259.5	145.3	20.8 Influenza and pneumonia
Haiti	195.3	122.0	35.7 Diabetes mellitus
Guyana	180.9	85.2	30.5 Diabetes mellitus
Trinidad and Tobago	179.7	107.5	33.3 Diabetes mellitus
Italy	161.5	125.1	15.7 Cerebrovascular disease
Jamaica	159.1	113.1	29.6 Diabetes mellitus
Dominican Republic	102.5	78.5	18.6 Cerebrovascular disease
Ecuador	101.4	87.6	17.9 Cerebrovascular disease
China	100.1	113.4	16.9 Cerebrovascular disease

Note: Among nine places of origin outside the U.S. with the highest count of deaths.

Data source: NYC Health Department Office of Vital Statistics, 2020-2021

New Arrivals

Since spring 2022, more than 229,000 immigrants have arrived in NYC and entered NYC's emergency housing system. Many of these immigrants came from the U.S.' southwest border after declaring an intent to pursue asylum in the U.S. This recently arrived population is less likely to have existing family or community connections in NYC, relative to previous waves of newcomers, contributing to a temporary increase in the City's emergency shelter population.

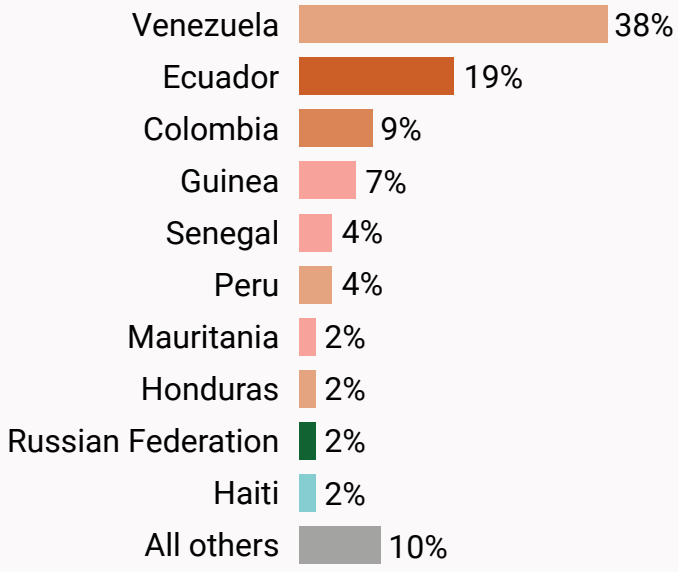
While these new New Yorkers may not yet be represented or identifiable in much of the data presented elsewhere in this report, the following information highlights select characteristics of this population and the efforts and opportunities to support their well-being. The size and circumstances of this population are changing rapidly. The data presented in the rest of this section were accurate as of June 30, 2024.

Over 200,000 people entered NYC emergency housing between spring 2022 and June 30, 2024; of those, 65,300 still resided in emergency housing at the end of June 2024. Seventy-eight percent of these shelter residents were members of families with children under the age of 18, 19% were single adults, and the remainder were adult couples and families with no members under the age of 18.

More than one-third of the total asylum seeker shelter population were under the age of 18. Very few newer arrivals were over the age of 60, a marked difference with NYC's overall immigrant population. One out of every five immigrants overall is over the age of 65.

Venezuela is the most common place of origin among the population of asylum seekers that have passed through NYC emergency housing at some point since spring 2022. The most common place of origin outside of Latin America is Guinea. While initially the vast majority of new arrivals were from Central and South America, as of June 2024, perhaps half were from Asia, Africa, the Caribbean and Europe, in that order.[51]

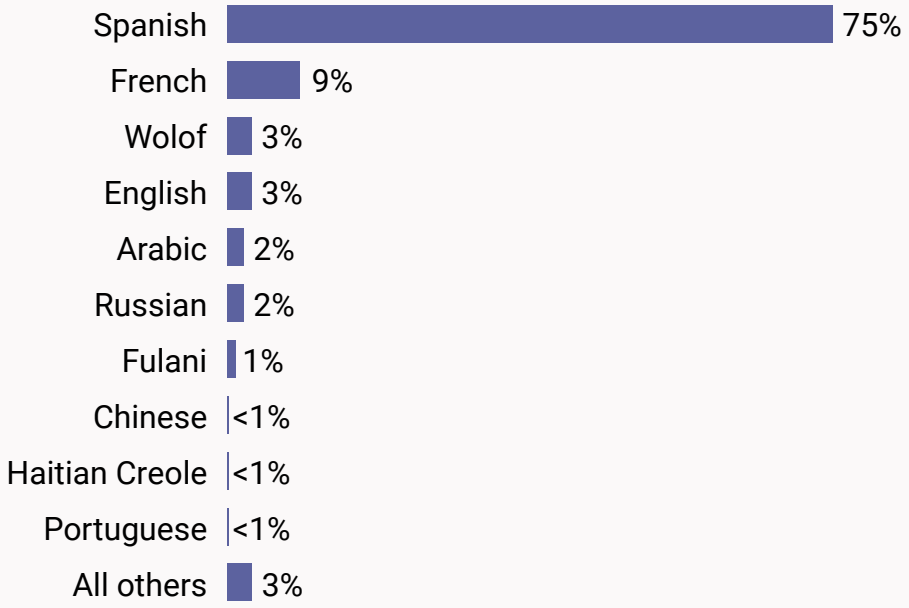
Top places of origin among new arrivals to New York City between April 2022 and June 2024



Data source: NYC Office of Asylum Seekers Operations

Three in four asylum seekers in NYC government care note Spanish as their preferred language, followed by French, Wolof (a predominant language in some West African countries), Russian and English.

Top preferred languages among new arrivals to New York City between April 2022 and June 2024



Note: Fulani is also known as Peul, Pulaar, Fula, Fulah, and Fulfulde.

Data source: NYC Office of Asylum Seekers Operations

NYC government, community health care providers and social service organizations provide a range of services for immigrants. They focus on meeting immediate needs and then connecting people as quickly as possible to a primary care home in the local health care system. Services as of July 2024 included initial health screenings and urgent care capacity at the city's Arrival Center, health insurance enrollment at existing community-based enrollment sites, and referral and navigation to primary care providers. Examples of additional screenings and on-site services include tuberculosis testing for people living in congregate settings and mental health support including crisis counseling and psychological first aid. For more detail on the City's support structure for asylum seekers as of March 2023, see The Road Forward: A Blueprint to Address New York City's Response to the Asylum Seeker Crisis by visiting nyc.gov and searching for **road forward**.

As of June 2024, there were nearly 21,000 new students living in temporary housing who had newly enrolled in NYC public schools since spring 2022. This has required a large-scale public health effort to ensure that they have timely access to recommended and required immunizations. NYC government has employed a combination of on-site vaccine operations at sanctuary shelters and in-person and phone-based outreach to families. These operations and outreach efforts connect families with health care providers who can provide medical and mental health care.

"A lot of asylum seekers from places in Africa are not supported by current language service requirements/options."

— Coalition for Asian American Children and Families

Data source: NYC Public Schools

Partners' Experiences

Federally qualified health centers (FQHCs) have been indispensable collaborators in this work. Many independent FQHCs, along with the NYC Health + Hospitals (H+H) system, have become primary care homes for recently arrived immigrants. Two of the City's FQHC partners — the Institute for Family Health (IFH) and Terra Firma, a medical-mental health-legal partnership at the Bronx Health Collective — are highlighted here for their innovative and tireless efforts to ensure access to services for recently arrived children and families. Alongside other community health care providers, IFH and Terra Firma have worked directly with NYC government and with sanctuary shelters for families with children to engage new immigrants in care, and to provide vital health education, immunizations, holistic health care and social services.

From Terra Firma (terrafirma.nyc):

- On housing instability: "Many newly arrived immigrants are at risk for experiencing homelessness. Not having stable housing often means placing health care needs on a back burner."
- On Terra Firma's structure: "The Terra Firma model of wraparound service delivery meets medical, mental health, social service and legal needs of immigrants. [It] co-locates ... services within a community health center in one place, at one time."
- On the shelter-based service model: "Conducting immunization drives at family shelters, in conjunction with the NYC Department of Health and Mental Hygiene and Department of Homeless Services, is an excellent way to reach many children and their caregivers at one time."
- On clinical-legal partnerships: "Terra Firma has been working with legal partners ... to conduct ... legal clinics for the patients we serve. Due to the [lack of free] immigration attorneys in NYC ... [legal] clinics allow for providing legal assistance to a large number of migrant families at one time."
- On trauma during migration and the importance of comprehensive care including mental health support:
  - "A family from Colombia had their two children kidnapped for two days by criminal elements on their journey in Mexico. The family had to pay $3,000 to have their children released. When seen at an immunization drive in a Bronx shelter, the mother related how regressed her children's behavior had become, with frequent bed-wetting and fears of parent-child separation. Although coming to the mobile unit for immunizations, she was grateful that the team was able to connect her children with comprehensive medical care and mental health services."
  - "One 6-year-old from Venezuela was seen by Terra Firma/Bronx Health Collective's mobile medical team during an immunization drive. The pediatrician noticed that the child was unable to walk properly. The medical team was able to get neurology and genetics appointments for the child almost immediately upon arrival in NYC. The family was incredibly grateful and hadn't expected to receive such comprehensive care."

From the Institute for Family Health (institute.org), an FQHC helping tens of thousands of patients across 27 health centers:

- On accessibility of services and scheduling challenges: "We provide care at a free clinic and also sliding-scale care at all of our sites along with free medications. A common challenge is wait times for dental and mental health care. In working with asylum seekers, we learned they have many hurdles to navigate, like meeting with lawyers and other ancillary appointments. ... [They may] at times miss their scheduled health appointments due to more pressing priorities."
- On trust building and models of care for new arrivals: "Our presence at the asylum shelters offers the immigrants the opportunity to meet with us and establish a connection. ... Although we are not care managers, we follow the tenets of care management, establishing trusting relationships and helping navigate their health care needs. ... The family medicine model at IFH allows for one provider to take care of the entire family, removing the need to call for numerous appointments and navigate different systems. Dealing with call systems where messages are largely in English and patients not knowing what they need makes it difficult for families. ... We work closely with our medical team at our health centers to assist in locating clients needing urgent follow-up. Our relationship with the NYC Health Department facilitated our connection with the shelter staff to enable us to reach patients in need of urgent follow-up. We found that providing printed directions to their appointment in Spanish was extremely helpful, and if the family has Medicaid, they receive a round-trip MetroCard when they complete their appointment."
- On the range of needs of recently arrived immigrants: "Our providers have begun to create a checklist of best practices for care of the asylum-seeking patients (both children and adults) and screenings that are important for them. ... Many traveled by foot for months and drank unclean river water on their journey. Some ... need further testing or treatment for parasites, for example. We've seen cases of anemia from poor nutrition. Many pregnant women have not had prenatal care. Further, the need for mental health care is palpable. ... We have also encountered severe dental needs, particularly in children who are in pain. ... Because of the higher demand for health care and staff shortages, it is difficult to access care and emergency appointments."

From Charles B. Wang Community Health Center (cbwchc.org):

- On federal actions and rhetoric: "New immigrants may not fully understand or be aware of the services they are entitled to receive. Concerns about 'public charge,' immigration 'crackdowns' or general anti-immigrant rhetoric can dissuade immigrant New Yorkers from pursuing preventative health care."
- On care provision: "Asylum-seeking populations ... face additional health care challenges. ... Visits with our providers take much longer due to lack of patient medical records and language barriers. In particular, the lack of vaccine records presents an extra challenge. ... The majority of asylum seekers do not have a cell phone. Some only use WhatsApp and rely on their shelter's Wi-Fi. These issues create challenges for us to remind them of their upcoming appointments."

From Korean Community Services of Metropolitan New York (kcsny.org):

- On models of care for new arrivals:
  - "Coordinated efforts among health care providers, social service agencies, legal advocates and community organizations facilitate comprehensive support. A holistic approach that considers social, economic and psychological factors, along with trauma-informed practices, promotes healing and well-being."
  - "Meeting stringent certification requirements and ensuring language availability at scale can pose significant obstacles to the seamless delivery of services. Moreover, effectively navigating cultural differences and addressing the specific needs of diverse immigrant groups requires ongoing training and cultural competency development among staff members. Limited resources can constrain the expansion of services."

From Make the Road New York (maketheroadny.org):

- On the models of care provision: "The peer-to-peer model of outreach and direct service support via promotores [promoters: peer educators or patient advocates] and [community health workers] has enabled us to serve the new migrants. We have our staff at the welcome centers in Manhattan every week, connecting people to care, helping people enroll in Emergency Medicaid and connecting them to NYC Care and providing referrals."
- On common health challenges: "We have been connecting [new migrant] parents of newborns to pediatric care, pregnant people to prenatal care for the first time, and many others to primary care or to care for chronic conditions that have been unaddressed for months or even years."

Progress on New York City Immigrant Health Over the Past Decade

The City has made significant efforts to better assess and promote immigrant health over the past decade, including the following:

2014-2015 Mayor's Task Force on Immigrant Health Care Access

In 2014, the City created the Task Force on Immigrant Health Care Access to increase access to health care services among immigrant populations. It brought together City agencies, health care providers, immigrant advocates and public health experts to identify key barriers to health care access and recommend steps the City could take to help immigrants overcome them. Identified barriers to immigrants' access to health care included lack of affordable care, limited service delivery and provider capacity, inadequate cultural and linguistic competency among health care providers, lack of knowledge and understanding of care and coverage options available for immigrants, lack of access to high-quality interpretation services, and lack of knowledge and understanding of language and translation services available to immigrants and health care providers.

The task force published its report[52] in 2015, containing four recommendations:

1. Create a direct-access health care program to provide uninsured immigrants and others with access to coordinated primary and preventive health services
2. Expand the capacity of the NYC health care system to provide culturally and linguistically competent primary and preventive health care services to immigrants
3. Conduct public education and outreach on health care and coverage options for immigrants and the organizations that serve them
4. Increase access to high-quality medical interpretation services

Implementation of Lessons From Unaccompanied Child Migrants Work

In 2014, in response to an increase in the number of unaccompanied immigrant children being placed with sponsors, usually their own family members, in New York City by the federal Office of Refugee Resettlement, the City government established an interagency task force to address the needs of children and their caregivers. The task force facilitated training on public health insurance eligibility and enrollment, worked with the NYC Department of Education and the state Education Department on amendments to school registration procedures and published a Resource and Referral Guide that was also distributed to local caregivers of NYC-bound children arriving at the southwest border. It also temporarily stationed health and social services staff at the federal Immigration Court in Manhattan to connect children and caregivers to support.

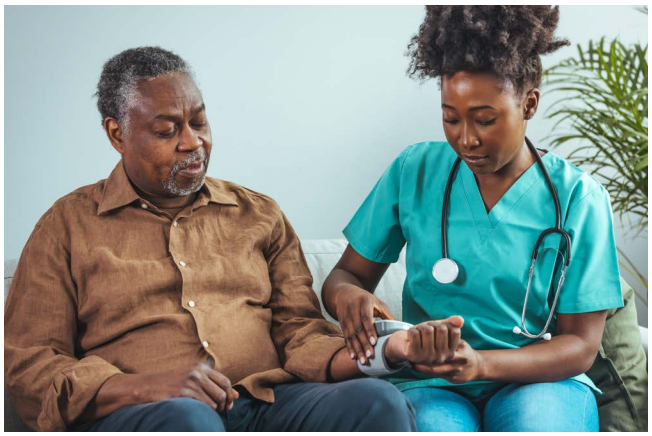
Municipal Identification Cards as a Health Tool

In 2015, NYC launched a municipal identification card program, IDNYC, to facilitate residents' access to government services and amenities such as health services. The IDNYC card is available to all NYC residents ages 10 and older regardless of immigration status. Since the program's launch, IDNYC cardholders have saved $1,403,692 by using the integrated BigAppleRx prescription drug discount program at more than 2,000 pharmacies citywide.[53]

In 2016, IDNYC added an integration with the city's public hospital network, through which 11,460 cardholders have linked their IDNYC cards to NYC H+H patient registration accounts to facilitate health care access and vaccinations. In 2017, IDNYC added an integration with the NYC Health Department Citywide Immunization Registry to allow cardholders to access their and their children's official immunization records to assist in school, child care and camp registration, and more. A total of 18,904 cardholders made use of this tool. IDNYC also partnered with the New York State Department of Health Donate Life Registry to allow cardholders to easily register as an organ and tissue donor, has ensured acceptance by the New York State of Health insurance marketplace, and has partnered with local health care providers to reach patients who would benefit from the IDNYC program.[54]

2016-2017 ActionHealthNYC Program and Evaluation

The NYC Health Department and partner agencies launched a direct-access demonstration program for undocumented



and uninsured New Yorkers. ActionHealthNYC was a one-year program that provided comprehensive and coordinated patient-centered care to enrollees. The noninsurance health care access program used a network of primary care sites to ensure that each member had access to health care at an affordable and predictable cost. The program also had a thorough evaluation afterward. The program reached many low-income immigrants, helping to reduce disparities in access to care. The evaluation results showed an increase in access to primary care[55] and an accompanying decrease in emergency department visits[56] among enrollees with chronic conditions.

2019 CCHR Human Rights Law Enforcement Guidance on National Origin Discrimination

In 2019, the NYC Commission on Human Rights (CCHR) published law enforcement guidance regarding discrimination based on national origin. The NYC Human Rights Law prohibits discrimination on the basis of actual or perceived "alienage and citizenship status," and "national origin," by most employers, housing providers and providers of public accommodations in NYC. This guidance document also clearly outlines human rights protections for hospital patients with limited English proficiency under the New York State Hospital Financial Assistance Law. The CCHR issued an updated version of its guidance in January 2025."[57]

Expansion of Immigration Legal Services in Long-Term Care and Hospital Settings

In 2017, the City expanded its immigration legal services grant funding program to create a new $1.5 million "ActionNYC in NYC H+H" medical-legal partnership program, co-locating immigration attorneys in public hospitals and long-term care facilities. This program continues to operate today, providing critical support to immigrant patients and ensuring appropriate insurance coverage based on immigration status.

Public Health Insurance for DACA Recipients

In 2014, the City launched a public education campaign to provide young NYC immigrants who were beneficiaries of the 2012 federal Deferred Action for Childhood Arrivals (DACA) immigration program with information and support regarding eligibility for public health insurance. This effort, funded by the New York State Health Foundation, included outreach to community-based organizations and advertising in subways, bus shelters and newspapers in languages spoken by immigrants across NYC. These benefits were largely unknown to the population, and in the period immediately following the campaign, the number of new applications rose dramatically.

In 2017, City officials testified in support of state-level efforts to protect DACA beneficiaries from losing their health insurance coverage as a result of the first Trump administration's attempt to end the DACA program. Soon thereafter, Governor Cuomo and the state Department of Health released new guidance to prevent insurance lapses for this population.

Public Charge Rule

Historically, federal immigration agencies interpreted the late 19th century "public charge" law — which denies adjustment of status and certain visa issuance to immigrants deemed likely to become recipients of certain welfare benefits — to only apply where an immigrant receives cash assistance or institutionalization for long-term care at the government's expense.

In 2019, the federal government under President Trump issued a new rule seeking to expand the types of public benefits considered to be negative factors against an immigrant's visa or green card application, including nonemergency Medicaid, Supplemental Nutritional Assistance Program (SNAP) and public housing assistance. The NYC Health Department — in collaboration with other City agencies — submitted a public comment in opposition to the rule change, and NYC joined New York State and others in filing lawsuits to prevent the new rules from going into effect. In addition, City officials mobilized to conduct extensive outreach and education to community partners and New Yorkers about what was and was not included in the rule, mitigating the "chilling effect" of the rule on the use of services not part of the public charge rule.

The City encouraged clients to seek legal advice before they disenrolled from or did not sign up for benefits to which they were lawfully entitled. Additionally, the City provided public guidance that City services, including health services at public hospitals and clinics, were not part of the new public charge rule. Messaging from City government clearly stated that the NYC government values immigrants and is committed to providing services to all New Yorkers regardless of income or immigration status. This messaging also emphasized that City employees do not ask about immigration status except in limited circumstances such as health insurance enrollment to determine eligibility and that there are strict laws in place to protect confidentiality. The NYC Health Department and other City agencies also conducted research to assess decreases in immigrant utilization of benefits.

After President Biden's inauguration, in 2021, he issued an executive order directing a review of these public charge rule changes. The next year, the federal government adopted a new rule that rescinded the Trump administration policy and reverted the rules to their prior state.

The City continues to provide guidance to immigrant residents about accessing public benefits and health services.[58]

Launch of NYC Care Program

In August 2019, the City launched NYC Care, a direct-access program that built on the lessons and successes of ActionHealthNYC. The program is based at the City's public hospital system and currently has over 100,000 members. NYC Care, a noninsurance program for individuals ineligible for insurance, has the following member benefits:

- A dedicated primary care provider and initial primary care appointment within two weeks
- 24/7 customer assistance
- After-hours access to pharmacies
- A program membership card

NYC Care is now the largest program of its kind in the nation, providing coordinated primary and specialty care services to New Yorkers who are unable to access affordable health insurance. The program has over 145,000 active members.[59]

Conclusions

New York City has been a city of immigrants for centuries and today is one of the most diverse places in the world. NYC values all people and has always depended on the contributions of immigrant artists, entrepreneurs, laborers and professionals. Immigrants have been and continue to be key to the city's growth, success and vibrancy. Recent arrivals continue a long-standing trend of immigrants contributing to the economic well-being of the U.S. and having lower health care expenditures than U.S.-born persons.[60,61] Investing in the health and well-being of immigrant New Yorkers helps our whole city and country thrive.

Results detailed in this report highlight a range of needs. Strategies to address them include:

- Reducing language and cultural barriers to meet basic needs for housing, education and health care
- Engaging immigrant communities to share resources about available services and their rights
- Focusing resources of diverse institutions to the groups most in need
- Eliminating federal and state discriminatory eligibility requirements that prevent individuals from accessing needed public benefits and programs because of their immigration status

We encourage community-based organizations, funders, policymakers and all those who care about the health and well-being of New Yorkers to use these data to inform their work. We encourage researchers to further explore how the health of immigrants affects the well-being of all people; collaborate closely with immigrant communities and those who serve them in the development, interpretation and dissemination of research, including about topics rarely available in standard data sources; construct narratives that counter xenophobia, racism, and historic and structural inequities; and connect with policy experts, others who are informed and those with influence to convert evidence into action.

Although this report highlights select health inequities, there are limitations to the available data. Many aspects of the health experiences of immigrant New Yorkers cannot be captured here. One key factor not captured is documented immigration status, which is known to have a particularly strong impact on health care access and outcomes. Many NYC government services are available to all people in the city, regardless of immigration status, and the NYC Health Department does not ask about immigration status in providing services or conducting surveys as a matter of policy and inclusion. Lack of knowledge of this policy or fear may prevent all immigrants from receiving the services they need.

Persistent inequities in access to health care and health outcomes underscore the continuing need for a health equity lens that recognizes the impact of long-standing exclusionary health and immigration policies. Organizations in NYC that work with immigrants witness the resilience of immigrant New Yorkers and their ability to adjust to adverse circumstances, yet we must collectively continue to create and expand upon programs of universal access and widespread education to achieve health justice for immigrant communities and all New Yorkers.

Resources for Supporting Immigrant Health in New York City

- MOIA Immigration Legal Support Hotline — 800-354-0365, or call **311** and say "Immigration Legal," Monday to Friday, 9 a.m. to 6 p.m. (ET); visit nyc.gov and search for **immigration legal services**
- Community Resources for Immigrant New Yorkers (New York Immigration Coalition) — nyic.org/resources-training/kyr
- Fact Sheet: Immigrant Eligibility for Public Benefits in New York State — Visit empirejustice.org/free-legal-resources and search by issue.
- Mayor's Office of Immigrant Affairs — Immigrant Resource Road Map available in 50 different languages: Visit nyc.gov and search for **immigrant resource road map**
- New York State New Americans Hotline — dos.ny.gov/office-new-americans; 800-566-7636, Monday to Friday, 9 a.m. to 8 p.m. (ET)
- Notify NYC — a858-nycnotify.nyc.gov: Emergency alerts provided in 14 different languages
- NYC Care health care access program — www.nyccare.nyc
- NYC Government and Nonprofit Services for Recently Arrived Immigrants — Visit nyc.gov and search for **services for recently arrived immigrants**
- Ready New York — nyc.gov/site/em/ready/ready-new-york.page: Tips and information to help prepare New Yorkers for all types of emergencies
- Receiving Health Care Services in New York City, Regardless of Immigration Status [PDF] — Frequently asked questions, available at nyc.gov/site/doh/health/health-topics/immigrant-health.page or by visiting nyc.gov/health and searching for **immigrant health care**
- Coalition for Asian American Children and Families AAPI Health Resources Hub — cacf.org/health-resources-hub
- HRA Immigrant Resources — Available at nyc.gov/site/hra/help/immigrant-resources.page or by visiting nyc.gov and searching for **hra immigrant resources**
- NYC Administration for Children's Services Resources for Immigrants — Available at nyc.gov/site/acs/about/resources-for-immigrants.page or by visiting nyc.gov and searching for **resources for immigrants**

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Online appendix:

https://www.nyc.gov/assets/doh/downloads/excel/episrv/ihr-appendix-2025.xlsx

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Cover artwork is a community mural titled “We Gon’ Be Alright” for the Kings County Hospital Wellness and Recovery Center. Unveiled in 2024, it was made by Fitgi Saint-Louis (@fitgisaintlouis), a New York City-based artist, who explores the African diaspora and her Haitian heritage across various mediums. The mural was commissioned through NYC Health + Hopsitals Arts in Medicine as part of the Community Mural Project and developed by the artist through a series of focus groups with community members, staff and patients. The mural celebrates and honors the community here that shows up each day for each other throughout the challenging journey toward recovery.

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