The Experience Of Immigration And Aging On The Health Of Older Adults In The El Paso, Texas, Border Region

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THE EXPERIENCE OF IMMIGRATION AND AGING ON THE HEALTH OF OLDER ADULTS IN THE EL PASO, TEXAS, BORDER REGION

SONIA LIZET RAMOS

Master’s Program in Sociology

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Dedication

I dedicate this accomplishment and completing this thesis to my entire family: Bianca Ramos, Alondra Ramos, Santiago Ramos Jr., Alexander Ramos, Gabriel Ramos, and Lala Ramos. Thank you for supporting me and motivating me never to give up on my academic and career goals. I want to give a special thanks: para mis padres, Sonia y Santiago Ramos llegaron sin nada y me lo dieron todo, for always believing in me and watching over my sleepless nights. I want to thank my partner, Yandir Castaneda, for being there for me through thick and thin and for being my backbone. Also, to my grandmother Margarita who was the inspiration for this thesis, I hope I am making you proud. Lastly, I also wish to dedicate this thesis to my mentor, Dr. Ophra Leyser-Whalen, to give me the confidence to apply to graduate school for the patience and time she has given me. She is truly an inspiration. Thank you for the knowledge and confidence you gave me in writing.
THE EXPERIENCE OF IMMIGRATION AND AGING ON THE HEALTH OF OLDER ADULTS IN THE EL PASO, TEXAS, BORDER REGION

by

SONIA LIZET RAMOS, B.S

THESIS

Presented to the Faculty of the Graduate School of
The University of Texas at El Paso
in Partial Fulfillment
of the Requirements
for the Degree of

MASTER OF ARTS

Department of Sociology & Anthropology
THE UNIVERSITY OF TEXAS AT EL PASO

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Abstract

Healthcare access continues to be a problem for immigrant populations in the United States, especially for Latino immigrants at the US-Mexico border. There is limited social research examining the experience of access to health care of older adult Latino immigrants during their life course in the U.S. In U.S.-Mexico border communities, documented and undocumented residents face unique experiences when accessing health care. This thesis focuses on understanding the intersectionality of the immigration process and health care access of older adult Latino immigrants on the U.S.-Mexico. Using qualitative data collected from participants living in the County of El Paso, Texas, I identified the unique pathways older Latino immigrants face when accessing health insurance and health care on both sides of the border, and the role of support systems.
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Introduction

In American society, migration has become a topic of unresolved debate, shaping the lives of documented and undocumented individuals as they age. Throughout the United States’ migration history, there has been a variation in migratory policies such as providing accessible and affordable care coverage to documented and undocumented immigrants (Montes de Oca, Garcia, Saenz, and Guillen, 2011). Immigration enforcement laws have aggravated immigrants’ health, yet few have examined the intersection of health, aging, and immigration along with the U.S.-Mexico border areas. The absence of universal health care in the United States causes nearly 31 million people to have no health insurance, relying on expensive emergency care (Kaiser Family Foundation, 2018). These lead to higher overall healthcare costs resulting in a more significant impact on poorer health outcomes throughout the life course (Viladrich, 2012). I address the severe health care inequalities immigrants face through their life courses.

The participants in this research navigate the act of being Latinos immigrants living in the U.S.-Mexico borderland communities, which demonstrates characteristics that often contrast with those populations away from the border. Recent scholars studying the health of Latino immigrants point out that significant barriers to accessing health care can be exacerbated by other obstacles, including transportation, language, economy, childcare, age, and immigration status (Montes de Oca, García, Sáenz and Guillén, 2011). Yet, Latino immigrants in the borderland have certain advantages such as cross-border health utilization, Spanish speaking health care professionals, and social support systems, and face unique disadvantages of living in a region with constant surveillance of immigration status.


**Literature Review**

This section introduces and reviews essential research to establish the relevance of this study’s research question: how do elderly Mexican immigrants in El Paso connect their immigration process experiences to their overall health status? The reviewed studies on immigration, aging, and health analyze pervasive ways the immigration process has and is currently limiting access to needed health care services impacting migrants as they age. This proposal examines these critical areas of literature, focusing on the intersection of health, aging, and immigration in the US from the turn of the 20th century to current times. These prominent bodies of research intersect and represent the most salient research findings that both support and challenge discourses of immigration and aging on health.

In the United States, immigrants are often identified as vulnerable populations because of the high risk of poor health, being uninsured, and experiencing social exclusion. Some studies have noted factors that can lead to vulnerability, such as stigma and marginalization, which are generated by politics, social inequality, and lack of socioeconomic and public benefits (Derose, Escarce, and Lurie, 2007). This approach aligns with a growing literature in the field illustrating how immigration laws implement selective inclusion, which refers to "the particular traits that make certain immigrant populations deserving of publicly supported health care" (1449), which excludes others (Torres and Young, 2016).

The immigration process puts on display the way the government constructs laws to differently target immigrants who have legal and unauthorized statuses, which can contribute to feelings of discrimination. However, scholars have left gray areas on how older adults experience the immigration process. This paper proposes a study of understand how the US immigration experience can affect immigrant health as they age. I begin with the theoretical
frameworks guiding my study, then outline existing literature on US immigration policy periods and their effects on health and conclude with the methods of my proposed study.

**Theoretical Framework**

This study utilizes two theoretical frameworks: (a) life-course perspective and (b) Foucault's governmentality theory. The use of these theoretical approaches helps explain health patterns immigrants face within their daily interactions with social inequalities and political institutions through various life-course events, which can create peculiar health outcomes later in life.

The life-course approach helps to describe circumstances that shape immigration experiences on older adult immigrants. According to Montes de Oca et al., (2011), there is a relationship between aging and life course, which can serve to interpret the way social, political, and institutional conditions influence the health of aging immigrants. Researches have illustrated that people who migrate to the United States tend to be healthier, but over the long term, their health began to deteriorate (Wakabayashi, 2010). For this reason, the life-course perspective helps to develop an understanding of how immigration policies create structural barriers that cause difficulty for immigrants to age in a healthy manner.

According to Walters (2015), Foucault defines the concept of governmentality as a way the government designs political power to manage who will play what role within society. The use of governmentality theory proposes to identify how the immigration process is built to target a particular population, causing disconnections from informal social institutions and cultural practices reproducing feelings of exclusion, impacting physical and mental health (Walters, 2015). For instance, immigration eras have shown how immigration policies have produced boundaries to define who has access to the health system.
These two theoretical frameworks allow us to examine and add to the small body of research related to the lived experiences of immigrants that face distinct immigration processes while aging, which affects their health.

**Immigration and Health**

The immigration literature review presented here outlines the association between immigration and health, with a focus on the elderly population. Individuals migrating to the United States face the challenge of adapting to life in a new country with a different culture, norms, and political climate. Even though the United States has long been considered a nation of immigrants, it has built strict immigration policies that can influence health. There is evidence that most immigrants that come to the United States as young adults primarily to work are healthier and wealthier, often experiencing better health outcomes when they first arrive. However, as immigrants start to assimilate to America, their health appears to deteriorate over time. Several factors may contribute to the decline of health, such as unique barriers immigrants face due to immigration policies conferring or denying legal-residency status that contribute to poor access and utilization of health services. In general, immigration studies have emphasized that migrants’ health status was affected by living in harsh conditions, not having access to health care, and experiencing risks at work when living in the United States.

Prior studies have explained that immigration policies may modify health policies targeting undocumented and legal immigrants, yet more research still needs to focus on the intersectionality that the United States' historical immigration policies have had on immigrant health care access. In terms of our elderly immigrant population, researchers mention that throughout U.S. history, there have been dramatic immigration policy shifts that physically affected people later in life (Mueller and Bartlett, 2019). The unfavorable circumstances under
which some immigrants have entered the country, and the substandard conditions in which many
live following their arrival regardless of immigration status, only exacerbate poor health.

**Immigration and Heath Insurance**

Most immigrants in the U.S. do not have an insurance card to show the emergency room
or clinic when they have an unexpected health concern. The cost of American healthcare
expenditures is drastically increasing, and the number of people purchasing medical coverage is
declining. The United States healthcare system, in contrast to others, is recognized to be the most
expensive. Prior studies illustrated the high rates of uninsurance among elderly Latino
immigrants, which seem to be more vulnerable due to the restrictions health insurance has on
immigration status (Wong et al., 2006). Newly arrived immigrants are not eligible for any public
benefits until they achieve citizenship or an individual who has been lawfully admitted for
permanent residence and has resided continuously as a lawful permanent resident in the U.S. for
at least 5 years before filing (Montes de Oca et al., 2011). Therefore, any newly arrived
immigrants with fewer than 5 years of residence in the U.S. are not eligible for most public
services, including Medicare or Medicaid. Immigrants with fewer than 5 years of residence in the
U.S. or under an immigration process are worried about seeking health care being seen to be
dependent on the government.

As previously noted, Latino immigrants are excluded from government-funded health
insurance programs, which causes some of them to rely on the emergency department.
Cunningham (2006) illustrated a continued increase in undocumented immigrants and uninsured
individuals along the U.S.- Mexico border communities. Studies have reported that Latino
immigrants would use a hospital emergency department for primary care rather than primary
medical care or routine care due to the disproportionate access to health insurance (Samara et al., 2019).

Another alternative for accessing health care for residents living along the U.S.-Mexico border is using Mexico health care. Many studies addressed that Mexico meets uninsured and underinsured health care needs with more affordable medical and complementary and alternative medicine (CAM) care (Su et al., 2011). Wong et al. (2006) found that uninsured and low-income individuals who often visited Mexico were more likely to seek more affordable healthcare treatment than in the U.S. Conversely, those with insurance and trust and/or familiarity with the U.S. healthcare system were less likely to do so. Further, those without documentation cannot cross back into Mexico to seek services because of the risks of reentry to their homes in the U.S.

**Eras, Immigration Policies, and Health**

During *Railroad Period* (1910-1941), a significant number of Mexicans migrated to the U.S. to work in several industries. By 1920 there was an expansion of labor demands for male immigrants, which led to the growth of communities throughout the southwestern region. The Great Depression created massive deportation and America’s decline in its Mexican American population (Durand, 2000; Mueller and Bartlett, 2019). Corporations started to create exclusionary policies targeting different groups of immigrants, increasing inequality in the U.S. economic system.

The *Bracero Period* (1942-1964) presents different characteristics compared to those who experienced migration during the railroad period and other migratory phases. This immigration era emerges from the Bracero Program, which was established by an agreement between the United States and Mexico due to the World War II labor shortage (Montes de Oca, Ramirez Garcia, Saenz, and Guillen, 2011). The Program set the stage for about 350,000
Mexicans to arrive annually. They were mostly young adult men between the ages of 18 and 30, physically and mentally healthy, who were documented and undocumented. During this era, regardless of immigrants being part of the Bracero Program or not, they experienced challenges on their migration trajectory coming for an opportunity but facing exploitation of long work hours with minimal wages, which in the long-term deteriorated health (Montes de Oca et al., 2011).

The Bracero program promoted social security, transportation, food, decent housing conditions, and medical attention to attract Mexicans who were desperate for work and willing to take arduous jobs. These working conditions were not the most adequate, causing immigrants to face long-term health effects. In particular, the immigrants in this program suffered exploitation because the lack of labor regulation forced them to work long hours even if they had repetitive work injuries and exposure to pesticides. The selection procedures for Braceros required passing a series of physical exams to determine their ability to be part of the U.S. labor force Braceros saw the program as an opportunity to benefit their economic situation that made them not complain about racial discrimination, low wages, and poor working and living conditions. Eventually, the plan of the Braceros Program gave some immigrants the right to health care that in some cases gave them the ability to attend to illnesses left untreated for long periods and to save as much money as possible. However, many times Braceros working in rural areas employers treated them as undocumented (immigrants not selected for the Braceros program), affecting their health care by having to return to work immediately, thus not recovering fully (Montes de Oca et al., 2011). Even though the program came with some benefits for some immigrants, they faced everyday civil rights violations and threats, including threats of mass deportation such as during “Operation Wetback” in 1954. Molina (2010) described the public
health clinics that were used to target Mexicans with a documented or undocumented status for deportation, which left lasting hesitancy about using publicly funded health programs, even when eligible. Immigration studies concluded that even when the Bracero Program gave workers the capacity to migrate back and forth to the United States, this has shown an effect on health that this program has on immigrants as they age, including hypertension, diabetes, body aches, and depression (Mueller and Bartlett, 2019).

The Post-IRCA period (1965-1986) caused the end of the Bracero Program in 1964, transforming the United States migration experience. Mueller and Bartlett (2019) characterized the Post-IRCA period by the flow of undocumented migrants working on unskilled labor. Also, during this era, studies illustrate that there was an increase of females immigrating to the United States to reunify with their family because, in some cases, the father migrated first alone to work (Hamilton, Palermo and Green, 2015; Mueller and Bartlett, 2019). The people who decided to migrate had the same reasons as the migrants in the Bracero program, which were to find adequate jobs and wages that will help them support their families.

Montes de Oca et al. (2011) analyzed how during the Post-IRCA period, Mexico had “significant progress in control and prevention of infectious diseases by having advanced in the sanitary and health conditions” (p.1127). This event may present a significant impact on why Mexican immigrants migrated with good physical and mental health. However, the increase of militarization on the U.S. — Mexico border displaced migrants to use routes that could be dangerous and isolated, putting at risk their physical and mental health and their lives (Montes de Oca et al., 2011). The migrants entering the United States unauthorized or without legal documentation during this period were recognized to have an undocumented status creating barriers to access to health insurance (Montes de Oca et al., 2011; Mueller and Bartlett, 2019).
Eventually, employers continued to exploit migrants, but took advantage of the undocumented status and the U.S. laws (Montes de Oca et al., 2011; Mueller and Bartlett, 2019).

During the *Clandestine Migration period* (1987-2010), an estimated two million Mexican residents were living in the United States (Montes de Oca et al., 2011). Since then, the number has doubled every ten years (Montes de Oca et al., 2011). Immigration studies describe migrants from this era as women, men, children, and older aged people having different immigration statuses (Montes de Oca et al., 2011; Viladrich, 2012).

Before increasing security on the U.S-Mexico border, President Clinton in August 1996 signed into law the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA), a bill inspired to help both native and foreign-born citizens. This law divided all immigrants into two groups depending on the time they arrived in the United States and decided who is eligible for federal benefits. The division of legal immigrants is determined by who came after August 1996 and they had to live in the United States for five years in order to be eligible for a few welfare benefits (Viladrich, 2012). As a result, some immigrants experienced a change of legal status that affected their eligibility for welfare benefits. Immigration research explains that the creation of the PRWORA is to ensure individuals who decide to migrate to the United States can sustain themselves without the need for any public assistance at the time and in the long run (Edwards, 2001; Viladrich, 2012, 2019). Eventually, the implementation of the PRWORA demonstrated that the government wanted to continue to build barriers for immigrants to prevent them from obtaining the proper documentation for health benefits forcing them to continue to contribute to society by working even as an older adult.

During this era, the United States health care system faced another reform. According to Viladrich (2019), before the passage of the Affordable Care Act (ACA), which intended to
expand social rights and protect people, Congress debated whether to provide accessible and affordable care coverage to the undocumented population even if they were previously uninsured. The establishment of the ACA in 2010 expanded coverage and access to many uninsured people, but still excluded some U.S. citizens and other legal immigrants from obtaining health insurance. The population falling in the coverage gap is due to ongoing affordability concerns either by living in a state that did not expand Medicaid, or they are lawfully present immigrants waiting for five years before becoming eligible for Medicaid. The ACA continued to build barriers to all undocumented immigrants from any type of health care benefits such as the federally subsidized health exchanges and Medicaid. According to the Anthropologies of Medicine, the ACA segregates by the state of residence, income, and citizenship status (Csordas, 1995). The ACA created a boundary shift by providing health insurance to the citizen and long-term legal immigrants and revoked unauthorized and temporal immigrants (Joseph and Marrow, 2017). The continuous exclusion of undocumented immigrants to health insurance programs has made them rely on their family members for economic assistance to seek healthcare in the form of complementary and alternative medicine services that are more reasonably priced for uninsured patients (Viladrich, 2019).

In reference to my study in El Paso, TX, Mulligan and Castañeda (2018) highlight Texas’s lack of participation in the ACA by opting-out of the Medicaid expansion, leaving a significant portion of people uninsured, causing some legal immigration statuses as a category of exclusion in health care. Moreover, the Operation Phalanx Period (2010-2016) was established when President Obama authorized deploying up to 1,200 National Guard troops at the U.S.-Mexico border in support of the Customs and Border Protection (CBP) agency (Jones and
Johnson, 2016). The purpose of this era was to continue the militarization in the southern border against illegal immigration and the endless drug trafficking.

The *Trump Era* (2016–present) began since President Donald Trump presented his campaign promises to change the United States from being a nation of immigrants to anti-immigration. In the first months of the Trump presidency, he began a program of stepped-up immigration raids by Immigration and Customs Enforcement (ICE), allowing the state and local law enforcement to collaborate. Callaghan, Washburn, Gurram and Burdine’s (2019) study analyzed the anti-immigration policies delivered by the Trump administration causing immigrants and their families to face the fear of seeking for public assistance programs or limit their interactions with health providers. In the case of mixed-status families, eligible immigrants stay away from health care assistance because of the concern about deportation, especially with the proposed “public charge” rule announced in September 2018. In 2020, the Supreme Court announced that it would allow the Trump administration’s “public charge” policy to take effect, reshaping the U.S immigration flows again.

Immigration studies have illustrated that the public charge doctrine is one of the oldest laws of American immigration. The public charge rule’s old definition is a person who is or is likely to rely on “public assistance for a substantial part of his livelihood” (Edwards, 2001, pg. 2). The new interpretation of the public charge rule is a noncitizen who receives a specific public benefit for more than 12 months within a 36-month and an individual who is more likely than not to become a public charge in the future (Public Charge Fact sheet, 2020). Addressing that, the government restricts immigrants from accessing publicly funded health care and creates a need to rely on their sponsors—people who agree to take on the legal obligation of financially supporting an applicant for lawful permanent residence (USCIS Public Charge Fact Sheet, 2020).
According to the USCIS Public Charge Fact Sheet (2020), the determination of an applicant for the likelihood of becoming a public charge in the future is considered by the following factors: “age, health, family status, assets, financial status, education, and skills, prospective immigration status, and expected period of admission” (para. 15). Immigration studies illustrate that the goal of this policy is to target low-income immigrants who may need extra support from programs including Medicaid, Supplemental Nutrition Assistance Programs, or other federal or state assistance (Edwards, 2001). However, being a new policy, there is little research that examines how creating this exclusionary policy would increase the risk for poor physical, social health outcomes, and inadequate health care. This public charge rule is causing immigrants to have to decide whether they should renew their documentation or take care of their health because they do not want to fall out of their immigration status.

**Language Barriers**

The reforms continued to build direct legal barriers to all undocumented immigrants by excluding undocumented immigrants from public and private health insurance programs in the U.S. However, another factor that influences health care access is language. Unfortunately, limited research addresses the unique language barriers elderly Latinos immigrants face living along the U.S.-Mexico border. Some border health care studies described that the language barrier could impact their interaction with doctors when they want to understand or explain their health (Martinez, 2008). Therefore, according to Martinez (2008), many Latino immigrants use family members, friends, or other network support as an interpreter when the doctor does not speak their language. Other studies highlighted those clinics that use bilingual staff members to provide interpretation services due to the cost of professional interpreters (Elderkin-Thompson et al., 2001).
**Support Network**

Social networks play an essential role in access to health care among elderly Latino immigrants. Fuller-Iglesias and Antonucci (2016) highlighted the meaning of familism by stating that it is a cultural value among Latino populations that “involves an individual’s strong identification with and attachment to the family unit with strong feelings of loyalty, reciprocity, and solidarity among members of the same family” (p. 2). Other studies described that Latino immigrant traditionally, family members live close to one another or live in the same household, which can be composed of family and friends (Angel, Angel, and Markides, 2000). When it comes to caring for elderly family members, their adult children often become their source of support. However, some family members cannot provide care for their elderly, relying on their friends or hired caregivers. Fuller-Iglesias and Antonucci (2016) explain that elderly Latino immigrants extended their support network by people who can help take care of their needs. While other studies illustrated marriage results in better health through shared resources and income, shared support, and social control of health behaviors without seeking another support system (Grieco et al., 2012).
Methods

Setting

My research was conducted in El Paso County, Texas, which has an estimated population of 844,064 (World Population Review, 2022) and is on the western tip of Texas, bordering Mexico to the south and the state of New Mexico to the north and west. The racial breakdown of the population consists of 82.9% as Hispanic or Latino, 11.6% White non-Hispanic or Latino, 4.0% Black or African American, 1.1% American Indian and Alaska Native, and 1.4% Asian (World Population Review, 2022), making racial and ethnic minorities the majority of the population. The population is summarized in Table 1.

Table 1: El Paso Demographic Compared to State and National Figures.

<table>
<thead>
<tr>
<th>Demographics</th>
<th>United States</th>
<th>Texas</th>
<th>El Paso County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>328,239,523</td>
<td>28,995,881</td>
<td>844,064</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>18.5%</td>
<td>39.7%</td>
<td>82.9%</td>
</tr>
<tr>
<td>White, non-Hispanic/ Latino</td>
<td>60.1%</td>
<td>41.2%</td>
<td>11.6%</td>
</tr>
<tr>
<td>African American</td>
<td>13.4%</td>
<td>12.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>1.3%</td>
<td>1.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>5.9%</td>
<td>5.2%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

El Paso County is bilingual and binational with easy access to Mexico. In 2018, 3.5 million pedestrians and 11.2 million vehicle passengers crossed a port of entry from Juarez to El Paso (BTS.gov, 2018), reflecting the binational ties in the region. El Paso County also has an estimated 80,000 residents living in a colonia, or informal settlement, most of which are concentrated on the outskirts of El Paso. The colonias often lack access to basic infrastructure, are disproportionally comprised of recent immigrants, and are at heightened risk for many health issues (Mauleon and Ting, 2000).
Recruitment and Sample Demographics

The target sample was first-generation (foreign-born) Latino immigrants 65 or older. Interviews focused on the experiences of access to health insurance of elderly immigrants during their life course in the U.S. The University of Texas at El Paso IRB board approved this study in August 2020, and I advertised the study between August 2020 through June 2021. Participants were recruited through non-probability sampling of convenience and snowball sampling. Facebook was one social media platform used for advertising, primarily on my page and shared by my existing contacts. Also, the study was promoted through fliers sent through email to non-profit organizations and informants such as the organization AYUDA Inc, which shared the information to their community "Promotores de Salud," which in English translates to community health workers. The study was advertised during COVID, when many organizations were not open. For this reason, I recruited participants through fliers instead of going to community centers. Several participants indicated that they discovered the study through AYUDA Inc.’s Promotores de Salud who handed out the flyer. The recruitment flyers and text (English and Spanish versions) are provided in Appendix A. Participants self-selected into the study in hopes that only those comfortable with discussing their immigration experience throughout their life-course connections to their overall health status would volunteer.

The sample represents 12 respondents 65 years or older first-generation immigrants living in El Paso County, Texas (foreign-born: undocumented or documented), born in Mexico but migrated to the United States. The demographic information the participants were asked to provide was gender, birth year, years in the U.S., year first-time used health care, legal status, previous and current health insurance, and year obtained current health insurance. The collection
of the demographics was through series of closed and open questions (Appendix B). A full
description of the demographic characteristics of my sample is in Table 2.
## Table 2: Participant Demographics

<table>
<thead>
<tr>
<th>Participants</th>
<th>Gender</th>
<th>Year Born</th>
<th>Number of Years in the U.S.</th>
<th>First Time Used Health Care in the U.S Year (Approximately)</th>
<th>Original Status</th>
<th>Change Status</th>
<th>Previous Health Insurance</th>
<th>Current Health Insurance</th>
<th>Estimated Year Obtained Current Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>Female</td>
<td>1954</td>
<td>38 Years</td>
<td>1988</td>
<td>Legal Permanent Resident</td>
<td>Unchanged</td>
<td>Employment</td>
<td>Medicare</td>
<td>2019</td>
</tr>
<tr>
<td>Participant 3</td>
<td>Female</td>
<td>1942</td>
<td>40 Years</td>
<td>Don’t Remember</td>
<td>Legal Permanent Resident</td>
<td>Unchanged</td>
<td>U.S. Citizen</td>
<td>Medicare and Medicaid</td>
<td>2007</td>
</tr>
<tr>
<td>Participant 4</td>
<td>Female</td>
<td>1948</td>
<td>51 Years</td>
<td>1970</td>
<td>No Legal Status</td>
<td>Legal Permanent Resident</td>
<td>Spouse Employment</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Participant 5</td>
<td>Male</td>
<td>1945</td>
<td>45 Years</td>
<td>1991</td>
<td>Legal Permanent Resident</td>
<td>Unchanged</td>
<td>Unknown</td>
<td>Medicaid</td>
<td>2010</td>
</tr>
<tr>
<td>Participant 6</td>
<td>Female</td>
<td>1946</td>
<td>45 Years</td>
<td>1978</td>
<td>Legal Permanent Resident</td>
<td>U.S. Citizen</td>
<td>Uninsured</td>
<td>Medicare and Medicaid</td>
<td>2011</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Female</td>
<td>1954</td>
<td>20 Years</td>
<td>Don’t Remember</td>
<td>Legal Permanent Resident</td>
<td>U.S. Citizen</td>
<td>Uninsured</td>
<td>Medicare and Medicaid</td>
<td>2019</td>
</tr>
<tr>
<td>Participant 8</td>
<td>Male</td>
<td>1949</td>
<td>45 Years</td>
<td>2016</td>
<td>U.S. Citizen</td>
<td>Unchanged</td>
<td>Uninsured</td>
<td>Medicare and Medicaid</td>
<td>2014</td>
</tr>
<tr>
<td>Participant 9</td>
<td>Female</td>
<td>1955</td>
<td>38 Years</td>
<td>Not Remember</td>
<td>U.S. Citizen</td>
<td>Unchanged</td>
<td>Unknown</td>
<td>Medicare</td>
<td>2020</td>
</tr>
<tr>
<td>Participant 11</td>
<td>Male</td>
<td>1941</td>
<td>56 Years</td>
<td>Not Remember</td>
<td>Legal Permanent Resident</td>
<td>U.S. Citizen</td>
<td>Employment: Humana</td>
<td>Humana</td>
<td>1964</td>
</tr>
<tr>
<td>Participant 12</td>
<td>Female</td>
<td>1955</td>
<td>32 Years</td>
<td>1991</td>
<td>Legal Permanent Resident</td>
<td>U.S. Citizen</td>
<td>Uninsured/Emergency Medicaid</td>
<td>Cigna</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
To participate in the study, participants needed to identify as Latinos, speak English, Spanish, or both, and be 65 or older. Participants contacted me via email or phone to express their interest in participating. I first conducted a pre-screening (Appendix C) in the participant's native language, making sure they were eligible for the study and then setting up an interview time. Of the 17 that completed the pre-screening, 12 followed up, and I conducted their interview. They were then provided with the informed consent form (Appendix D) and notified me if they wanted to proceed with the study.

**Data Collection**

Singleton and Straits (2017) state that qualitative research allows one to obtain a richer understanding from personal interaction. The use of qualitative research to interpret and provide an invaluable perspective viewpoint makes its world visible (Creswell, 2018). Initial recruitment progressed slowly, resulting in not reaching the proposed saturation point of data at 20 participants. Therefore, this research is complemented by field notes and shorthand writing techniques to capture the conversation to the fullest without leaving any details out. Using the participant's native language, I highlighted that they could withdraw from the study at any point within the interview, which was restated on the consent form. I protected the confidentiality of all my participants by not collecting any of their signatures since, for the UTEP's IRB, this group was considered a protected population.

Interviews took place via Zoom. Interviews were audio-recorded, and if the participants were capable or able, video chat was used where possible. When joining the Zoom call, Zoom advises the participant that their conversation is being recorded and requests that they agree. I did not keep the video recording. The video feature's primary use was to make the conversation more comfortable and respond to nonverbal cues such as facial expressions and gestures that facilitate
engagement and build trust. Archibald et al. (2019) illustrate Zoom, the feature provided for recording storage, is either on the host's device or using Zoom's "Cloud recording" without a secure password. All of the interviews were stored on a Google Drive and kept password-protected, which the UTEP IRB requested. The videos themselves were deleted and only audio files were retained. No recording was stored on any cloud without a secure password.

In the participant's native language, I began the interview by briefly explaining the nature of the study. I hoped to indicate to participants to feel free to share their perspectives and collect the authentic and lived experiences. If the participant felt uncomfortable or upset at any point, they could cease the interview with no questions asked and offered a list of counseling resources (Appendix E). Fortunately, no participant seemed to experience significant distress, and all discussions proceeded in their entirety. Furthermore, the participants were not asked directly about their immigration status; it came out in their stories about health insurance access. Unfortunately, I found it difficult to ask probes in my first interviews, as this was a learning process, and I did not feel comfortable interviewing. Following the consultation, I emailed the participants a $20 Wal-Mart virtual gift card and PIN.

**Data Analysis**

The analysis of qualitative interviews started by voice recording all participants’ interviews, which allowed me to transcribe and code my data. The interviews were listened to in Spanish and were transcribed word-for-word, then translated to English. After finishing the transcription-translation, I reviewed transcripts line by line and started to make notes of words and statements the participants repeated in the interview. Then coding occurred allowing the data to reveal themes and patterns. This study used the inductive approach to help create a coding framework and repeated themes to identify substantive categories (Singleton and Straits, 2017).
Then, in discussion with my thesis chair, we identified tentative themes. Using these mechanisms ensures a clear interpretation of the data. Afterward, I placed the appropriate participants' quotes with the matching themes.

Following the initial coding and data analysis, I isolated the selected quotes. After conducting several reviews of these coded interviews, I began to create categories and subcategories. The interviews were grouped and categorized into themes that were defined as "language barriers," "health insurance," "relationship with doctors," "used alternative medicine," "seek health care in another country," "health insurance the U.S. vs. birth country," and "support system," which illustrated the experiences of access to health insurance of older adult immigrants. Through this process of developing codes, I was able to link broader themes with the collective experiences shared by the participants of this study.
Results

Of the 12 participants, all reported that they were born in Mexico, speak Spanish, and regardless of their age, they thought they were in good health when they first entered the U.S. There was 5 men and 7 women, ranging in age from 67 to 80. Most participants entered the U.S. as legal permanent residents or U.S. citizens, with about half changing their immigration status during their time in the U.S. The demographics of the respondents are summarized in Table 1.

Prior studies documented the aging population, increasing immigration, and fiercely debated health care insurance rights have become a significant issue in the U.S. (Viladrich, 2019; Waskabayshi, 2010). Perhaps this sample does not feel as strongly because it is based on the U.S.-Mexico border and thus participants were able to use health care on both sides of the border and rely on greater support systems on both sides of the border, yet respondents’ answers do reflect awareness of immigration status and health insurance at different points in their lives. This section will discuss the experiences of access to health insurance of older adult immigrants during their life course in the U.S., with particular attention to the intersections of immigration status and health insurance. In addition, the results suggested that the pathways that link the ability to access health insurance included those unique to border communities, such as the use of medical care, including Complementary and Alternative Medicine (CAM), on both sides of the U.S.- Mexico border, identified barriers that created difficulty to navigating health care access, and the role of supportive networks.

Health Insurance and Immigration in Earlier Days

Currently, due in part to their elderly status, the participants have insurance through Medicare, Medicaid, and the Marketplace, yet some mentioned that they struggled before they had health insurance. The cost of American health care expenditures is drastically increasing,
and the numbers of people obtaining medical coverage are declining (Garfield et al., 2018). Immigrants often have fewer federal laws that protect them from hazardous work conditions, lack of access to health care, lower wages, and often lack of proper documentation, which places Mexican migrants in a vulnerable situation. For example, Participant 6 said, "I used to have economic problems many years ago, and I could not pay my medical care for years.” This situation described how socioeconomic resources in the early and intermediate stages of one’s life play an essential role in modifying opportunities and conditions for seeking health care. Latino immigrants often migrate for financial reasons, moving as an opportunity to improve economically and overcome events associated with poverty in their birth country (Montes de Oca et al., 2011). Furthermore, Zeki Al Hazzouri et al. (2011) emphasized that compared to non-immigrants, immigrants are "more likely to have higher household income" when they have been in the U.S. for a long time (p. 1032).

Hospital Discount Programs

Although Participant 6 could not afford out-of-pocket medical care, she could sometimes utilize county-level programs. For example, the public and private hospital system provides required medical services for patients who have no coverage regardless of immigration status. However, under the Federal Poverty Level, federal public-funded programs become limited and leave gaps in health coverage for some people (Mulligan and Castañeda, 2017). Luckily, Participant 6 was able to use a program: "It was easy, good, more or less even when I didn't have insurance as I told you… Well, with the discount the hospital provided, it was easy, it helped me not to be more expensive." Participant 8 highlighted his participation in the economy as an uninsured working immigrant who was able to negotiate with a hospital to get payment plans. He
said that for him, "It was easy because I paid everything in payment plans because I don't have insurance because I didn't qualify, I earned well at my job."

Like Participant 6, Participant 12 reported being uninsured as a young adult, and also stated that he got health coverage through a hospital discount program, yet that was still no solution to substantially lower the cost. Participant 12 stated:

The first time I used health care here, I did not have Medicaid or any health insurance or public benefit. The social worker told me that I could apply for Emergency Medicaid or something to help me pay. I applied and qualified but the co-pay was about $15,000, something I could not pay. I did not have that money.

The economic constraints illustrated by several participants point to the relatively low income of the El Paso region. Latino immigrants in the El Paso population are marginalized in terms of health care coverage and access to services for various factors such as low income, low education levels, language barriers, and citizenship status (Rivera, Ortiz, and Cardenas, 2009).

Documentation Status

Regarding citizenship status, documentation was an issue for some at one point during their care. Mulligan (2015) emphasized that health insurance decides the individual’s health care service and provider. Although anti-immigration policies limit access to health care services, some doctors have shown professional and ethical responsibility to provide care to all people irrespective of immigration status or background. Almost all participants, except for one, described that their immigration status did not lead to fear or distrust of their doctors. As Participant 1 explained: “My doctors take care of me, citizens or not; everyone is treated the same wherever I go.” The one participant who feared seeing a doctor due to her being undocumented explained, "Well, now, with less fear and more confidence. I could talk to my doctor before I was afraid, they would call immigration on me because you see how it is with people who do not have papers." The participant’s circumstance illustrated how existing
immigration policies posed a challenge in creating a doctor-patient relationship, causing them to distrust the service. Participant 11 indicated that his doctor did not request documentation, but the health insurance company did: “The doctors do not ask you anything about your status. But the health insurance did ask for social security or identification cards and documentation that someone without immigration status cannot get.” Consequently, providing required documents can be challenging for people who are undocumented or under immigration proceedings due to fears about potential data sharing and violations of privacy and confidentiality about their immigration status. Thus, immigrant status, the doctor-patient relationship, and patient's perceptions of doctors' expectations are crucial elements influencing patients' health.

Furthermore, Sered and Fernandopulle (2007) explained that the government creates laws that can place obstacles in the way of members of America's lower socioeconomic levels, preventing a specific population from obtaining the proper documentation for health benefits and forcing them to continue working and living in harsh conditions. Participant 3 explained how lack of verification of employment created a barrier to qualify for health insurance:

Even though the admission and medical care process were easy, I needed to pay the total cost of the emergency services. I was a Legal Permanent Resident, but I believe that was not the issue. I did not qualify for government health benefits and hospital discounts because I did not have proof of employment. I took care of my children, and my husband was the one who worked.

The above quote also illustrates that limitations in healthcare access make people disproportionately dependent on the emergency department for care because hospitals are required to provide health care to any individual regardless of insurance or legal status who visits the emergency department and treat them until they are safely discharged (Samra et al., 2019). Thus, the emergency department is an initial approach to health care for many Latino immigrants who do not have health insurance and/ or proper immigration documentation. Samra et al. (2019)
highlighted that immigrants' ineligibility to health insurance or public benefit causes them to
decrease the use of preventive and primary services and often rely on the emergency department.

Participant 7 also described a situation when she sought emergency care as a Legal Permanent Resident but was not able to qualify or obtain public health insurance coverage due to not meeting the required salary range:

The first time I received medical care, I went to the emergency hospital because I knew the medical staff would not deny the service. At that time, my legal status was Permanent Resident, and thank God I now am a U.S. citizen... before I changed my status, my family and I did not have any health insurance, because of my husband’s earnings and owned a house. But not because of my status.

Participant 4 provided details regarding the experience of living with an undocumented status and being uninsured, yet she felt that her status was not a barrier to obtaining health care because she had the protection of having a husband who was a U.S. citizen with health insurance. She stated that in the year 1970 she first used healthcare in the U.S. when she was in labor while she was still undocumented and uninsured:

Yes, I sought care, suddenly because since I didn't have papers and then I couldn't register at the hospital. At that time, I was not working. When doctors gave me care, they asked for my documents, but my husband had to sign but they never denied me the attention for health. I believe because my husband did have health insurance.

The complexity of living in a mixed-status family and having a relative with legal status (i.e., documented) was critical for immigrants (Romero Morales & Consolali, 2020). The participant explained that she felt more comfortable navigating the health care system and getting health care when her husband accompanied her, perhaps because before the Emergency Medical Treatment and Labor Act (1986), hospitals could turn away people in labor (cite).

Cross-Border Utilization

Other difficulties in accessing health insurance led to some participants crossing the U.S.-Mexico border to meet some of their health care needs through more affordable medical care,
including CAM. Participant 6 could sometimes use hospital discount programs, but generally felt that U.S. health care was unaffordable, which for her crossing the border to access Mexico healthcare services was important because of the cost and convenience:

I used to have economic problems many years ago, and I could not pay my medical attention for years. I used to go to Juarez to see the doctor before I had Medicaid. At every doctor's appointment, I used to take my children. In Juarez, the doctor was cheaper, and here I didn't have insurance. It was more expensive here, for that reason I was going to Juarez. If people in the U.S. could access affordable health care on the U.S. side of the border, it would be more likely that fewer people would take the trouble to cross the border to seek health care services in Mexico.

Participant 6 explained that crossing the border was out of necessity, and now she does not utilize Mexican health services, "But now I'm very comfortable with Medicaid, and Medicare covers everything. I don't have to be going to Juarez with a doctor. Here I have everything.” This situation reflects how the lack of health insurance coverage is one of the most significant predictors of cross-border utilization of health care services (Su et al., 2011).

Although research finds that Latino immigrants face challenges accessing the conventional health care system, leading them to seek less expensive CAM and thus, two participants with health insurance described using (CAM) in Mexico to supplement their care on the U.S. side. Participant 10 responded positively towards seeking more holistic care in Mexico:

Yes, but in Mexico, in Juarez, it has helped me a lot. Here in the United States, I have gone twice, and in those two times, the therapist gave me twelve sessions, and in the last session, I no longer wanted to go because I could not get up from bed or walk. But I went to my last session and told the therapist that I could hardly come. I told my therapist that I did not want to come, and he said he was not done with my therapy. I told him he had not done anything to me. In the last treatment, he did grab me and crack my bones like a rabbit. In Mexico, the doctor began to give me water therapy, and after this, he put hot ointment on me, grabbed me by the feet and hands, and cracked my bones. It made me feel much better. But now, I have not been able to go because of the pandemic. But I have gone to get an acupuncture massage, and it has helped me a lot. They put needles on me, they put bandages on me, and they have helped me so much.
Participant 12 explained that she has health insurance and supplemented her care with the use of prayer and herbs. After first visiting her doctor on the U.S. side, she continued to experience discomfort, so she decided to travel to Mexico for the use of a healer by saying:

I went with a healer in Ciudad Juarez when I felt that the doctors were not helping me, and my discomfort was not improving. The healer gave me medicinal herbs and made prayers for healing, and I saw I got better. They helped me a lot. With the help of the doctors and the healers, they did help me, as everything together helps if we have faith in it.

Having the flexibility to cross the border for medical care allows people to decide the affordability, accessibility, and quality of their health needs. Su et al. (2011) found that irrespective of health insurance status, if people are dissatisfied with the quality of health care they receive on the U.S. side, they tend to seek health care elsewhere. Participant 4 explained how her legal immigration status influenced seeking health care services south of the border: "Now that I have a lawful permanent resident status, it allows me to go to Juarez to see the doctor if I need to go." Thus, Latino immigrants' status can impact those seeking their health care needs in Mexico based on the challenges faced in the U.S., such as unaffordable health insurance, high medical costs, and language or cultural barriers.

On the other hand, using Mexico’s health insurance system wasn’t always a good option. All participants expressed an opinion about Mexico’s health insurance, but it wasn't easy for the participants to compare U.S. and Mexico health insurance because they tended to use more health care services in their destination country. Wong et al. (2006) described Mexico's health care system as composed of public and private insurance, where the public sector provides health insurance to the uninsured and employed, while the private sector covers any individual who can purchase private insurance Marketplace or out of pocket. Mexico's health insurance structure is built to guarantee access to health care to all citizens but does not cover certain pre-existing...
conditions and requires an annual contribution fee (Barraza-Llorens et al., 2002). Laurell (2015) illustrated that Mexico's public social security institution excludes coverage of common high-cost chronic diseases, leaving people to rely on private health care if they can afford it. The private sector has more financial and human resources than the public sector, leading to class inequities, which contributes to decision-making about which sector to seek care in and one's overall experience of that care.

The participants expressed that individuals' limitations to access Mexico Social Security Institutes have increased the amount of out-of-pocket health costs, impacting low-income individuals' quantity and quality of health care. For instance, Participant 3 stated that "Well here in the United States health insurance is better because I have Medicare and Medicaid, which helps low-income individuals while over there in Mexico people need to have a job to get coverage for any health care access.” Yet, Participant 3 is talking about her current situation, whereas she had described not being able to access government benefits or hospital discount programs in the past.

The absence of universal health care coverage in the U.S. places a heavier burden on local governments to provide for the uninsured. In contrast, Mexico's universal health coverage approach significantly faces inequalities when delivering health care services to uninsured populations. Participants 11 and 12 described that Mexico's health care system lacks structure. Kierans et al. (2013) emphasize that Mexico's health care programs' primary focus is improving health and reducing out-of-pocket health payments. However, it has driven people to navigate problematic health, meaning that individuals must steer through public and private health care services due to inadequate infrastructure. For example, Participant 12 explained that even though
she had visited Mexico for CAM, she still believed that Mexico's health care system was inefficient:

No, here [United States] medical care gives you many facilities to pay and seek health, while in Mexico if there is no coverage or payment, there is no treatment, and doctors don't help you. They don't give you the services you need, medications, and any health care service. Everything is a waiting game. And here in the United States, if you arrive, the doctors give your health care as you need it.

Participant 11 illustrated acquaintances' experiences with Mexico's health care system, in which they had faced limited resources, long waiting times, and inconsistency of care:

I have heard that everyone complains that they do not have appointments for who knows how many months. Many clinics or hospitals do not take good care of them because they do not have the resources to provide health care services. It is a big issue in Mexico, and while in the U.S., it is more organized and accessible, always makes appointments when you need them. I continue with lung care because I got COVID. If I were in Mexico, it would be challenging since hospitals struggle with people who need oxygen. Something that I still need even when I no longer have COVID.

The participant’s challenges demonstrated that health inequalities in Mexico increase the inefficiency and inconsistency of delivering health care to people.

Only three participants reported not needing to use health insurance or services in Mexico when they had adequate health care in the U.S. For instance, Participant 7 described that her current access to health care had not given her the need to familiarize herself with Mexico's health insurance system, even though she could have used more cross-border health care when she did not have adequate insurance in the past, which she did not address in her interview:

I don't know Mexico's health care insurance system, and I didn't practice it much because we came here to the U.S. I can talk about my health care, health, and everything related to health from here in the United States have gone well, but I don't know about Mexico.

Another participant described that having complete access to health care in the U.S. removed the need for using Mexican health care by saying: "No, since, my wife and I have health care here in the U.S. thanks to the government and for my work, as long as we do not lack
anything, it is fine; what else can we ask for? (Participant 5)" Participant 11 stated that he did not need to cross to Mexico to use health care since his health safety net is in the U.S.:

No, no, the truth is I do not even like to go to Mexico. I'm going because I have to go. After all, my wife wants to visit relatives, well that's before, but I don't like to go there. And then I have all my doctors and help here, so I do not need to go except to visit relatives.

Supplementary Health Care

Participants reported that they used CAM because it is accessible, affordable, and culturally familiar, which has also been found in previous studies (Johnson et al., 2016; Montalto et al., 2006; Wolsko et al., 2002). Most participants described trusting the combination of CAM with the treatments provided by their doctors. The participants recounted situations that they first sought mainstream care with doctors; however, if they continued to feel ill, they turned to CAM. The most used CAM mentioned by the participants was religion/prayers, followed by herbal teas (see Table 3). Participant 6 illustrated the importance they placed on prayer for help in health matters by saying, "Prayers are what help me other than medicine and my doctor." Similarly, Participant 7 stated that she turns to prayers as a kind of health action, saying, "I only recommend myself to God and the wisdom of my doctors." Other participants expressed a combination of prayers with another form of CAM. For instance, Participant 9 described that a combination of prayer, herbal teas, and medication were used to relieve pain and cure her illness by saying:

Well, natural teas (herbal teas) are just what I take, and I also pray it is all that I do to see if it helps me with my bones because sometimes the medicine that is given to me is not very strong, and the pain doesn't go away.

Participant 11 shared that he used herbal teas and prayer to treat colds and COVID, stating:

Yes, I drink herbal teas like chamomile, ginger, and others like lemon with onion to treat me when I have a cold or even when I got COVID, my wife made me teas and that also
helped me. But I only do that nothing else except I also pray to my Father God that he never abandons us.

One participant described that other than prayers and herbal teas, she used the chiropractor and massage treatments in desperate times:

I have gone to get a massage, and it helped me. Also, I went to a chiropractor, and helped me. I have taken herbal teas for everything and asked God for help at desperate times, which I highly recommend (Participant 1).

Avoiding becoming a “Public Charge”

The public charge rule was one connection participants made between legal status and health insurance. The federal public charge rule denies legal status to immigrants who are more likely to depend on the government-funded benefits (Makhlouf, 2018). This idea is also reflected in other studies that show that the public charge rule is an obstacle for immigrants in seeking health care access. Participants in this study stated that they had been concerned about answering certain questions from people they deemed untrustworthy such as anyone working in government, particularly those that could affect immigration status or health coverage options.

For instance, Participant 8 explained his concern over the government change of policies and laws over time, including the public charge rule, that can have profound consequences on obtaining affordable health insurance:

To say with the insurance, for example, the government takes away one aid, they put another one, and the coverage goes up and down because of so many politics that we do not know if the next one we are going to be covered. I worked for many years, and due to my good pay, Medicaid did not cover for two years. Now it covers all my medical care; hopefully, it stays like this.

In discussing the public charge rule, some participants illustrated the reason for avoiding and advising others about not using government-funded benefits, which was a barrier to health care access. During their young adult years, some participants experienced being uninsured and paid high premiums for medical care due to fear of the immigration-related consequence of the
public charge rule. Participant 2 explained that those Latino immigrants who come to the U.S. wanting to change their legal status should work first then consider seeking any health assistance through the government to avoid becoming a public charge. He discussed his son-in-law's situation:

As of right now my daughter is fixing my son-in-law’s papers, I suggest to them not to get any health insurance of any kind, any food stamps, or any government assistance, during his immigration process. The only focus is to work, so he can get health insurance through employment when he has his legal status.

Collins et al. (2020) illustrated a causal connection between the use of health care and one's eligibility to live in the U.S. Policies that strengthen the detention, criminalization, and deportation of immigration populations cause increased fear of entering the public sphere and engaging with social services, including health care. Participant 3 provided personal insight into why Latino immigrants should avoid access to health insurance through government assistance: "During my immigration process, the officers asked about government benefits and saw that I didn't apply to any, so they approved my case." This circumstance confirms other studies showing that undocumented Latinos prefer to remain uninsured rather than jeopardize their immigration status. The participant felt that the need for status regulation superseded access to health insurance until becoming a U.S. citizen by illustrating, "I was never a public charge for the government until now, but the difference is that I am a citizen, and they give me food stamps" (Participant 3).

Most participants currently have health insurance such as Medicare, Medicaid, Humana, and Cigna (see Table 1) that covers their health care needs, which is good since they are aging and have multiple chronic health conditions (see Table 4). Yet, immigrants who arrived during their youth or working ages demonstrated a greater reliance on public benefits such as Medicaid than older age immigrants, who have more ability to rely on Medicare in their later years.
Participant 9 described her circumstances of derivative citizenship status, meaning obtaining citizenship through having parents with U.S. citizenship, and aging having a significant impact on her eligibility for health insurance:

But the ability to pay for my doctor was improved by my age, and my legal status, which is a benefit we all have when we are 65 years old. I'm doing better now because I don't have to pay anything. Before, I did have to pay because I didn't have insurance.

The sharp lines immigration and welfare reform have drawn between noncitizens and citizens determines whether younger or older age arrival to the U.S. can affect access to health insurance programs (e.g., Medicaid, Medicare, and Marketplace health insurance) on which older adults rely (O'Neil and Tienda, 2015). Citizenship plays a role in eligibility for public benefits (such as Medicare and Medicaid) and Marketplace health insurance. Public benefits eligibility is based on proving qualified immigration status, including U.S. national, citizen, permanent resident, who must wait five years after obtaining qualified status. While for Marketplace health insurance, permanent residents can be in their five-year waiting period and do not have an eligible status. Also, qualifications for Marketplace health insurance subsidies are unrestricted to individuals with an income from 100% to 400% FPL or are ineligible for other coverage yet, offer coverage for a dependent child until a child reaches the age of 26. For Medicare, other than immigration status, to qualify, people need to be 65 or older and pay Medicare taxes (O'Neil and Tienda, 2015). Eligibility for Medicare does not require income level. Yet, Texas has not expanded Medicaid under the ACA. Individuals who are eligible for Medicaid in Texas must meet certain financial criteria with having dependents, be a resident of Texas, a U.S. national, citizen, permanent resident, legal alien, pregnant, be responsible for a child 18 years of age or younger, blind, have a disability or a family member with a disability, or be 65 years of age or older (Kaiser Family Foundation, 2021).
Language Barriers

Latino immigrants have faced a variety of barriers in accessing health care. According to Heyman et al. (2009), access to health care can go beyond the limitations encountered by immigration policies for Latino immigrants, including individual and structural barriers such as finances, language, transportation, childcare, etc. When asked about barriers to accessing health care, some participants mentioned language had been an obstacle at some point in their health care experience; however, others felt like language was not a barrier most of the time. Nearly 66.75% of the El Paso population speaks Spanish, being one of the cities with more Spanish speakers than English (World Population Review, 2021). Because most of the regional population is bilingual, health care staff rely on their bilingual skills to support doctors or other staff who cannot provide language access for Spanish-speaking patients (Martinez, 2007). Several participants described that living at the U.S.-Mexico border grants access to bilingual medical staff and interpreters who speak Spanish. Other participants reported having doctors with the same cultural background. For instance, Participant 6 said: "When I talk to my doctors, all speak Spanish. They are all Mexicans." Additionally, participants revealed the use of other medical staff when the doctor did not speak the patients’ native language, such as Participant 7: “The doctors speak Spanish, and then when the doctor does not speak Spanish, they introduce me to a person who speaks Spanish.”

However, a few participants shared that if there was no Spanish speaker in a doctor's office, it is more difficult to access language service programs for interpreters. For instance, Participant 4 said, "When I arrived, it was challenging to communicate with someone because I did not know the language which demonstrates how language posed a barrier that may have
reduced their full consumption of health care services. One participant shared that her experience of not speaking the same language as the doctor made her feel ignored:

Language is the main barrier, and I used not to understand it. Now I know a little but not everything. Back then, when I went to the doctor for the first time, the staff struggled a lot to find a translator, unlike now that they already have a few more translators. I felt that sometimes the doctor ignored me or did not understand what was happening to me; what hurts me. Both the doctor and I could not explain to each other about my health.

Support Systems

The decision to leave one's country of origin and move to another often brings disconnection from familiar social institutions and cultural practices and isolation from sources of support in one's new homeland. These participants were perhaps buffered from these hardships given that they are living on the border and usually have ready access to both the U.S. and Mexico. The participants described their social network in the U.S. as being composed of family and friends, where family was defined narrowly as blood relatives (see Table 5). Most aging immigrants' ties with adult children represent the most critical extramarital component of their family network, informal support system, and financial and social relationships (Angel, Angel, and Markides, 2000), which affects health directly or indirectly through financial or logistical help. Table 5 summarizes the supportive sources of support.

On an interpersonal level, Participant 1 revealed that her family, such as adult children and grandchildren, shared the same house, supporting her economically and with house chores:

My children and grandchildren have helped me economically and home chores or repairs. They all helped me financially, all provided me equally. When I did not have any food or when a problem came out, it either was one thing or another. I had support from all of my family. I am not alone, thanks to God, and they have been with me in the bad times. And my grandson, the oldest, hasn't left us. All my children and some of my grandchildren live here at my house.

Similar to Participant 1, Participant 9 shared the same household as her children, who assisted her with transportation and finances, “My children help me financially and with the
transportation. They take me everywhere I need to go. One of my daughters and grandchildren live in my house.”

Other participants who did not share the same household with their family talked about how they still received their support. Speaking more directly about health, in some situations it was more than one family member who took the caregiver role. Participant 7 described how grateful she was for her daughters’ support to buy groceries during the COVID-19 pandemic:

Well, thank God I have some wonderful daughters who are always here whenever I need help. So that's all I have to say because now with this pandemic, well, I don't go out to the store because I have my beautiful daughters who do not leave me here alone at home.

Participant 8 shared that his adult children became available for support, not wanting him to risk his health: “My children have helped me with everything, and they have not left me alone. They bring me my groceries here at home so that I do not risk my life against COVID-19.”

Participant 5 explained that his adult children helped him as needed with transportation to his doctor appointments and financially: “My children have helped me take me to my doctor's appointments. Also, when I need money. Well, they only helped me when I needed to.” One participant described how in one case, her children became closer and help when she is sick:

I have the support of my family in everything. My children have helped me pay for my doctor consultations and medicine since they are older and all work. Also, my children take me to the doctor when I cannot drive due to headaches or sciatic pain. When I get sick with my pains, all my children get together, come to my house to clean, make me, or take me food, and give me my medicine. I wouldn't know what to do without them (Participant 12).

Participant 4 explained that her granddaughter is her primary caregiver and how her granddaughter supported her economically, with transportation, and personal care:

“My granddaughter helps me financially and self-care and transportation. When I had my surgery, my granddaughter took care of me while my daughter worked.”
Family support, however, can be complicated by family members having differential immigration statuses. Rodriguez et al. (2017) illustrated that being part of a mixed-status family, immigrants want to build an environment that is secure for their families, which at times causes difficulties finding forms of assistance. Participant 10 revealed a lack of family support due to his children not having legal immigration status and distance:

Well, my main problem is that my children are here in the United States, and they don't have papers. One day I will eventually get sick, and I will need someone to help me bathe, dress, have someone help me. I do not know who here is going to help me do that. And then my granddaughters and daughter who live with me, well my daughter has a tourist visa who cannot come right now, they are women, they will not be able to help me, so I am thinking of leaving with my sons. I have two sons and two daughters. Two of my sons and one daughter live in Dallas. So, everyone is far away, and they don't live here, and they don't have papers. As for my children who are in Dallas cannot come.

As shown, most participants described how their family remains the primary system for elderly care (see Table 5). This may be due to the necessity for resources given inadequate finances and/ or health coverage, in addition to the strong sense of familialism and caring for elderly family members in Latino cultures. Several studies indicated elderly care in Latino immigrants is influenced by the concept of la familia, demonstrating that the family is the primary source of support and intergenerational dependency (Clark and Huttlinger, 1998; Ruiz et al., 2012).

About half of all current immigrants living in the U.S. are married (Grieco et al., 2012). Participants who are married illustrated that they often help one another in times of need and assist one another. For instance, Participant 2 explained that his wife is the one who provides transportation to his health care along with other family members as needed:

Well, my wife takes me to my doctors' appointments, sometimes my sons, my daughters, the granddaughters. They all take me, my grandson, too. Right now, I have not had any problems with who is taking me to the doctor. All my family helps me with all. They have always been with my wife and me. When my wife cannot drive me to the doctor, all my children tell me I'll take you. They never let me down, thank God.
The following participants described that they have the support of their adult children but have not needed it yet. Participant 6 mentioned the following:

I have not asked my children for any help; they are already grown up and have their own family who needs them. That is why I have my husband; he is the one who helps me with everything in the house or takes me to my appointments, so I do not have to ask my children for anything or bother them.

Another participant, Participant 11 mentioned that the only support he needs is his wife and a hired helper:

No, I don't need any of that because only I and my wife have each other help. In addition, a promoter comes to help me, and they even come to clean my house. But my family is very close, just that I don't bother them with this because I can, I don't need help. Only my wife and I live here in the house. I do everything, even I can drive, and if I can't go, they come to my house.

Some participants reported a combination of support systems of alternating helpers because their families found it challenging to care for their needs. Participant 3 explained:

That my people, my friends when my husband was sick, helped me. My daughters worked. They could not help me a lot. My daughters run errands for me, and my "compadres" take me to the bank. Between my daughters and friends taking me to my appointments, I must shuffle on who helps me.

In sum, participants illustrated that their social support networks have influenced their access to health care by assisting them with their different needs.
Discussion

This qualitative research helped me gain insight and understand how participants' immigration processes contributed to their health care access as they aged. Through the participants’ experiences, I used their voices to address life events, which show a series of advantages and disadvantages depending on contextual situations developed from their immigration status that contribute to health conditions. Adding nuance to the existing literature that takes a macro perspective in looking at immigration eras and overall demographic, population health, I got a glimpse into the everyday lives of older immigrants as they navigated health systems. In this study, I provided findings of life-course patterns Latino immigrants have faced since they first used the U.S. health care system without health insurance. Due to the absence of health insurance at their younger ages, Latino immigrants often did not have a regular source of health care.

I used the life-course approach to understand how the immigration process impacts health care access for Latino immigrants who live in El Paso County, Texas. I identified a series of specific access and barrier factors immigrants face when seeking health care. Moreover, I used the governmentality perspective to analyze how immigration policies are associated with the participants' uncertainty about accessing health services when they were younger and had fewer safety nets, because Medicare or other health insurance covered them later in life. Participants shared their health care interactions through various life-course events, which revealed how social support, political, and institutional conditions impacted their health care access as they aged.

Newly arrived in the U.S., Latino immigrants self-rated their health as "good." Because participants were in good health when they first came to the U.S., many did not have experiences
with health care professionals and using health insurance in Mexico. Thus, many participants highlighted their health care experience, mainly in the U.S., and how good health diminished over time (see Table 5). At a younger age, underinsured or uninsured participants used other ways to access healthcare, such as visiting the emergency department, crossing the U.S.-Mexico border, and using CAM. Many participants discussed relying on public hospitals as a safety net. Because without private or public health insurance, individuals may be limited in treatment or services at clinics except in hospitals. Yet, participants illustrated that hospitalizations could be expensive even if some qualified for hospital discounts.

In this study, I revealed how participants as young adults in an immigration process were concerned about the public charge, which led them to avoid using government-funded benefits limiting healthcare access. Participants in immigration processes reported that they avoided medical care at a younger age because they did not want to be exposed to anti-immigration policies, such as the public charge rule, which they believed would be uncovered through the use of health care help from hospitals and/or public insurance. Most participants, however, trusted their physicians; only one participant concluded that she feared having a relationship with a doctor when she was a young adult without health insurance or legal status. Currently, the participants as older adults expressed that due to their legal status, they no longer had to worry about being a public charge and accessing health care is more accessible. This situation relates to Foucault's perspective of neoliberal governmentality because it reflects how the restructured provision of health services is a commodity of evaluating eligibility instead of being a human right.

The interaction between doctors and patients is essential to creating a welcoming and attractive environment for immigrants (Wang et al., 2021). When asked about relationships with
physicians, participants mentioned supportive aspects. Participants revealed that they felt fine communicating with their doctors because they did not ask about their immigration status, and most of them spoke Spanish. Derose (2000) indicated that hospitals have limited access to interpreters and bilingual medical forms even if state and federal laws are required to provide the service. According to Flores (2014), "language is integrated into governmentality in that it serves to frame how issues are discussed and how people are expected to use language" so that in the U.S, there are more resources and opportunities for the English language (p. 2). Many elderly Latino immigrants have limited English proficiency. Yet, participants provided information on how they always search for doctors who speak Spanish, noting that living on the U.S.-Mexico border, they interact with informal interpreters, such as bilingual medical staff. Having direct communication with doctors who speak the same language is preferred by participants because they will not feel ignored. Otherwise, they want to have the ability to communicate and understand their health conditions.

This study adds to limited evidence addressing CAM because many older adults avoid reporting the practice to doctors because of the fear of disapproval. Thus, I recommend further research into this area. A notable finding is the importance of personal beliefs that contributed to healthcare-seeking practices for elderly Latino immigrants even after being covered by Medicare. As older adults, the participants revealed they had navigated between the conventional U.S. medical system and CAM to treat illness and receive health care, even after first seeing their doctor on the U.S. side when their discomfort continued. Although eleven of the 12 elderly Latino immigrants mentioned that they currently have Medicare or other health insurance, some still relied on CAM. Religion/prayer were the most commonly used CAMs, sometimes used along with other CAMs (see Table 3). The U.S.-Mexico border faces unique independence in
both communities; crossing to seek healthcare services in Mexico is common for individuals with U.S. citizenship or permanent residence (Byrd and Law, 2009).

For most elderly Latino immigrants, ties with adult children represent the most critical extramarital component of their family networks, informal support systems, and social relationships (Heyman et al., 2009). Participants described how their family members and friends are currently essential for contributing to their health encounters. In this study, participants illustrated the significance of familism for elderly immigrants as the ability to support their needs. These components were realized in the lived experiences of most of the participants in this study. For instance, some participants described how their family members residing with or close to them impacted their access to health care. Yet, when the family is not available, participants refer to friends, neighbors, or other people who can contribute to their health advantages.

**Limitations and Future Directions**

This research allowed me to examine elderly Latino immigrants, which in this sample, all participants were Mexican, by far the largest population group along the U.S. Mexico border. My thesis sample size was small and represented only selected Latino immigrants in El Paso County, Texas, thus these results cannot be directly generalized to other border populations. The sample excluded younger participants; the inclusion of younger adults and children would probably have increased the numbers of uninsured participants and the use of Mexican medical care when not limited by household income, immigration, or health status. Also, this study was limited by excluding participants who cannot afford the internet or are not familiar with social media, given that we interviewed via Zoom because of the pandemic. The participants had to have help with the Zoom; which felt less intimate. Another limitation is that my Spanish-to-English interpretation of
the interviews reflects my personal biases as I did not utilize the assistance of an interpreter or have anyone double check my Spanish interpretation. Also, I did not ask to the participants about having a regular source of care/ a regular primary care physician, which could have spoken more to health care access because insurance doesn’t necessarily mean access, so this was an omission on my part. Further research is warranted to understand the consequences of the immigration process and health care access on the well-being of the elderly population, focusing on other immigrant groups in other U.S. regions. My thesis data were thin, in part because of a lack of good probes, thus in this thesis I cannot speak to everything fully yet I still uncovered part of these people’s unique stories.
Conclusion

In general, it is ideal to consider how access to health care insurance is essential for elderly Latino immigrants in El Paso County, Texas, especially when they go through a transformation in their lifestyles as they age in the U.S. This study allowed me to identify their age, the number of years in the U.S., immigration status, and their experiences when accessing health care. The evidence showed the circumstances that impact the insufficiency of health access for elderly Latino immigrants beginning with the first time they used the U.S. health care system until the present day. The analysis of the health care experiences of older Latino immigrants through a life course perspective and Foucault's theory of governmentality focuses on the sequence of events related to the surveillance of immigrants linked to access to health care. Participants highlighted some limitations they faced in their earlier days when accessing health care and not having eligibility requirements for health care insurance. Also, the study presented the influence of significant immigration policy reforms, including the public charge rule, which influenced many participants' healthcare-seeking practices and attitudes.

At the same time, participants described their health care experience after obtaining Medicare or another type of health insurance. Some participants identified patterns that were found effective for their health, such as the use of CAM. Participants explained that even before or after being covered by Medicare, an advantage of living in the El Paso County border community revealed local interaction patterns wherein if there are no Spanish interpreters, the medical staff relies on their bilingual staff. Moreover, the study illustrated the role of supportive networks. Most of the participants reported that as they aged, families preserve a solid commitment to supporting their relatives to continue to say that the family plays a central role in health care decisions.
This study can help fill an academic literature gap and call attention to the immigration experience that contributes to why their access to health care insurance. This study can inform what barriers remain as major obstacles for older immigrant adults' health status, which may be useful for government officials as they consider providing health services to all immigrants as a human right no matter their immigration status.
References


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Appendices

Appendix A- Recruitment Flyers [English and Spanish]

Are you a Latino Immigrant Aging in the United States?
Are you 65 + years of age?
Seeking research participants to share their story and experiences of how their immigration process impacts overall health status.

Participation involves an hour interview & $20 Wal-Mart virtual gift card for participation
For more information, contact:
(915)667-3749 or slramos3@miners.utep.edu
¿Es usted un inmigrante latino de la tercera edad viviendo en los Estados Unidos?
¿Tiene más de 65 años?
Buscando participantes de investigación para compartir su historia y experiencias de cómo su proceso de inmigración afecta el estado de salud en general.
La participación implica una entrevista de una hora y una tarjeta de regalo virtual de Walmart de $20 por participar
Para obtener más información contacte:
(915)667-3749 or alramos3@miners.utep.edu
Hello, my name is Sonia Lizet Ramos and I am recruiting participants for my Master’s in Sociology thesis at the University of Texas at El Paso (UTEP). I am doing my research on elderly Latino immigrants, their experiences of their immigration process and how that impacts their overall health status. I am seeking elderly Latino immigrants (undocumented and documented) 65 years or older who were born in a Latin country. All interviews will be conducted over video calling (Zoom Platform) or telephone and you need to be fluent in English, Spanish or both. Study participation will include demographic information, followed by interviews taking 45 minutes to 1 hour. I will compensate participants upon completion with a $20 Wal-Mart virtual gift card.

While I do not anticipate feeling discomfort from this study, some questions may be sensitive in nature. Also, please know that this is confidential and that nobody will be made aware of your participation unless you choose to share as such. If you or anyone you know, might be interested in participating, please contact me at Phone: (915)667-3749 or slramos3@miners.utep.edu for further details. I have made this post public, so please feel free to share with anyone you believe may be interested in this kind of study.
Hola, mi nombre es Sonia Lizet Ramos y estoy reclutando participantes para mi tesis de Maestría en Sociología en la Universidad de Texas en El Paso (UTEP). Estoy haciendo mi investigación sobre los inmigrantes latinos de la tercera edad y cómo sus experiencias en el proceso de inmigración impactan su estado de salud en general. Estoy buscando a inmigrantes latinos de la tercera edad (indocumentados y documentados) que nacieron en un país Latino Americano.

Todas las entrevistas se llevarán mediante de videollamada (Plataforma Zoom) o por teléfono. Usted debe hablar inglés, español o ambos con fluidez. La participación en el estudio incluirá información demográfica, seguida de una entrevista que tomará de 45 minutos a 1 hora. Al finalizar, compensaré a los participantes con una tarjeta de regalo virtual por Wal-Mart por la suma de $20.

Si bien no anticipó sentir incomodidad durante la entrevista del estudio, algunas preguntas pueden ser sensibles por naturaleza. Además, tenga en cuenta que la investigación es confidencial y que nadie se enterará de su participación a menos que elija compartirla como tal.

Si usted o cualquier persona que conozca puede estar interesado en participar, por favor póngase en contacto conmigo en el teléfono: (915)667-3749 o slramos3@miners.utep.edu para más detalles. He hecho pública este anuncio, así que no dudes en compartirlo con cualquier persona que creas que pueda estar interesada en este tipo de estudio.
Email Invitation [English and Spanish]

Subject line: Invitation to Participate in the research project titled: The Experience of Immigration and Aging on the Health of Older Adults in the El Paso, Texas, Border Region

Dear (Name of participant),

Thank you for your interest in participating in my research study that will help me learn about the experience of being an elderly Latino immigrant in the United States and how the immigration process impacts overall health. I am looking for elderly Latino immigrants (undocumented and documented) 65 years or older who were born in a Latin country. I will conduct all interviews over video calling (Zoom Platform) or telephone, and you must be fluent in English, Spanish, nor both. Participation in the study begins at the pre-screening stage. I will ask you three demographic questions that will help address specific attributes such as country and years of residence in the United States. These questions will let me distinguish if you are suitable to be part of the study. Once you present that you have these demographic characteristics and agree to continue participating in the study, I will proceed with the interview which will take 45 minutes to 1 hour. After the interview is complete, I will compensate you with a $20 Wal-Mart virtual gift card.

If you are willing to participate, please suggest a day and time that suits you, and I will be ready to schedule the best time that will work for both of us. Below you can find an attachment of the consent form for you to read and describes the study. If you have any questions, please do not hesitate to ask.

Thank you,

Sonia Lizet Ramos
Línea de asunto: Invitación a participar en el proyecto de investigación titulado: La experiencia de Inmigración y Envejecimiento sobre la Salud de los Adultos Mayores en El Paso, Texas, Región Fronteriza

Estimado/a (nombre de la/del participante),

Gracias por su interés en participar en mi estudio de investigación que ayudará a conocer la experiencia de ser un inmigrante latino de edad avanzada en los Estados Unidos y cómo el proceso de inmigración impacta la salud en general. Busco inmigrantes latinos de la tercera edad (indocumentados y documentados) de 65 años o más que hayan nacido en un país latino. Realizaré todas las entrevistas por videollamada (Plataforma Zoom) o por teléfono, y usted debe dominar el inglés, el español o ambos. La participación en el estudio comienza en la etapa de preselección y le haré tres preguntas demográficas que ayudarán a abordar atributos específicos como el país y el año de nacimiento y los años de residencia en los Estados Unidos. Cual por estas preguntas me dejaran distinguir si usted esta apto para ser parte del estudio. Una vez usted presente tener estas características demográficas y acepte continuar siendo parte del estudio, seguiré con entrevistas que tomarán de 45 minutos a 1 hora. Una vez completada la entrevista, compensaré a los participantes con una tarjeta de regalo virtual de Wal-Mart de $ 20.

Si está dispuesto/a a participar, sugiera el día y la hora que más le convenga, y estaré lista para programar la cita de la entrevista al mejor momento para los dos. A continuación, puede encontrar un formulario de consentimiento adjunto para que lea el procedimiento del estudio. Si tiene alguna pregunta, no dude en preguntar.

Gracias,

Sonia Lizet Ramos
Appendix C – Pre-Screening Guide [English and Spanish]

1. I would first like to ask you:
   a. Were you born in a Latin American country?
      ( ) Yes (Continue 1b)
      ( ) No (Say “thank you” and Discontinue the interview.)

   b. Do you live in EL Paso County?
      ( ) Yes (Continue 1c)
      ( ) No (Say “thank you” and Discontinue the interview.)

   c. Do you speak?
      ( ) English (Continue 1d)
      ( ) Spanish (Continue 1d)
      ( ) Both English or Spanish (Continue 1d)
      ( ) Other language (Say “thank you” and Discontinue the interview.)

   d. What is your age?
      ( ) Under 64 years Old (Say “thank you” and Discontinue the interview.)
      ( ) 65-69 (Continue 1e)
      ( ) 70-74 (Continue 1e)
      ( ) ≥75 (Continue 1e)

   e. In this interview, I will be asking questions about hardships, legal experiences, health, and disease that may cause emotional reactions. Are you willing to participate in this interview, and as part of this interview, if you feel comfortable answer these questions when I ask them?
      ( ) Yes (Continue)
      ( ) No (Say “thank you” and Discontinue the interview.)

Let’s schedule an interview time. I w would also like you to first review the consent form which I will email to you. I will ask you to consent when we conduct the actual interview.
1. Primero me gustaría preguntarle:

   a. ¿Usted naciste en un país Latinoamericano?
      ( ) Sí (Continuar 1b)
      ( ) No (Diga "gracias" y suspenda la entrevista).

   b. ¿Usted vive en el condado de El Paso?
      ( ) Sí (Continuar 1c)
      ( ) No (Diga "gracias" y suspenda la entrevista).

   c. ¿Usted habla?
      ( ) Inglés (Continuar 1d)
      ( ) Español (Continuar 1d)
      ( ) Tanto en inglés como en español (Continuar 1d)
      ( ) Otro idioma (Diga "gracias" y suspenda la entrevista).

   d. ¿Cuál es su edad?
      ( ) Menos de 64 años (Diga "gracias" y suspenda la entrevista).
      ( ) 65-69 (Continuar 1e)
      ( ) 70-74 (Continuar 1e)
      ( ) ≥75 (Continuar 1e)

   e. En esta entrevista, haré preguntas sobre las dificultades, las experiencias legales, la salud y las enfermedades que pueden causar reacciones emocionales. ¿Usted está dispuesto a participar en esta entrevista, y como parte de esta entrevista, si se siente cómodo, responda estas preguntas cuando las haga?
      ( ) Sí (Continuar)
      ( ) No (Diga "gracias" y suspenda la entrevista).

Programemos una entrevista. También me gustaría que primero revisara el formulario de consentimiento que le enviaré por correo electrónico. Le pediré su consentimiento cuando llevemos a cabo la entrevista real.
Appendix B - Interview Guide [English and Spanish]

Demographic:

a. What is your country of birth?

b. What year were you born?

c. How many years have you lived in the U.S.?

Open-ended:

1. When you first came to the U.S., did you have any long-term (chronic or acute) health conditions or disabilities?

2. What are some of the challenges or barriers (language, transportation, children care, economic, etc.) you have experienced while seeking health care in the United States?

3. How is the health insurance system here in the U.S compared to your home country?

4. Remember the first time you used health care in the U.S. for any health problem:
   a. What year (approximately) was that?
   b. How difficult or easy was it for you to get medical care?
   c. How difficult or easy was it for you to handle payment for health insurance, referrals, treatments, etc.?

5. Describe what health problems you have faced as an older adult immigrant in the U.S.

6. In present-day, if your immigration status has changed since you arrived in the U.S., how has your health and ability (pay /obtain) emergency services, and routine healthcare changed?

7. Now that you are an elder person, does your immigration status serve as a barrier for seeking or delaying health care?
8. (If changed immigration status): Was your previous migration status a barrier for seeking healthcare or did it force you to delay health care services?

9. Have you felt that your immigration status has caused barriers to seek or build a relationship with doctors? How so?

10. What kind of things do you do to stay healthy?

11. Presently, what challenges do you have when you have to seek health care, and do you get the care you want?

12. How do you believe your health overall would be if you were still in your country of birth?

13. If you have any health problems, does your immigration status make it difficult to manage your illness? How so?

14. If you have you heard of policies or rule changes, what are they and how do you think those policy and rule changes have impacted your health and health care decisions?

15. How do your age and health affect your immigration status?

16. Describe your family member’s support (financially, personal or home care, medications, taking her/him doctor's appointment, etc.). Who and what do they do?

17. How has your immigration status (either scenario being Documented or Undocumented) influenced you to look for or use alternative and complementary health care such as herbal medicine, acupressure, acupuncture, hypnosis, prayer, and spirituality among others?

18. Tell me about any health conditions that influence your diet.

19. What advice would you give to someone coming to the United States from your country of birth regarding health and healthcare decisions?
20. Is there any specific information or clarification you would like to know about immigration policies connected to your health?
Demográfica:

d. ¿Cuál es su país de nacimiento?

e. ¿En qué año nació usted?

f. ¿Cuántos años ha vivido en los EE. UU.?

Preguntas abiertas:

1. Cuando llegó por primera vez a los Estados Unidos, ¿tuvo alguna condición de salud o discapacidad a largo plazo (crónica o aguda)?

2. ¿Cuáles son algunos de los desafíos o barreras (idioma, transporte, cuidado de los niños, económico, etc.) que haya experimentado mientras buscó atención médica en los Estados Unidos?

3. De acuerdo con lo que usted piensa ¿cómo es el sistema de seguro de salud aquí en los EE. UU. en comparación con su país de origen?

4. Recuerde la primera vez que recibió atención médica en los EE. UU. para cualquier problema de salud:

   a. ¿Qué año (aproximadamente) fue eso?

   b. ¿Qué tan difícil o fácil fue para usted recibir atención médica?

   c. ¿Qué tan difícil o fácil fue para usted manejar el pago del seguro médico, referencias, tratamientos, permisos para faltar al trabajo por enfermedad (¿por ejemplo, su jefe aceptó las ausencias? ¿Le pagaron los días de incapacidad?), instrucciones de hacer su trabajo diferente debido a su enfermedad/dolencia (por ejemplo, ya no poder estar de pie, no cargar cosas pesadas, etc.), etc.?

   d. ¿Le pidieron alguna documentación legal antes de darle la atención médica?
e. ¿Qué tal fácil o difícil fue para usted proporcionar los documentos necesarios para recibir atención médica?

5. Describa los problemas de salud que ha enfrentado actualmente como adulto mayor inmigrante en los Estados Unidos.

6. En la actualidad, si su estatus migratorio ha cambiado desde que llegó a los Estados Unidos, ¿cómo ha cambiado su salud y capacidad (pagar /obtener) los servicios de emergencia y su atención médica de rutina?

7. Ahora que usted es una persona mayor, ¿su estatus migratorio es un obstáculo o problema para buscar o retrasar la atención médica?

8. (Si cambió su estatus migratorio): ¿Su estatus migratorio anterior fue un obstáculo para buscar atención médica o le obligó a retrasar los servicios de atención médica?

9. ¿Ha sentido que su estatus migratorio ha causado barreras para buscar o construir una relación prolongada con los médicos? ¿Cómo es eso?

10. ¿Qué tipo de cosas hace usted para mantenerte saludable?

11. En la actualidad, ¿qué desafíos tiene cuándo tiene que buscar atención médica y recibir la atención que desea?

12. ¿Cómo cree que sería su salud en general si aún estuviera en su país de nacimiento?

13. Si usted tiene algún problema de salud, ¿su estatus migratorio dificulta el manejo de su enfermedad? ¿Cómo es eso?

14. Si ha oído hablar de políticas o cambios de reglas migratorias, ¿cuáles son y cómo cree que esos cambios en las políticas y reglas migratorias han impactado en sus decisiones de salud y atención médica?

15. ¿Cómo afectan su edad y salud a su estatus migratorio?
16. Describa el apoyo de su familia (apoyo económico (por ejemplo pago de la consulta o las medicinas), personal o domiciliaria (por ejemplo limpiar o hacer arreglos en la casa), medicamentos, llevarle a la cita con el médico, etc.). ¿Quién y qué hacen por usted en relación con su atención médica?

17. ¿Cómo ha influido su estatus migratorio (ya migración con documentos o sin documentos) para obligarle a buscar o usar atención médica alternativa y complementaria como medicina herbolaria, acupresión, masaje de acupuntura, hipnosis, oración (Rezo) y espiritualidad, entre otros?

18. Platíquenos acerca de cualquier condición de salud que influya en su dieta.

19. ¿Qué consejo daría a alguien que emigra a los Estados Unidos desde su país de nacimiento con respecto a las decisiones de salud?

20. ¿Hay alguna información o aclaración específica que le gustaría saber acerca de las políticas de inmigración relacionadas con su salud?

21. ¿Hay alguna otra cosa que guste platicarnos acerca de su salud, su edad, el hablar/escribir inglés, y su experiencia de migración a los E.U.?
Appendix D- Safety Information Sheet [English and Spanish]

University of Texas at El Paso (UTEP) Institutional Review Board
Informed Consent Form for Research Involving Human Subjects

**Protocol Title:** The Experience of Immigration and Aging on Health of Older Adults In El Paso, Texas, Border Region

**Principal Investigator:** Sonia Lizet Ramos

**UTEP:** Sociology Department

In this consent form, “you” always means the study subject. If you are a legally authorized representative, please remember that “you” refers to the study subject.

**Introduction**

You are being asked to take part voluntarily in the research project described below. You are encouraged to take your time in making your decision. It is important that you read the information that describes the study. Please ask the study researcher or the study staff to explain any words or information that you do not clearly understand.

**Why is this study being done?**

The purpose of the study is to learn about the experience of being an elderly Latino immigrant in the United States and how the immigration process impacts overall health.

Approximately, 20 people will be enrolling in this study in El Paso County.

You are being asked to be in the study because you are an immigrant (undocumented or documented), an individual born in another country, not in the United States, an older adult 65 years or older, and speak English, Spanish, or both.

**What is involved in the study?**

If you agree to take part in this study, your involvement will last about approximately 45 minutes to an hour with perform in-depth interview questions related to being a Latino immigrant living in the United States and what health challenges you faced as you came to the United States. I want to meet with you via the Zoom Platform because I want to communicate and interact with you about your everyday life and health as an elderly Latino immigrant by not exposing you to
the COVID-19 virus. I will record conversations using Zoom audio recording option if it is allowed by you. Since the study will be remote, you can choose the location and availability of your interview where it will be comfortable for you to share your experiences.

This study involves remote and/or virtual research interactions with participants by the research staff. Therefore, privacy and confidentiality are not guaranteed due to the nature of the electronic conferencing platforms that will be used.

**What are the risks and discomforts of the study**

The risks associated with this research are no greater than those involved in daily activities, but there still may be some emotional impact. Talking about important issues such as hardships, legal experiences, health, and disease may cause emotional reactions. These emotional reactions may come up during the interview or may evolve later after some time when processing what shared during the interview. Moreover, any legal risks to participating will be minimized because of the strict confidentiality and privacy measures during the interview process as well as with the handling of data collecting, storage, and presentation. Additionally, due to the use of online conferencing systems, your privacy and confidentiality is not guaranteed.

**What will happen if I am injured in this study?**

The University of Texas at El Paso and its affiliates do not offer to pay for or cover the cost of medical treatment for research related illness or injury. No funds have been set aside to pay or reimburse you in the event of such injury or illness. You will not give up any of your legal rights by signing this consent form. You should report any such injury to Sonia Lizet Ramos (915) 667-3749 and to the UTEP Institutional Review Board (IRB) at (915-747-6590) or irb.orsp@utep.edu.

**Are there benefits to taking part in this study?**

You are not likely to benefit by taking part in this study. This research may help us to understand the immigration process experiences’ impacts on the health of elderly Latin immigrants living in El Paso County. I hope that others may help in the future from what we learn from this study and address serious health care inequities based on country of birth, ethnic origin, age, or preferred language. Hopefully we can identify facilitators and barriers within the health care system.
What are my costs?

There are no direct costs.

Will I be paid to participate in this study?

Participants will receive a compensation for their participation in the form of $20 Wal-Mart virtual gift card upon completion of the interview by forwarding an email with Walmart eGift Card number and PIN.

What other options are there?

You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.

What if I want to withdraw, or am asked to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you do not take part in the study, there will be no penalty or loss of benefit.

If you choose to take part, you have the right to skip any questions or stop at any time. However, we encourage you to talk to a member of the research group so that they know why you are leaving the study. If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them.

The researcher may decide to stop your participation without your permission, if he or she thinks that being in the study may cause you harm and may affect legal status the study may be stopped.

Who do I call if I have questions or problems?

You may ask any questions you have now. If you have questions later, you may call Sonia Lizet Ramos at (915)667-3749 and sramos0993@miners.utep.edu.

If you have questions or concerns about your participation as a research subject, please contact the UTEP Institutional Review Board (IRB) at (915-747-6590) or irb.orsp@utep.edu.
What about confidentiality?

Your part in this study is confidential. The following procedures will be followed to keep personal information confidential. To protect your privacy and keep all your responses confidential, I will not use your real name in any of the notes or recordings made for the study. I will replace your name with a pseudonym. Once interviews are transcribed, all audio recordings will be destroyed. Transcripts and all other research materials will be kept on password protected computers.

The results of this research study may be presented at meetings or in publications; however, your name will not be disclosed in those presentations.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include, but are not necessarily limited to:

Office of Human Research Protections
UTEP Institutional Review Board

Because of the need to release information to these parties, absolute confidentiality cannot be guaranteed.

All records will be such as audio recording records will be in password protected computer files. After the project has terminated all recording will be destroyed.

Authorization Statement

I have read each page of this paper about the study (or it was read to me). I will be given a copy of the form to keep. I know I can stop being in this study without penalty. I know that being in this study is voluntary and I choose to be in this study.

Participant’s Name (printed)

Participant’s Signature     Date
Authorization Statement

I have read each page of this paper about the study. I know that being in this study is voluntary and I choose to be in this study. I will get a copy of this consent form now for me to keep. Please feel free to print a copy for your records.

☐ Yes, I agree to participate in this research project. I have read the following informed consent form and I understand what the research entails.
☐ No, I do not agree to participate in this research project.

Verbal Consent:
If you agree to continue in this study, I will ask the following list of specific questions during our interview recording.
☐ Do agree to participate in this research project voluntarily?
☐ Do you understand the consent form, and understand what the research entails?

An explanation of the research was given, questions for the subject were solicited and answered to the subject’s satisfaction. The subject has provided oral consent to participate in this study.

________________________________________________
Person obtained verbal consent Name and Title (Print)

________________________________________________
Signature of Person obtained verbal consent
Date verbal consent obtained

☐ If you do not agree to consent to participate in this study verbally, I will stop recording and not continue this study without penalty to you.
En este formulario de consentimiento, "usted" siempre se refiere al sujeto del estudio. Si usted es un representante legalmente autorizado, recuerde que "usted" se refiere al sujeto del estudio.

**Introducción**

Se le pide que participe voluntariamente en el proyecto de investigación que se describe a continuación. Le recomendamos que se tome su tiempo para tomar su decisión. Es importante que lea la información que describe el estudio. Por favor, pídale al investigador del estudio o al personal del estudio que explique cualquier palabra o información que no entienda claramente.

**¿Por qué se está realizando este estudio?**

El propósito del estudio es aprender sobre la experiencia de ser un o una inmigrante latino(a) de edad avanzada en Estados Unidos y cómo el proceso de inmigración ha impactado su salud en general.

Aproximadamente, 20 personas se inscribirán en este estudio en el condado de El Paso, Texas.

Se le invita a este estudio porque usted es un o una inmigrante (con o sin documentos), es una persona que nació en otro país (no en los Estados Unidos), es un adulto mayor de 65 años o más, y habla inglés, español o ambos.

**¿Cuál es su participación en este estudio?**

Si acepta participar en este estudio, su participación durará aproximadamente de 45 minutos a una hora respondiendo preguntas durante una entrevista relacionadas con ser un o una inmigrante
latino(a) que vive en Estados Unidos y qué desafíos de salud enfrentó al llegar a los Estados Unidos. Quiero reunirme con ustedes a través por la plataforma Zoom porque quiero comunicarme e interactuar con usted sobre su vida diaria y su salud como un inmigrante latino de edad avanzada al no querer exponerlo al virus COVID-19. Si usted está de acuerdo, grabaré las conversaciones usando la opción de grabación de audio de Zoom. Dado que el estudio será remoto, usted puede elegir la ubicación y horario de su entrevista donde sea cómodo para usted el compartir sus experiencias.

Este estudio implica interacciones de investigación remotas y/o virtuales con los participantes por parte del personal de investigación. Por lo tanto, la privacidad y la confidencialidad no están garantizadas debido a la naturaleza de las plataformas de conferencias electrónicas que se utilizarán.

¿Cuáles son los riesgos e incomodidades del estudio?

Los riesgos asociados con esta investigación no son mayores que los involucrados en las actividades diarias, pero todavía puede haber algún impacto emocional. Hablar sobre temas importantes como dificultades, experiencias legales, salud y enfermedades puede causar reacciones emocionales. Estas reacciones emocionales pueden surgir durante la entrevista o pueden evolucionar más tarde después de algún tiempo al procesar lo que se compartió durante la entrevista. Además, cualquier riesgo legal para participar se minimizará debido a las estrictas medidas de confidencialidad y privacidad durante el proceso de entrevista, así como con el manejo de la recopilación, almacenamiento y presentación de datos. Además, debido al uso de sistemas de conferencias en línea, su privacidad y confidencialidad no está garantizada.

¿Qué sucederá si me lesiono en este estudio?

La Universidad de Texas en El Paso y sus afiliados no ofrecen pagar o cubrir el costo del tratamiento médico por enfermedad o lesión relacionada con la investigación. No se han reservado fondos para pagarle o reembolsarle en caso de tal lesión o enfermedad. Usted no renunciará a ninguno de sus derechos legales mediante la firma de este formulario de

¿Hay beneficios para participar en este estudio?

No es probable que usted se beneficie al participar en este estudio. Esta investigación puede ayudarnos a comprender el impacto de las experiencias del proceso de inmigración en la salud de los inmigrantes latinos mayores que viven en el condado de El Paso. Espero que otros puedan ayudar en el futuro de lo que aprendemos de este estudio y abordar las graves desigualdades en la atención de la salud basadas en el país de nacimiento, el origen étnico, la edad o el idioma preferido. Esperemos que podamos identificar los factores que facilitan u obstaculizan el acceso al sistema de atención de la salud médica.

¿Cuáles son mis costos?

No hay costos directos.

¿Se me pagará para participar en este estudio?

Se le compensará su participación en forma de tarjeta de regalo virtual de Wal-Mart de $ 20 al finalizar la entrevista. La tarjeta virtual será enviada por medio de un correo electrónico con el número de tarjeta de regalo y un PIN.

¿Qué otras opciones hay?

Usted tiene la opción de no participar en este estudio. No habrá sanciones involucradas si decide no participar en este estudio. ¿Qué pasa si quiero retirarme o se me pide que me retire de este estudio?

Participar en este estudio es voluntario. Usted tiene derecho a elegir no participar en este estudio. Si no participa en el estudio, no habrá penalización ni pérdida de beneficio.
Si elige participar, tiene derecho a omitir cualquier pregunta o detener su participación en cualquier momento. Sin embargo, le recomendamos que hable con un miembro del grupo de investigación para que sepa por qué abandona el estudio. Si hay hallazgo nuevo durante el estudio que pueda afectar si desea seguir participando, se le hablará de ellos.

El investigador puede decidir suspender su participación sin su permiso, si él o ella piensa que participar en el estudio puede causarle daño y puede afectar el estado legal.

¿A quién llamo si tengo preguntas o problemas?

Puede hacer cualquier pregunta que tenga ahora. Si tiene preguntas más tarde, puede llamar a Sonia Lizet Ramos al (915)667-3749 y al correo electrónico: slramos3@miners.utep.edu.

Si tiene preguntas o inquietudes sobre su participación como participante de investigación, comuníquese con la Junta de Revisión Institucional (IRB) de la UTEP al (915-747-6590) o irb.orsp@utep.edu.

¿Qué pasa con la confidencialidad?

Su participación en este estudio es confidencial. Se seguirán los siguientes procedimientos para mantener la confidencialidad de su información personal. Para proteger su privacidad y mantener la confidencialidad de todas sus respuestas, no utilizaré su nombre real en ninguna de las notas o grabaciones realizadas para el estudio. Reemplazaré su nombre por un seudónimo. Una vez que se transcriben las entrevistas, todas las grabaciones de audio serán destruidas. Las transcripciones y todos los demás materiales de investigación se mantendrán en computadoras protegidas con contraseña.

Los resultados de este estudio de investigación pueden presentarse en reuniones o en publicaciones; sin embargo, su nombre no será revelado en esas presentaciones.

Las siguientes organizaciones pueden inspeccionar y/o copiar sus registros de investigación para garantizar la calidad y el análisis de datos incluyen, pero no necesariamente se limitan a:
Oficina de Protección de la Investigación Humana

Junta de Revisión Institucional de la UTEP

Debido a la necesidad de difundir información a estas organizaciones, no se puede garantizar la confidencialidad absoluta.

Todos los registros serán tales como registros de grabación de audio estarán en archivos de computadora protegidos por contraseña. Después de que el proyecto haya terminado, todas las grabaciones serán destruidas.

Declaración de autorización

He leído cada página de este documento sobre el estudio (o me fue leído). Se me dará una copia del formulario para conservar. Sé que puedo dejar de participar en este estudio sin penalización. Sé que estar en este estudio es voluntario y elijo estar en este estudio.

Nombre del Participante (Impreso)

Firma del Participante       Fecha

Firma de la Persona que Obtiene el Consentimiento       Fecha

Declaración de Autorización

He leído cada página de este documento sobre el estudio. Sé que participar en este estudio es voluntario y elijo estar en este estudio. Recibiré una copia de este formulario de consentimiento ahora para que yo lo conserve. Por favor, no dude en imprimir una copia para sus registros.

☐ Sí, acepto participar en este proyecto de investigación. He leído el siguiente formulario de consentimiento informado y entiendo lo que implica la investigación.

☐ No, no estoy de acuerdo en participar en este proyecto de investigación.

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Consentimiento verbal:

Si acepta continuar en este estudio, haré la siguiente lista de preguntas específicas durante la grabación de nuestra entrevista.

☐ ¿Usted está de acuerdo en participar voluntariamente en este proyecto de investigación?

☐ ¿Usted entiende el formulario de consentimiento y comprende lo que implica la investigación?

Se dio una explicación de la investigación, se solicitaron preguntas para el sujeto y se respondieron a satisfacción del sujeto. El sujeto ha dado su consentimiento oral para participar en este estudio.

____________________________________________________________________________

Persona que obtuvo el consentimiento verbal Nombre y cargo (Impreso)

____________________________________________________________________________

Firma de la persona que obtuvo el consentimiento verbal

____________________________________________________________________________

Fecha en que se obtuvo el consentimiento verbal

☐ Si usted no acepta su consentimiento para participar en este estudio verbalmente, dejaré de grabar y no continuaré este estudio y habrá ninguna penalización para usted.
Appendix E – Resources List

List of free/discounted Counseling resources/
Lista recursos de asesoramiento gratuitos/con descuento

1. Centro De Salud Familiar La Fe-El Paso

Address/ Dirección:
608 S. St. Vrain, El Paso, Texas 79901
Phone/Teléfono:
(915) 545-7055
Hours of Operation/ Horas de operación:
8 a.m. to 5 p.m., Monday – Friday
Language/Idioma:
English and Spanish

2. Catholic Diocese of El Paso
CATHOLIC COUNSELING SERVICES

Address/ Dirección:
499 St. Matthews St El Paso, Texas 79907
Phone/Teléfono:
(915) 872-8424
Email/ correo electrónico:
ccs@elpasodiocese.org
Hours of Operation/ Horas de operación:
Monday – Friday9:00am - 12:00pm & 1:00pm - 5:00pm
Language/Idioma:
English and Spanish

3. Project Amistad

Address/ Dirección:
3210 Dyer St. El Paso, TX 79930
Phone/Teléfono:
(915) 298-1132
Hours of Operation/ Horas de operación:
M-F 7 a.m. - 5 p.m. MST
Language/Idioma:
English and Spanish
4. **Family Service of El Paso**  
   **Address/ Dirección:**  
   6040 Surety Dr. El Paso, Texas 79905  
   **Phone/Teléfono:**  
   (915) 781-9900  
   **Hours of operation/ Horas de operación:**  
   Monday-Thursday: 8AM-8PM  
   Friday: 8AM-7PM  
   Saturday and Sunday: CLOSED  
   **Language/Idioma:**  
   English and Spanish

5. **Centro San Vicente**  
   **Address/ Dirección:**  
   8061 Alameda Ave. El Paso, Texas 79915  
   **Hours of operation/ Horas de operación:**  
   8AM-5PM  
   **Address/ Dirección:**  
   10780 Pebble Hills suite G1, EL Paso Texas 79935  
   **Phone/Teléfono:**  
   (915) 859-7545 ext. 1248  
   **Hours of operation/ Horas de operación:**  
   8AM-5PM  
   **Language/Idioma:**  
   English and Spanish

6. **Amanecer Community Counseling Center**  
   **Address/ Dirección:**  
   1219 Barranca 79935 El Paso, Texas,  
   **Phone/Teléfono:**  
   (915) 779-5600  
   **Hours of operation/ Horas de operación:**  
   8AM-7PM  
   **Language/Idioma:**  
   English and Spanish
Table 3: Complementary and Alternative Medicine

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion/Prayers</td>
<td>7</td>
</tr>
<tr>
<td>Herbal Teas</td>
<td>5</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>Therapist</td>
<td>2</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>1</td>
</tr>
<tr>
<td>Massages</td>
<td>1</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>1</td>
</tr>
<tr>
<td>Hydromassage</td>
<td>1</td>
</tr>
<tr>
<td>Hot ointments</td>
<td>1</td>
</tr>
<tr>
<td>Healers</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4: Current Health Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>4</td>
</tr>
<tr>
<td>Arthritis</td>
<td>4</td>
</tr>
<tr>
<td>Heart Conditions</td>
<td>3</td>
</tr>
<tr>
<td>Hearing Conditions</td>
<td>3</td>
</tr>
<tr>
<td>Asthma</td>
<td>2</td>
</tr>
<tr>
<td>Thyroid</td>
<td>2</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
</tr>
<tr>
<td>Hip Conditions</td>
<td>1</td>
</tr>
<tr>
<td>Hernia</td>
<td>1</td>
</tr>
<tr>
<td>Prostate</td>
<td>1</td>
</tr>
<tr>
<td>COVID-19</td>
<td>1</td>
</tr>
<tr>
<td>Anemia</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Allergies</td>
<td>1</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Self</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Economic</td>
<td>5</td>
</tr>
<tr>
<td>Home</td>
<td>2</td>
</tr>
<tr>
<td>Transportation</td>
<td>6</td>
</tr>
<tr>
<td>Running Errands</td>
<td>2</td>
</tr>
<tr>
<td>Groceries</td>
<td></td>
</tr>
<tr>
<td>Self-Care</td>
<td></td>
</tr>
<tr>
<td>Give Medication</td>
<td>1</td>
</tr>
</tbody>
</table>
Vita

Sonia Lizet Ramos was born and raised in El Paso, Texas. She received her Bachelor of Science in Biological Science from the University of Texas at El Paso (UTEP) in Fall 2017. After graduating with her bachelor's, she began the master’s program in sociology at UTEP in the Fall of 2018. While studying at UTEP, she worked as a teaching assistant for the academic year 2018-2019, then as a Family Immigration Paralegal in a law firm, and currently as a Legal Assistant at the EOIR El Paso Immigration Court. Her long-term goals are to earn her Ph.D. and continue to work with immigration communities. She hopes to open a non-profit organization someday and become a professor so that she continues educating.