MASTER OF ARTS IN SOCIOLOGY RESEARCH & PRACTICE

AMERICAN UNIVERSITY

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ASSESSMENT
DEPARTMENT OF SOCIOLOGY
2023

AMERICAN UNIVERSITY
WASHINGTON, DC

DEPARTMENT OF SOCIOLOGY

Graduate Committee: David Reznik, Nicole Angotti, Tracy Weitz & Ernesto Castañeda

Ernesto Castañeda, Graduate Program Director

Master of Arts in Sociology Research & Practice Assessment Report

Program Objectives:

- Placement in doctoral programs and/or careers in social advocacy, research, teaching, human services, or policymaking
- Production of publicly available scholarship facilitated by practicum experience

Program Measures/Benchmarks:

- Professionally relevant placements in Sociology-related doctoral programs and/or social science-related research and practice fields (100% of those graduating)
- At least one authorship credit in publicly available scholarly publication generated through Practicum research work (100% for those who completed the practicum sequence)

Program Outcomes (2019-21 & 2020-22 cohorts):

- Professional placements (see appendix for details): *2019-21 cohort* – 100% (5 enrolled in fully-funded PhD programs & 1 hired for a research position, n=6); *2020-22 cohort* – 100% (2 enrolled in fully-funded PhD programs & 2 hired for information science/research positions, n=4)
- Authorship credits (see appendix for details): *2019-21 cohort* – 83% (5 students named as authors in publicly available scholarly publications, n=6, everybody was a coauthor in public sociology pieces); *2020-22 cohort* – 100% (4 students named as authors in publicly available scholarly productions, n=4)

Analysis:

- Not only were placement benchmarks met over the past two cohorts, but the unanimity of all students achieving this program objective demonstrates program excellence; important to note as well the quality of the PhD placements (e.g., Ivy League institutions – Cornell University; top 10 Sociology PhD programs – Indiana University; etc.) and research firms (e.g., Mathematica Policy Research, etc.)
- Authorship credit benchmark met in both cohorts, with a unanimous percentage in the most recently graduated cohort once again demonstrating program excellence; important to note the volume of scholarly output from select students (e.g., Daniel Jenks, Carina Cione, Jessica Chaikof, Emma Vetter, etc.)
- It is also important to note the diversity of the students in terms of race, ethnicity, religion, sexual preference, and gender identity.

Previous Challenges:

- A couple of students have left the program after the first semester, which is heavy on research methods. However, once engaged in the practicum sequence, retention has been close to 100% (except for one leave for medical reasons).

- We have included a more active approach to SOCY-624 Introduction to Qualitative Research which includes data analysis of interviews about chronic health and disability, along with conference presentations, all with good results. We will make more changes to the 1st-semester coursework to address the heavy emphasis on research methods and instead start our unique practicum model of hands-on research from the first semester. To do this, we will delay when students are expected to take the Quantitative Methods course so that when they do, they are ready to learn by analyzing data related to the practicum project.
- While some cohorts used to be small (4 and 6 students), there has been an increase in cohort sizes (8 people 2021-2023), as well as a noticeable increase in applications, and interest, including among international students, even by those funded by Fulbright.
- Some classes were small, but people from other programs increasingly seek to enroll in SORP classes. Thus, going over the minimum class size recommendations.

Planning:

- Looking ahead to the assessment of the 2021-23 cohort, which at 8 is larger than any of the previously assessed cohorts, it is crucial to mandate and collect CV's/résumés from every student as well as formalize tracking protocols for placement results and career advancement.
- Given the volume of public sociology authored by students of the past two cohorts, it is important to develop a formalized protocol for measuring the public impact of such scholarship.

Request:

- To maintain the current levels of inclusive excellence, we would request that one of the GFA students is allocated to help the GPD with a TA assignment to help with the administration of the program and better tracking of student placements, publications, applications, and to lead more aggressive and targeted marketing and outreach for recruitment.

Overall Assessment:

- The MA in Sociology, Research, and Practice produces students with real experience in research, as demonstrated in published research and manuscripts in progress.
- The publication outcomes in two years are close to those of a doctoral program in an R1 university.
- Post-graduation placements are solid in both the research industry and the academy.

Master of Arts in Sociology Research & Practice
American University

RECENT PLACEMENTS

2020-2022 Cohort (Graduating Class N=4)

SteVon Felton, Sociology, Cornell University, 2022

Jessica Chaikof, Social Policy, Heller School, Brandeis University 2022

Daniel Jenks, Mathematica Policy Research, 2022

Isabella Goris, Administrative Services and Student Employment Specialist, University Library, American University, 2022

2019-2021 Cohort (Graduating Class N=6)

Deziree Jackson, Sociology, Indiana University, 2021

Emma Vetter, Sociology, George Mason University, 2021

Sarah Schech, Sociology, SUNY at Albany, 2021

Jhamiel Prince, Criminology, Law and Society, University of California Irvine, 2022

Abby Ferdinando, Director, KRC Research, 2022

Carina Cione, Program Coordinator, Center for Latin American and Latino Studies, 2022

American University SORP Cohort: Master of Arts in Sociology Research & Practice (SORP)

Research Skills to Improve Society
The Master of Arts in Sociology Research and Practice will prepare you for a doctoral program or a career in **social advocacy**, research, teaching, human services, or **policymaking**. In this program, you will learn methods of doing research on health and society; engage in a research project focused on issues in Washington, DC; build your **qualitative and quantitative data analysis** capacity; and hone your ability to present results of research to various audiences.

Our students immerse themselves in research focusing on migration dynamics and the social determinants of health—particularly related to **social inequities** of race/ethnicity, social class, gender, and sexuality—in connection to other sociological subfields, such as urban sociology, race/ethnicty, and social movements.

AU's program is set apart by its **practicum experience**, in which you will work with faculty over four semesters to complete a **professional-quality research** project. Practicum provides a unique opportunity to learn the **practical skills** necessary to conduct research and communicate your findings. You will gain practical, **hands-on experience** working side-by-side with faculty on cutting-edge research to **improve society's health** and well-being.

The American University Sociology Master's Program has been ranked 15th in the nation as "Best Practicum Experience" on its recently published "The Best Master's Program in Sociology Degree Programs."

Student Successes:

As a result of their commitment to research, students who have completed the Master of Arts in Sociology Research and Practice at American University are well equipped for graduate programs. Within the last two years our SORP students have been accepted by various doctoral programs:

- 2021: Deziree Jackson, Sociology, Indiana University
- 2021: Emma Vetter, Sociology, George Mason University
- 2021: Sarah Schech, Sociology, State University of New York at Albany
- 2022: SteVon Felton, Sociology, Cornell University
- 2022: Jessica Chaikof, Social Policy, The Heller School for Social Policy and Management, Brandeis University
- 2022: Jhamiel Prince, Criminology, Law and Society, University of California Irvine'

In 2021, eight students joined SORP and are finishing their program this semester.

Student Publications:

SORP students engage in several research projects over the course of the program, some of which have been published in credible academic journals, newspapers, and blogs. SORP students work can be found in the following portfolio (organized from most to least recent):

2023: The Implications of Health Disparities: A COVID-19 Risk Assessment of the Hispanic Community in El Paso

Access Here

Authors: Cione, Carina; Vetter, Emma; Jackson, Deziree; McCarthy, Sarah; Castañeda, Ernesto

Publisher: Switzerland: MDPI AG

Publication: International Journal of Environmental Research and Public Health, 2023, Vol. 20 (2), p.975

Date: 5 January 2023

Description: Since the outbreak of the COVID-19 pandemic in the United States, Latinos have suffered from disproportionately high rates of hospitalization and death related to the virus. Health disparities based on race and ethnicity are directly associated with heightened mortality and burden of illness and act as underlying causes for the staggering impacts of COVID-19 in Latin communities in the United States. This is especially true in the city of El Paso, Texas, where over 82% of the population is Hispanic. To ascertain the level of danger that COVID-19 poses in El Paso, we constructed a point-in-time risk assessment of its Latin population and assessed a Latin individual's likelihood of hospitalization or death related to COVID-19 by comparing relevant health profiles with high-risk co-morbidities that the Centers for Disease Control (CDC) identified in 2020. Data for this risk assessment comes from 1152 surveys conducted in El Paso. The assessment included comprehensive demographic, socioeconomic, and health data to analyze disparities across Hispanic sub-populations in the city. Results revealed that around 49.3% of Hispanics in the study had been previously diagnosed with a high-risk co-morbidity and therefore have an increased likelihood of hospitalization or death related to COVID-19. Additional factors that led to increased risk included low income, homelessness, lack of U.S. citizenship, and being insured. The findings from this study additionally demonstrate that structural inequality in the U.S. must be addressed, and preventive measures must be taken at local and state levels to decrease the mortality of pandemics. Baseline population health data can help with both goals.

2022: Young Immigrants' Integration into a New Home: The Case of Central American Children and Youth Settling in Washington, DC

Access Here

Authors: Ernesto Castañeda, Daniel Jenks, Cynthia Cristobal

Publisher: Emerald Publishing Limited

Publication: Sociological Studies of Children and Youth, Volume 29, p. 31-49

Date: 22 May 2022

Abstract:

Purpose: To describe some of the tensions that both unaccompanied and accompanied immigrant children and youth face when reuniting with family members living abroad after years of living apart, separated by borders and anti-immigrant policies are described.

Methods: Fifty-eight interviews with immigrant minors from El Salvador, Honduras, and Guatemala and the tensions they reported having after moving in with their biological parents or legal sponsors in the Washington, DC, metropolitan area are drawn upon.

Findings: Youth reported that getting used to cohabitation and in-person relationships with their parents or other sponsors was difficult at first, though it improved over time. Despite the biological, emotional, and financial bonds, minors had to learn how to relate to new authority figures and follow their rules. Many reported feeling lonely and missing grandmothers and other family members and friends left behind in the country of birth.

Research implications: Interviews with counselors and local authorities that interface with these families show that parenting and youth programs in the places of settlement can become effective interventions to improve relations between children and parents recently reunited, which can indeed help with scholastic achievement and socio-economic advancement.

Value: The interview extracts bring a window into intrafamily dynamics, often overlooked in discussions of the integration of immigrant children and youth into their new homes and communities.

2021: Centroamericanos en su Paso por Mexico hacia los Estados Unidos

Access Here

Authors: Ernesto Castañeda, Cristian Mendoza Gómez, Daniel Jenks, Fernanda Pérez, Fernando Rocha

Publication: Editorial de la Universidad Autónoma de Ciudad Juárez (UACJ), Ciudad Juárez, México

Date: December 2021

2021: American University Researchers Describe Findings in Mental Health Diseases and Conditions (Symptoms of PTSD and Depression among Central American Immigrant Youth)

Access Here

Authors:

Publisher: NewsRX LLC

Publication: Mental Health Weekly Digest, 2021, p. 99

Date: 8 November 2021

2021: Symptoms of PTSD and Depression among Central American Immigrant Youth

Access Here

Authors: Ernesto Castañeda, Daniel Jenks, Jessica Chaikof, Carina Cione, SteVon Felton, Isabella Goris, Lesley Buck, Eric Hershberg

Publication: *Trauma Care* 2021, 1(2), p. 99-118

Date: 11 August 2021

Description: The aim of this paper is to explore the mental health challenges that Central American immigrant youth face before and after arriving in the United States. This population is hard to reach, marginalized, and disproportionately exposed to trauma from a young age. This paper investigates the mental health stressors experienced by Central American immigrant youth and asylum seekers, including unaccompanied minors, surveyed in the U.S. in 2017. This mixed methods study uses qualitative data from interviews along with close-ended questions and the validated PHQ-8 Questionnaire and the Child PTSD Symptom Scale (CPSS). These new migrants face numerous challenges to mental health, increased psychopathological risk exacerbated by high levels of violence and low state-capacity in their countries of origin, restrictive immigration policies, the fear of deportation for themselves and their family members, and the pressure to integrate once in the U.S. We find that Central American youth have seen improvements in their self-reported mental health after migrating to the U.S., but remain at risk of further trauma exposure, depression, and PTSD. We find that they exhibit a disproportionate likelihood of having lived through traumatizing experiences that put them at higher risk for psychological distress and disorders that may create obstacles to integration. These can, in turn, create new stressors that exacerbate PTSD, depression, and anxiety. These conditions can be minimized through programs that aid immigrant integration and mental health.

2021: How to Help Unaccompanied Children from Central America—Ideas from the Washington, DC Area

Access Here

Authors: Ernesto Castañeda, Daniel Jenks

Publisher: Scholars Strategy Network

Date: 11 June 2021

Description: Since 2015, nearly 250,000 unaccompanied minors have arrived in the United States and been placed across the country with sponsors, who may be their parents, other family members, or friends. Many of these young people—from El Salvador, Guatemala, and Honduras—are motivated to travel by increasing violence and economic and political instability in their home countries, as well as a desire for reunification with their parents. Of these children, over 20,000 have moved to the Washington, D.C. region, where many face barriers to integration in their communities. Their difficulties include dealing with traumatic experiences, family separation, inconsistent or interrupted schooling, and language barriers in their new schools. As scholars and policymakers, we must rapidly respond to the needs of migrant children and find the best ways to support these young newcomers who now call our region home. Our research with the Center on Latino and Latin American Studies at American University includes interviews with fifty-eight recently resettled youth, thirty-six sponsors, and seventeen social service providers and school staff in the District of Columbia, Fairfax County in Virginia, and Prince George's County and Montgomery County in Maryland. The stories from these youths, sponsors, and practitioners illuminate a cross-section of the experiences of resettled Central American minors—experiences that, we hope, can inform policy interventions at the county level that can help the unaccompanied minors thrive.

2021: Consider budget priorities for policing

Access Here

Author: Daniel Jenks

Publication: Wednesday Journal of Oak Park and River Forest

Date: 4 May 2021

2020: Speaking about Health Disparities — A teachable moment about structural racism

Access Here

Authors: Curtis Smith, Carina Cione, Deziree Jackson, and Ernesto Castañeda

Publication: *Medium*

Date: 10 December 2020

2020: Hispanic Health Disparities and housing: Comparing measured and self-reported health metrics among housed and homeless Latin individuals

Access Here

Authors: Ernesto Castañeda, Blaine Smith, Emma Vetter

Publication: Journal of Migration and Health 1-2

Date: 1 December 2020

Abstract: Previous studies argue that Hispanics are healthier and less likely to experience homelessness than other populations in their same socioeconomic position. However, earlier studies have not explored the relationship between housing status and health for Latin individuals. This study examines 1) the health disparities between homeless and housed Hispanics in El Paso, Texas, and 2) the Hispanic health and homelessness paradoxes using an intersectional framework to understand health risks. A large number of Hispanic residents of El Paso (N = 1152) were surveyed. Demographic, health, and housing data were collected. We contribute to the literature by providing detailed health indicators for homeless Hispanics. To our knowledge, this is the first study to examine health disparities between housed and homeless Hispanics. Bivariate analysis, as well as data coded from interviews, indicated that homeless Hispanics were more likely to have barriers to care, less likely to have health insurance, slightly more likely than housed Hispanics to experience mental illness, alcoholism, and addiction, and more likely to be underdiagnosed for health problems, including hypertension. This study shows how certain traditional methods for collecting health data, including self-rated health and reported diagnoses, can be ineffective at revealing health disparities. This paper calls for innovative, mixed methods approaches to understand the social and structural determinants of health for marginalized populations.

2020: Understanding How El Paso, Texas Voted in the 2020 Presidential Election

Access Here

Authors:

Publication: *Medium*

Date: 25 November 2020

2020: Defunding the Police is an Immigrants' Rights Issue, Too

Access Here

Authors: Daniel Jenks and Ernesto Castañeda

Publisher: *Medium*

Date: 6 July 2020

2020: Why are Black and Latin people in the US more affected by Covid-19?

Access Here

Authors: Ernesto Castañeda, Carina Cione, Abby Ferdinando, Jhamiel Prince, Deziree Jackson, Emma Vetter, Sarah McCarthy

Publication: Corona Times

Date: 11 June 2020

2020: How to Understand Protest

Access Here

Authors: Ernesto Castañeda, Daniel Jenks

Publication: *Medium*

Date: 7 June 2020

2020: Latinos en El Paso at Risk from COVID-19

Access Here

Authors: Deziree Jackson, Abby Ferdinando, Carina Cione, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, Emma Vetter

Date: 30 May 2020

2020: Health Disparities and the Coronavirus and Why This Matters for El Pasoans

Access Here

Authors: Carina Cione, Deziree Jackson, Abby Ferdinando, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, and Emma Vetter

Publication: El Paso News

Date: 29 May 2020

2020: Latinos and COVID in Border Cities

Access Here

Authors: Carina Cione, Deziree Jackson, Abby Ferdinando, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, and Emma Vetter

Publication:

Date: 29 May 2020

2020: Latinos, Health Disparities, and COVID-19

Access Here

Authors: Ernesto Castañeda, Abby Ferdinando, Carina Cione, Jhamiel Prince, Deziree Jackson, Emma Vetter, and Sarah McCarthy

Publication: El Paso News

Date: 23 May 2020

2020: COVID-19 Susceptibility among Latin People in El Paso, TX

Access Here

Authors: Carina Cione, Ernesto Castañeda, Abby Ferdinando, Jhamiel Prince, Deziree Jackson, Emma Vetter, Sarah McCarthy

Publication: SSRN Electronic Journal

Date: 22 May 2020

Description: The Latin population in the United States has received relatively little attention despite their vulnerability to COVID-19 during the current pandemic. On Monday, May 4, 2020, the City of El Paso recorded 1,029 cases and 22 deaths. With rising rates of infection and the recent resignation of the city's Public Health Director, El Paso and the region must take proactive precautions to suppress the spread of the virus. To assess the possible impact of COVID-19 in El Paso, we constructed a risk assessment about the populations that could be at higher risk. To do this, we used detailed survey data on health from a sample of 1,152 Hispanic individuals that was gathered with the support of NIH in 2011. To understand how COVID-19 may impact the Latin residents of El Paso, we analyzed risk factors associated with the virus on their own as well as interacting with each other.

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PUBLICATION AGREEMENT BETWEEN THE RUSSELL SAGE FOUNDATION AND ERNESTO CASTAÑEDA AND DANIEL JENKS

An AGREEMENT made on the 10th day of June, 2021, between Ernesto Castañeda and Daniel Jenks (the "Author") and the Russell Sage Foundation (the "Publisher") relating to the publication of a book now entitled *Reuniting Families: Central American Minors between Family Separation and Reunification.*

1. AUTHOR'S GRANT

The Author grants and assigns to the Publisher exclusive rights to the Work and revisions thereof, in all forms, languages and media during the full term of the copyright, including all renewals and extensions of copyright, throughout the World.

The Author authorizes the Publisher to copyright the Work in the United States and in all members of the Universal Copyright Convention in the name of the Publisher.

The Publisher will publish the book in keeping with its standard practice and will protect and maintain the copyright by acting as the Author's agent in applying for renewal, extension, or revision of copyright, as necessary.

2. AUTHOR'S WARRANTY

The Author represents and warrants that he/she has full power to make this agreement and that the manuscript as submitted is without matter that will be libelous or injurious or otherwise unlawful or in violation of any copyright or any right of privacy. The Author agrees that if it should be necessary to incorporate in the Work any material, either illustrations or text, that has been published or is the property of others, he/she will incorporate such material only with the Publisher's knowledge and consent and will obtain full permission in writing from the owner of the copyright of such material.

The Author agrees to hold the Publisher harmless from any claim, action, or proceeding alleging facts that constitute a breach of any warranty enumerated above, and further agrees to indemnify the Publisher against all damages, costs and expenses incurred in defense against each claim, action, and proceeding.

3. DELIVERY OF MANUSCRIPT AND AGREEMENT TO PUBLISH

The Publisher agrees to publish the Work at its own expense (unless otherwise specifically provided in this agreement) upon receipt of a manuscript deemed to be satisfactory by the Publisher and acceptable in content as well as form.

4. PRODUCTION

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P U B L I S H I N G   A G R E E M E N T

AGREEMENT made as of this 11th **day of** February **, 2021**, by and between **Columbia University Press**, 61 West 62nd Street, New York, N.Y. 10023 (the "Press") and **Ernesto Castañeda**, Department of Sociology, American University, 4400 Massachusetts Avenue, NW, Washington, DC 20016, and **Carina Cione**, Department of Sociology, American University, 4400 Massachusetts Avenue, NW, Washington, DC 20016 (the "Author").

1. DELIVERY BY AUTHOR.

(a) The Work. The Author shall deliver to the Press a new and original manuscript of a work in the English language of approximately (but no more than) **ninety thousand (90,000) words and up to five (5) black-and-white images, thirty (30) tables, and nine (9) graphs** in length, tentatively entitled ***Immigration Myths and Realities***.

(b) Description of the Work. **Eleven facts about immigrants and immigration.**

(c) Materials to be Delivered. The Author will deliver to the Press, on or before **January 31, 2022**, one (1) digital copy of the complete manuscript and all illustrations, photographs, maps, charts and other graphics necessary or appropriate to supplement the manuscript ("Art"), as well as all third party permissions as described in Paragraph 11 below in a format specified by the Press (hereinafter referred to collectively as the "Work"), in accordance with guidelines provided by the Press upon execution of this Agreement and satisfactory to the Press in content, length, medium and format. All Art shall be delivered in form and quality suitable for reproduction. The provisions of this paragraph concerning the time of delivery and the length and format of the Work are of the essence of this Agreement, and the obligations of the Press under this Agreement are contingent upon their strict fulfillment.

(d) Index. If the Press determines that the Work should include an index, the Press will give the Author the option to prepare and deliver such index, at the Author's sole expense by a date specified by the Press. **If the Author prefers that the Press prepare the index, the Author shall so notify the Press in a timely manner and the Press will do so. In the event the Author fails to deliver an index in a manner satisfactory to the Press or the Press prepares the index upon the Author's request, the Press will charge such costs to the Author's royalty account.**

2. GRANT OF RIGHTS. The Author grants and assigns to the Press the exclusive right, throughout the world (the "Territory") in **all languages except the Spanish language**, (i) to print, publish, distribute, sell and license any and all editions, versions and/or formats of the Work, in whole or in part, including as an Electronic Edition as defined herein, and (ii) to exercise the subsidiary rights in the Work specified in Paragraph 7. Each of the rights granted in this Agreement is granted for the full terms of copyright protection, including all renewals and extensions, provided under the copyright laws in effect in each country included within the

Daniel Jenks

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PROFESSIONAL EXPERIENCE

September 2021-present	Survey Analyst, Education and Employment Mathematica Policy Research, Washington, DC
January 2021 – present	Deputy Director Immigration Lab, Ernesto Castañeda, PhD. Dir. American University, Washington, D.C.

EDUCATION

2022	M.A.	Sociology Research & Practice American University, Washington, DC
2020	B.A.	Sociology, Minor Law and Society American University, Washington, D.C. GPA: 3.61 Major: 3.87

RESEARCH INTERESTS

Immigration, race and ethnicity, multiculturalism, gender, mixed-methods, disaster preparedness and response, environment and agriculture, sustainability, social theory.

PUBLICATIONS

*indicates equal authorship in alphabetical order
^indicates authorship order to be determined

Book Manuscripts

F *Families Reuniting: Central American Minors Ending Family Separation.* Ernesto Castañeda, Ph.D., and **Daniel Jenks.** Under contract at Russel Sage Foundation. Anticipated publication Fall 2023

Journal Articles

2021 Castañeda, Ernesto, **Daniel Jenks**, Jessica Chaikof, Carina Cione, SteVon Felton, Isabella Goris, Lesley Buck, and Eric Hershberg. 2021. "Symptoms of PTSD and Depression among Central American Immigrant Youth" Trauma Care 1, no. 2: 99-118. https://doi.org/10.3390/traumacare1020010

Book Chapters

2022 Castañeda, Ernesto, **Daniel Jenks**, and Cynthia Cristobal. "Immigrant Youth Integrating to a New Home." *Children and youths' migration in a global landscape.* Ed. Adrienne Lee Atterberry, Derrace Garfield McCallum, Siqi Tu, Amy Lutz. Series: *Sociological Studies of Children and Youth.* (Vol. 29). Chapter 2 pp.31-49. Bingley, United Kingdom: Emerald Publishing.

2021 Castañeda, Ernesto, **Daniel Jenks**, Cristian Mendoza Gómez, Fernanda Pérez, and Fernando Rocha. "Centroamericanos en su Paso por México hacia los Estados Unidos." Ética, política y migración. Editado por Luis Rubén Díaz Cepeda, Roberto Sánchez Benítez y Amy Reed-Sandoval. Editorial de la Universidad Autónoma de Ciudad Juárez, pp.125-146. Ciudad Juárez, México. https://elibros.uacj.mx/omp/index.php/publicaciones/catalog/view/191/170/1047-1

Journal Articles Under Review

n.d. Castañeda, Ernesto, and **Daniel Jenks**. "De-democratization in the United States and the Events of January 6th, 2021." *Social Sciences*. R&R

Journal Articles in Progress

n.d. Angotti, Nicole, **Daniel Jenks**, Sangeetha Madhavan. "Challenges and Opportunities for Data Collection During a Pandemic: Towards a More Nimble Sociology"

n.d. Castañeda, Ernesto, Natalie Schwartz, **Daniel Jenks**, and Christian Paolini. "Immigrant Reaction to Anti-Immigrant Initiatives: Understanding Anti-Immigrant Attitudes among Immigrants in Switzerland"

Policy Briefs

2021 **Daniel Jenks** and Ernesto Castañeda. "Supporting Unaccompanied Children from Central America in Arlington County Schools" *Scholars Strategy Network.* Harvard University: Cambridge, MA.

2021 **Daniel Jenks** and Ernesto Castañeda. "How to Help Unaccompanied Children from Central America: Ideas from the Washington, D.C., Area" *Scholars Strategy Network.* Harvard University: Cambridge, MA.

Other Publications

2021, Aug. Ernesto Castañeda, **Daniel Jenks.**"Central American Youth Migrants Show Signs of PTSD and Stress." with Daniel Jenks.* AULA Blog. Center for Latin American and Latino Studies. American University.

2021, May. **Daniel Jenks.** "Oak Parkers Should Reconsider Budget Priorities When it Comes to Policing". *Wednesday Journal.*

2020, Nov. Ernesto Castañeda, **Daniel Jenks.** "What Could a Biden Presidency Mean for Immigrants?" *Medium.*

2020, July **Daniel Jenks,** Ernesto Castañeda "Defunding the Police is an Immigrants'; Rights Issue, Too." *Common Dreams.*

2020, June Ernesto Castañeda, **Daniel Jenks**. "How to Understand Protest" *Medium.*

RESEARCH EXPERIENCE

July 2021 – present Research Assistant, Center for Latin American and Latino Studies, American University

March 2020 – present Research Assistant, Nicole Angotti, Ph.D.
COVID Conversations and Nimble Sociology
Department of Sociology, American University

Sept. 2019 – present Member, Immigration Lab, Ernesto Castañeda, Ph.D.
Department of Sociology, American University

January 2020 – July 21 Research Assistant, Ernesto Castañeda, Ph.D.
Central American Youth Immigrant Integration
Center for Health, Risk & Society, American University

April – May 2019 Research Intern, Sanskrit Sanskriti Samshodhika
Political Involvement in Religious Rites: The Kumbh Mela Festival
Jnana Prabodhini Prashala, Pune, MH, India

CONFERENCE PRESENTATIONS

Integration and Urban Belonging among Central American Youth in Washington, DC.

2022 "Children and Youths' Migration in a Global Landscape." Book launch. Migration Initiative. Cornell University. Ithaca, NY. Online. October 5.

2022	The 10th International Conference of the European Council for Social Research on Latin America (CEISAL). Helsinki, Finland. 13–15 June 2022
2022	Annual Conference of the Urban Affairs Association. Washington, DC. April 12th. With Ernesto Castañeda.*
2022	Annual Conference of the American Sociological Association (ASA). Washington, DC. August 5-9. With Ernesto Castañeda.*

Reunited: Central American Youth and the Aftermath of Family Separation

2022	Eastern Sociological Society Annual Meeting. Boston, MA. March 6th. With Ernesto Castañeda.
2021	Critical Migration Studies Conference, University of San Francisco. Virtual. November 5th.
2021	Mid-South Sociological Association Conference. Hybrid. October 23rd.

Capturing the COVID-19 Historical Moment: Toward a More Nimble Sociology

2021	American Sociological Association Annual Meeting, Virtual. August 8th.

Reunited: Central American Youth Migrants Finding Home in the United States

2021	American Association of Applied and Clinical Sociology Conference. Virtual. October 5th.

Reuniting Families: Central American Minors between Family Separation and Reunification.

2021	XX Hispanic & Lusophone Conference, University of California Santa Barbara, Virtual. May 14th.

Trauma Exposure and Mental Health of Central American Immigrant Youth in the Washington, D.C. Metropolitan Area.

2021	Robyn Rafferty Mathias Student Research Conference, American University. Washington, D.C. Virtual. April 10th. Co-Presenters: Jessica Chaikof, SteVon Felton, Isabella Goris. *Winner, Graduate Social Sciences Final Work*

Integration of Central American Immigrant Youth in the Washington, D.C. Metropolitan Region.

2020	Robyn Rafferty Mathias Student Research Conference, American University, Washington, D.C. Virtual. April 18th.

GUEST LECTURES

Migration from Central America: Understanding Health, Poverty, and Immigration

2021 Course on Global Social Problems and Social Justice. Department of Sociology, Catholic University of America, Washington, D.C., November 2nd

2021 Course on Gender, Poverty, and Health, Department of Sociology, American University, Washington, D.C., September 21st

Charles Tilly: Democratization, Categorical Inequalities, and Contentious Politics

2022 Course on Social Theory. Department of Sociology, American University, Washington, D.C., April 7th

2021 Course on Social Theory. Department of Sociology, American University, Washington, D.C., October 26th

Transnational Surrogacy: A Sociological Perspective

2021 Course on Birth and Death, Department of Sociology, American University, Washington, D.C., April 12th

GRANTS AND FELLOWSHIPS

Internal Funding

2022 Human Capital and the Economic Development Potential of Recent Afghan Refugees. American University College of Arts and Sciences Mellon Fund for Research Support. $5000. (Co-PIs Castañeda, Rizvi, Sajjad, Mobasher).

2022 American University Provost's Office Graduate Student Assistant Professional Development Award. $1000.

2022 "Welcoming and Potentializing the Skills of Refugee Afghans" Faculty-Student Research Grant – Creation and Discovery. American University. (Jenks Co-Author and Project Coordinator, Co-PIs Castañeda, Sajjad, and Rizvi). $7500.

2020 American University Department of Sociology Merit Assistantship. $16,500.

External Funding

2021 Elected Officials. Scholars Strategy Network. $1500.

External Grants Prepared and Submitted, Not Funded

2021-2023 "Human Capital and the Economic Development Potential of Recent Afghan Refugees". Washington Center for Equitable Growth. (Co-PIs Castañeda, Rizvi, Sajjad, Mobasher). $100,000.

2020-2022 "The Effects of Exclusion and Family Separation on Mental Health and Immigrant Integration: Central Americans in the Washington, DC Area." Carnegie Corporation of New York. (PI Castañeda) $200,000.

2020-2022 "Immigrant Integration, Insecurity, and Public Perception: The Central American Diaspora in the Washington, DC Metropolitan Area." Russell Sage Foundation. (Co-PIs Castañeda and Fontes) $136,478.

2020-2022 "The Lives of Central Americans in the Washington DC Region." National Geographic. Explorer Grant. (Co-PIs Fontes and Castañeda) $30,000.

SKILLS

R; SPSS; NVivo; Zotero; English (Native); Spanish (Intermediate); Hindi (Basic)

TEACHING EXPERIENCE

*course development
^major course adjustment for online instruction

As Instructor of Record

Department of Liberal Studies, Adelphi University

Fall 2022 — Society and the Individual (online, asynchronous)*

Department of Sociology, American University

Fall 2022 — Immigration, Race, and Ethnicity (online, asynchronous)^

As Teaching Assistant

Department of Sociology, American University

Spring 2022	Intro to Quantitative Research, Molly Dondero, Ph.D.
Fall 2021, Spring 22	Social Theory, David Reznik, Ph.D.
Fall 2021	U.S. Society in Global Perspectives, Jee-Hyun Kim.
Fall 2020, Spring 21	Ethics, Neoliberalism, and Social Change, Susan McDonic, Ph.D.
Fall 2020, Spring 21	U.S. Society in Global Perspectives, Susan McDonic, Ph.D.
Fall 2020, Spring 21	U.S. Society in Global Perspectives, Michelle Newton-Francis, Ph.D.
Fall 2020	Rise of Critical Social Thought, Ernesto Castañeda, Ph.D.

Department of Justice, Law, and Criminology, American University

Fall 2018 — Western Legal Tradition, Bill Davies, Ph.D.

Undergraduate Mentoring

Department of Sociology, American University

Spring 2022 — Capstone Advisor – Isabella Dorfman

SERVICE TO THE PROFESSION

Reviewer, Occasional

Sociology of Race and Ethnicity

OTHER PROFESSIONAL EXPERIENCE

Sept. – Dec. 2021 — Hire2Retire IT/HR Intern
National Rail Passenger Corporation (AMTRAK)

July – October 2020 — Enumerator
U.S. Census Bureau

June – August 2019 — Infrastructure Intern
Downtown DC Business Improvement District

Sept. – Dec. 2018 — Central Reporting Intern
National Rail Passenger Corporation (AMTRAK)

May – August 2018 — Camp Program Coordinator
Scouts, BSA, NEIC Pearson, WI

January – May 2018 — Legislative Intern
U.S. House of Representatives, Congressman Rick Nolan

VOLUNTEER EXPERIENCE

August 2022-present — College Access Mentor
Latin American Youth Center (LAYC)
Washington, D.C.

March-June 2016, various — Farmhand
Worldwide Opportunities on Organic Farms (WWOOF)
Ocate, NM; Prospect, OR; Estacada, OR; Trout Creek, MT

ACADEMIC MEMBERSHIPS

American Sociological Association
Association for Applied and Clinical Sociology
Scholars Strategy Network

HONORS

2020 Carla Howery Award for Contributions to the Discipline at the Undergraduate Level
2015 Eagle Scout, Scouts BSA

REFERENCES

Ernesto Castañeda-Tinoco, Ph.D.
Associate Professor
Department of Sociology
American University
4400 Massachusetts Avenue, NW
Washington, D.C. 20016
ernesto@american.edu | (202) 885-2412

Nicole Angotti, Ph.D.
Associate Professor
Department of Sociology
American University
4400 Massachusetts Avenue, NW
Washington, D.C. 20016
angotti@american.edu | (202) 885-2421

Hemant Apte, Ph.D.
Reader Emeritus
Department of Anthropology
University of Pune
Ganeshkhind Rd, Ganeshkhind
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Jessica Leah Chaikof
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(404) 354 – 5037

EDUCATION

2022- Doctoral Student, Social Policy, the Heller School for Social Policy and Management at Brandeis University, Waltham, Massachusetts.

2022 Master of Arts, Sociology Research & Practice, American University, Washington, D.C.

2019 Bachelor of Arts, Sociology, Minor Chemistry*, Cum Laude,* Wheaton College, Norton, Massachusetts

RESEARCH & TEACHING INTERESTS

Disability, Chronic Illness, Accessibility, Higher Education, STEM, Women's Health, Reproduction, Medical Sociology, Organizations, and Qualitative Research Methods

PUBLICATIONS

2021 Castañeda, Ernesto., Daniel Jenks, **Jessica Chaikof,** Carina Cione, SteVon Felton, Isabella Goris, Lesley Buck, and Eric Hershberg. "Symptoms of PTSD and Depression among Central American Immigrant Youth." *Trauma Care*, *1*(2), 99–118. https://doi.org/10.3390/traumacare1020010

MANUSCRIPTS IN PREPARATION

Newton-Francis, Michelle, **Jessica Chaikof**, Eriin Foley, Fridah Charity, Joshua Dietz, Michaela McParland, Margaret Murphy, and Youssef Yazbek. *Endometriosis at Work: How Employees Manage Endometriosis Pain & Their Work Lives*.

Chaikof, Jessica, Ernesto Castañeda, SteVon Felton, Daniel Jenks, and Isabella Goris. "Building Communities: Public Housing and Immigration in a Hispanic—majority City." (HACEP).

Chaikof, Jessica and Michelle Newton-Francis. "Endometriosis on Campus: How Students Manage Their Pain and Academics."

Chaikof, Jessica and Michelle Newton-Francis. "Endometriosis and the Chilly Climate in STEM education."

Chaikof, Jessica, Bulin Li, Isabella Goris, and Ernesto Castañeda, "Disability among Mexican-Americans in El Paso, TX."

CONFERENCE PRESENTATIONS

2023 Newton-Francis, Michelle, **Jessica Chaikof**, Eriin Foley, Fridah Charity, Joshua Dietz, Michaela McParland, Margaret Murphy, and Youssef Yazbek. *Endometriosis at Work: How Employees Manage Endometriosis Pain & Their Work Lives*. Eastern Sociological Society Conference, Baltimore, MD.

2022 **Chaikof, Jessica**, Isabella Goris, Bulin Li, and Ernesto Castañeda. *Disability among*

Mexican-Americans in El Paso. Sociological Research Jamboree sponsored by the Disability in Society ASA Section.

2022 **Chaikof, Jessica** and Michelle Newton-Francis. *Endometriosis on Campus: Student Experiences with Accommodations.* Sociological Research Jamboree sponsored by the Disability in Society ASA Section.

2022 Goris, Isabella, **Jessica Chaikof,** Bulin Li, and Ernesto Castañeda. *Disability among Mexican-Americans in El Paso*. Immigration and Interculturalism in European and U.S. Cities, Immigration Lab, Department of Sociology, American University, Washington, D.C.

2022 Castañeda, Ernesto, Daniel Jenks, **Jessica Chaikof,** SteVon Felton, and Isabella Goris. *Building Communities: Public Housing and Immigration in a Hispanic—Majority City.* Urban Affairs Association, Washington, DC.

2022 **Chaikof, Jessica** and Michelle Newton-Francis. *Endometriosis on Campus: Disability, Stigma, & Accommodations.* Eastern Sociological Society Conference, Boston, MA.

2021 **Chaikof, Jessica.** *Hidden Disability: Seeking Support and Understanding for Endometriosis in an Online Community*. Disability Summit, University of Maryland.

2021 Jenks, Daniel., **Jessica Chaikof**, SteVon Felton, and Isabella Goris. *Trauma Exposure and Mental Health Outcomes of Unaccompanied Central American Immigrant Youth in the Washington D.C. Metropolitan Area.* Robyn Rafferty Mathias Student Research Conference, American University. Winner of Graduate Social Sciences Final Work Award.

2021 **Chaikof, Jessica.** *Faculty Experiences with Accessibility & Accommodations for Students with Disabilities at a Small Liberal Arts College*. Robyn Rafferty Mathias Student Research Conference, American University.

2019 **Chaikof, Jessica.**, Jennifer Phillips and Karen McCormack. *Application of Universal Design Concepts for Disability Accommodations to Promote Diversity in STEM Training Environments* [Poster]. STEMposium, University of Oregon, Eugene, OR.

2019 **Chaikof, Jessica.** *Faculty Perceptions Toward Accessibility in the College Classroom* [Poster]. Eastern Sociological Society Conference, Boston, MA. Winner of Poster Session for Undergraduates.

INVITED PRESENTATIONS/TALKS/GUEST LECTURES

2022 **Chaikof, Jessica.** *Draft Editing*, Course on Qualitative Methods, Department of Sociology, American University, Washington D.C.

2022 **Chaikof, Jessica** and Michelle Newton-Francis. *Endometriosis on Campus: How Students Manage Their Pain and Academics*, Course on Gender, Poverty, and Health, Department of Sociology, American University, Washington D.C.

2022 **Chaikof, Jessica**. *Refining Results Section,* Course on Qualitative Methods, Department of Sociology, American University, Washington D.C.

2022 **Chaikof, Jessica**. *Endometriosis: Overview of IRB Process & Endometriosis Data Set*, Course on Qualitative Methods, Department of Sociology, American University, Washington D.C.

2022 **Chaikof, Jessica.** *Student Snapshot: My Lived Experience Navigating Adaptive Technology and Post-Secondary Education as a Student with a Disability*. Strengthening Accessibility & Inclusion within Professional Programs, University of Toronto, Toronto, Canada.

2022 **Chaikof, Jessica.** *Literature Reviews: What do I do with all of this literature?*. Course on Senior Capstone, Department of Sociology, American University, Washington D.C.

2022 **Chaikof, Jessica.** *Literature Reviews: What do I do with all of this literature?*. Course on Introduction to Social Research Methods, Department of Sociology, American University, Washington D.C.

2021 **Chaikof, Jessica** and Michelle Newton-Francis. *The Everyday Impact of Endometriosis in Higher Education*. The Advocacy Magazine, Virtual Meeting

2021 **Chaikof, Jessica.** *The Case of Endometriosis*. Course on Gender, Poverty, and Health, Department of Sociology, American University, Washington D.C.

2021 **Chaikof, Jessica.** *Disability and STEM: Making STEM More Accessible to Students with Disabilities.* Course on Researching Inclusivity in STEM Education (RISE), Department of Biology, University of Oregon, Eugene, OR

2020 **Chaikof, Jessica.** *Faculty Perceptions Toward Accessibility in the College Classroom*. Course on Disability and Difference, Department of Sociology, Wheaton College, Norton, MA.

RESEARCH EXPERIENCE

2021- Co-Investigator with Michelle Newton-Francis, Ph.D. *The Everyday Impact of Endometriosis on College Students.* Department of Sociology, American University

2021- Member and Co-Investigator with Ernesto Castañeda, Ph.D. *Central American Youth Immigrant Trauma and Mental Health.* Immigration Research Lab, Department of Sociology, American University

2018-9 Research Assistant, Justin Schupp, Ph.D. O*rganizational Structure of Farmers' Markets* Department of Sociology, Wheaton College

2015-6 Research Student, Carolyn Haller, Ph.D., *Recombinant protein polymers as biomaterials for drug delivery and tissue engineering.* Harvard Medical School, Beth Israel Deaconess Medical Center, Boston, Massachusetts

TEACHING EXPERIENCE

2022 Teaching Assistant, Introduction to Social Research Methods and Senior Capstone, Michelle Newton-Francis, Ph.D., Department of Sociology, American University

2021 Teaching Assistant, Introduction to Qualitative Research (combined grad and undergrad section), David Reznik, Ph.D., Department of Sociology, American University

FELLOWSHIPS

2022 Hon. Jonathan Brant Endowed Fellowship Fund

2022 Jack Shonkoff Fellowship in Child and Family Policy

GRANTS

2021 [Not Funded] CAS Graduate Student Research Fund, Fall 2021 (Competitive, $1000)

2021 [Awarded] Faculty, Student Grant, American University, Washington, D.C. (Competitive $2500.00)

MEDIA QUOTES

National Media

November 1, 2021. "In return to campuses, students with disabilities fear they're being 'left behind.'" By Stephanie Lai. *Washington Post,* Washington, DC.

Local Media

July 21, 2022. "AU's Immigration Lab: Researching "All Things Migration."" By Patty Housman. *American University College of Arts and Sciences News*. Washington, DC.

April 12, 2022. "University mishandled multiple disability accommodations, students allege." By Alisha Chhangani. *The Eagle.* Washington, DC.

April 11, 2022. "Disabled students raise concerns about ADA violations on AU shuttle bus, campus buildings." By Zoe Bell. *The Eagle*. Washington, DC.
September 30, 2019. "Parents 'move mountains' in fight against rare disease." By Julie M. Cohen. *Newton Tab*. Newton, MA.
March 18, 2019. "Some Worry Admissions Scandal Could Add Barriers for Students Who Need Accommodations." By Carrie Jung. *WBUR News*. Boston, MA.
October 15, 2017. "Students establish safe space to discuss disability issues at Wheaton." By Magdalene McCaffrey and Amber Wright. *The Wheaton Wire*. Norton, MA

Selected Blog Posts
October 2021. **Chaikof, Jessica.** "Striving to Make Higher Education More Accessible for All." *Usher 1F: Collaborative*
June 25, 2019. **Chaikof, Jessica**. "Finding Your Passion." *Hearing: Health & Technology Matters*
April 2019. **Chaikof, Jessica.** "University Faculty Experience in Support Students with Disabilities." *The American Cochlear Implant Alliance.*
January 2, 2018. **Chaikof, Jessica.** "Overcoming Obstacles." *The Usher Syndrome Society*

HONORS & AWARDS
2021 Robyn Rafferty Mathias Student Research Conference, Graduate Social Sciences Final Work, *Trauma Exposure and Mental Health Outcomes of Unaccompanied Central American Youth in the Washington, D.C., Metropolitan Area*
2019 Best Undergraduate Research Poster, *Faculty Perceptions Toward Accessibility in the College Classroom*, Eastern Sociological Society Conference
2019 Lyon's Pride Award, Dean of Students, Wheaton College, Norton, MA
2019 Inducted, Alpha Kappa Delta, International Sociology Honors Society

PROFESSIONAL SERVICE
2022- PhD 2022 Cohort Representative, the Heller School at Brandeis University, Waltham, Massachusetts
2018-9 Student Liaison, Diversity Equity & Access Leadership Senate (DEAL), Wheaton College, Norton, Massachusetts
2018 Student Representative, Search Committee for Accessibility Services Coordinator, Wheaton College, Norton, Massachusetts
2017-9 Co-Founder and President, WheAccess, First Student Disability Club on Campus, Wheaton College, Norton, Massachusetts
2016 Student Representative, Search Committee for Accessibility Services Coordinator, Wheaton College, Norton, Massachusetts

PUBLIC SOCIOLOGY
2022 Disability Advocacy Meeting with Massachusetts Gubernatorial Candidate, Danielle Allen
2020- Patient Advocate, Multi-Regional Clinical Trials Center (MRCT) of Brigham and Women's Hospital and Harvard, Boston, Massachusetts
2021 Disability Consultant, "We Are All Different," By Tracey Turner, *Pan Macmillan*, children's book
2020 Host, Town Hall on Persons with Disabilities: Nothing about Us Without Us!, Natalia Linos for Congress, Brookline, Massachusetts
2020 Disability Consultant, Natalia Linos for Congress, Brookline, Massachusetts

2018-9 Advocate and Spokesperson, Usher Syndrome Coalition, Maynard, Massachusetts

PROFESSIONAL MEMBERSHIPS

American Sociological Association
(Sections: Medical Sociology; Organizations, Occupations, and Work; History of Sociology and Social Thought; Disability in Society; and Animals and Society)
Eastern Sociological Society
D.C. Sociological Society

SKILLS

Microsoft Office, SPSS, STATA, NVivo, Web Hosting (Wix), Canvas

Deziree Jackson

Department of Sociology
Indiana University
1020 E Kirkwood Ave Ballantine Hall 744 Indiana University
dezjack@iu.edu

EDUCATION

In progress	Ph.D., Sociology, Indiana University, Bloomington, Indiana Minor: Social Science Research Methods
2021	M.A., Sociology Research & Practice, American University, Washington, D.C
2018	B.A., Sociology, University of Mary Washington, Fredericksburg, Virginia

RESEARCH AREAS OF INTEREST

Medical Sociology	Race and Ethnicity	Social Psychology	Research Methods
Intersectionality	Stress Process	Life Course	

PUBLICATIONS: PEER-REVIEWED RESEARCH

Cione, Carina, Emma Vetter, **Deziree Jackson**, Sarah McCarthy, and Ernesto Castañeda. 2023. "The Implications of Health Disparities: A COVID-19 Risk Assessment of the Hispanic Community in El Paso" *International Journal of Environmental Research and Public Health.* 20(2): 975. Special Issue Migration and Migration Status: Key Determinants of Health and Well-Being

PUBLINCATIONS: UNDER-REVIEW

Amaro, Emilia, Jordan Rodriguez, **Deziree Jackson**, Deirdre Popovich, Kellilyn M. Frias, Ernesto Castañeda. "Healthcare Utilization on the Texas-Mexico Border: The Impact of Cultural Health Capital" (*Submitted to Health & Society*)

SCHOLARSHIP

Castañeda, Ernesto Ph.D., Emma Vetter, **Deziree Jackson**, Sarah Schech-McCarthy, Carina Cione, Jhamiel Prince, and Ashli Melder. "Opening the Black Box of the Hispanic Health Paradox: Social Determinants of Health and Hispanic Health Disparities"

Selected Pieces
Cione, Carina, Ernesto Castañeda, Ph.D., Abby Ferdinando, Jhamiel Prince, **Deziree Jackson**, Emma Vetter, and Sarah McCarthy. "COVID-19 Susceptibility among Latin People in El Paso, TX." American University, Washington, DC, May 22. SSRN revised June 11, 2020, version on *academia.edu*

Ernesto Castañeda, Ph.D., **Deziree Jackson,** Abby Ferdinando, Carina Cione, Jhamiel Prince, Emma Vetter, and Sarah McCarthy. "Latinos in El Paso at Risk of COVID-19." 2020. *El Paso News*.

Curtis Smith, Carina Cione, **Deziree Jackson**, and Ernesto Castañeda. 2020. "Speaking about Health Disparities — A teachable moment about structural racism." *Medium.*

Castañeda, Ernesto, Abby Ferdinando, Carina Cione, Jhamiel Prince, **Deziree Jackson**, Emma Vetter, and Sarah McCarthy. "Latinos, Health Disparities, and COVID-19" 2020. *Medium*. Republished in *Social Problems and Global Issues*. Society for the Study of Social Problems (SSSP) Global Division Newsletter. p. 3-4.

PROFESSIONAL PRESENTATIONS

Jackson, Deziree "Strong and Stressed: Racial and Gendered Differences in the Performance of 'Strength'" *North Central Sociology Association*. 2023. Grand Rapids, Michigan.

Jackson, **Deziree** "Understanding Healthcare Decision-Making among Latinos along the US-Mexico border" *North Central Sociology Association.* 2022. Indianapolis, Indiana.

Jackson, Deziree with Sarah McCarthy and Emma Vetter. "Housing as Health Care: An Analysis of Homelessness in El Paso, Texas" *American Sociological Association*. 2021.Virtual due to COVID-19.

AWARDS/HONORS/FELLOWSHIP

2023 Butler A. Jones Scholarship ($400)

RESEARCH EXPERIENCE

Indiana University
- January 2022-present — Research and Graduate Assistant, Pamela Jackson Ph.D., Department of Sociology

American University
- July 2020–Sept 2021 — Research Assistant, Kellilyn Frias, Ph.D., HealthCARE Lab, Department of Marketing, Blue Cross Blue Shield
- January 2020 – May 2021 — Research Assistant, Immigration Lab, Ernesto Castañeda, Ph.D. Department of Sociology

University of Mary Washington
- January 2018 - May 2018 — Research Assistant, Leslie Martin, Ph.D., Understanding Your Rights: Arraignments and Fredericksburg General District Court in, Department of Sociology, University of Mary Washington

PROGRAMMING SKILLS/SOFTWARE EXPERTISE

Stata, R, SPSS, Qualtrics, Excel, Dedoose

TEACHING EXPERIENCE

Indiana University, Graduate Teaching Assistant
- Spring 2023 — Sociology of Gender, Dr. Brian Powell
- Fall 2022 — Sociology of Childhood, Dr. Hyeyoung Kwon
- Summer 2022 — Race and Racisms, Jenn Berry
- Spring 2022 — Introduction to Sociology, Dr. Art Alderson
- Fall 2021 — Society and the Individual, Dr. Stephen Benard

American University, Guest Lecturer

Fall 2020 — Social Research Methods, Dr. Nicole Angotti
"Healthcare Decision-making along the Southern Border"

PROFESSIONAL SERVICE

Indiana University

Mentorship to incoming graduate students, 2022-current
Public Sociology-Graduate Sociology Officer, 2022-2023

PROFESSIONAL AFFILIATIONS

American Sociology Association
- Medical Sociology
- Race and Ethnic Relations
- Mental Health

North Central Sociology Society

The Association of Black Sociologists
- ABS Graduate Student Mentorship Program

Emma Vetter

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Fairfax, VA 22031
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evetter@gmu.edu

EDUCATION

Ph.D.	Sociology Specialization: Institutions and Inequalities George Mason University, Fairfax, VA	2021 – present
M.A.	Sociology Research & Practice American University, Washington, D.C.	2021
B.A.	Sociology, Communication Studies (Double Major) Minor: Family Studies Grove City College, Grove City, PA *magna cum laude*	2017

PROFESSIONAL EXPERIENCE

August 2022 – present	Graduate Research Assistant The Education & Health Research Hub, Amy Best, Ph.D. The Urban Research Hub, Rashmi Sadana, Ph.D. Center for Social Science Research, George Mason University
August 2021 – May 2022	Graduate Teaching Assistant, Elizangela Storelli, Ph.D. Introduction to Sociology and Statistics for Behavioral Sciences Department of Sociology & Anthropology, George Mason University
September 2020 – July 2021	Research Assistant, Gay Young, Ph.D. Collective Emotions in the 2020 Presidential Election Department of Sociology, American University
March 2020 – May 2021	Research Assistant, Nicole Angotti, Ph.D. Health After 50 Center for Health, Risk, and Society, American University
January 2020 – May 2021	Research Assistant, Ernesto Castañeda, Ph.D. The Immigration Lab Department of Sociology, American University

May – June 2020 Research Assistant, Ernesto Castañeda, Ph.D.
Risk Factors for COVID-19 among Hispanics in El Paso, Texas
Department of Sociology, American University

August 2016 – May 2017 Student Assistant, William P. Anderson, Jr.; Ph.D.
Social Research Methods
Department of Economics and Sociology, Grove City College

RESEARCH INTERESTS

Social Networks; Health Disparities; Digital Nomads; Social Media; Housing; Early Adulthood

SCHOLARSHIP

Book Manuscripts in Preparation

The Hispanic Health Paradox: Social Determinants of Health among Latinos. Ernesto Castañeda, Ph.D., **Emma Vetter**, Deziree Jackson, Sarah McCarthy, and Carina Cione. University Press interested. Using data from NIH-funded grant.

Papers in Preparation

"Towards Nomadic Typology: A Conceptual Analysis of Traditional and Neo-Nomadic Communities." Maxwell Rollins and **Emma Vetter**.

Peer-Reviewed Journal Articles

2023 Carina Cione, **Emma Vetter**, Deziree Jackson, Sarah McCarthy, and Ernesto Castañeda. "The Implications of Health Disparities: The COVID-19 Pandemic in El Paso, Texas." *The International Journal of Environmental Research and Public Health.* 20(975):1-20. 10.3390/ijerph2004010001.

2020 Castañeda, Ernesto, Blaine Smith, and **Emma Vetter**. "Hispanic health disparities and housing: Comparing measured and self-reported health metrics among housed and homeless Latin individuals." *Journal of Migration and Health.* 1-2:1-8. 10.1016/j.jmh.2020.100008.

Technical Reports

2020 Cione, Carina, Ernesto Castañeda, Ph.D., Abby Ferdinando, Jhamiel Prince, Deziree Jackson, **Emma Vetter**, and Sarah McCarthy. "COVID-19 Susceptibility among Latin People in El Paso, TX." American University, Washington, D.C.,

May 22, 2020. *SSRN* revised June 11, 2020, also on NCBI/NIH, MPC Europe, version on *academia.edu* and *Research Gate*.
Covered by Robert Moore. March 14, 2021. "A year into the pandemic, COVID-19 has ravaged El Paso." *El Paso Matters*. El Paso, Texas.

Policy Briefs

2020 Castañeda, Ernesto, Ph.D., Carina Cione, Abby Ferdinando, Sarah McCarthy, Deziree Jackson, **Emma Vetter**, and Jhamiel Prince. "Latinos and COVID in Border Cities." May 29, 2020. Prepared for UnidosUS.

Other Publications

2020 **Vetter, Emma**, Sarah McCarthy, Ernesto Castañeda, Ph.D., and Carina Cione. November 25, 2020. "Understanding How El Paso, Texas Voted in the 2020 Presidential Election." *Medium.* (https://ernestoc.medium.com/understanding-how-el-paso-texas-voted-in-the-2020-presidential-election-52594721752c).

2020 Castañeda, Ernesto, Ph.D., Carina Cione, Abby Ferdinando, Jhamiel Prince, Deziree Jackson, **Emma Vetter**, and Sarah McCarthy. June 11, 2020. "Why are Black and Latin people in the US more affected by Covid-19?" *Corona Times*. (https://www.coronatimes.net/why-black-latin-us-more-affected-covid-19/).

2020 Jackson, Deziree, Abby Ferdinando, Carina Cione, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, Ph.D., and **Emma Vetter**. May 30, 2020. "Latinos in El Paso at Risk from COVID-19." *El Paso News*. (https://elpasonews.org/2020/05/30/latinos-in-el-paso-at-risk-from-covid-19/).

2020 Cione, Carina, Deziree Jackson, Abby Ferdinando, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, Ph.D., and **Emma Vetter**. May 29, 2020. "Health Disparities and the Coronavirus and Why This Matters for El Pasoans." *El Paso News*. (https://elpasonews.org/2020/05/29/health-disparities-and-the-coronavirus-and-why-this-matters-for-el-pasoans/).

2020 Castañeda, Ernesto, Ph.D., Abby Ferdinando, Carina Cione, Jhamiel Prince, Deziree Jackson, **Emma Vetter**, and Sarah McCarthy. May 23, 2020. "Latinos, Health Disparities, and COVID-19." *Medium.* (https://ernestoc.medium.com/latinos-health-disparities-and-covid-19-bdd07a01872b).
Republished in *Social Problems and Global Issues*. Society for the Study of Social Problems (SSSP) Global Division Newsletter. Summer 2020. p. 3-4.

SELECTED CONFERENCE PRESENTATIONS

F2023 "Towards Nomadic Typology: A Conceptual Analysis of Traditional and Neo-Nomadic Communities." Panel Presentation. Eastern Sociological Society. With Maxwell Rollins. February 24, 2023. Baltimore, MD.

2022 "Modern Hoboes: A Sociological Approach to the Increase in Van Life amongst Millennials." Roundtable Presentation and Table Presider. American Sociological Association. August 7, 2022. Los Angeles, CA.

2021 "Housing as Health Care: An Analysis of Homelessness in El Paso, Texas." Roundtable Presentation. American Sociological Association. With Sarah McCarthy and Deziree Jackson. August 9, 2021. Virtual.

2021 "Femininities and Intersectional Advantages in the 2020 Presidential Election." Roundtable Presentation. American Sociological Association. With Gay Young, Ph.D. August 9, 2021. Virtual.

2017 “Scheme (589), Secrets (596), Signal (600), and Spies: A Social Network Analysis of the Culper Spy Ring, 1778 to 1783.” Research Paper Presentation. Northeastern Ohio Undergraduate Sociological Symposium. April 8, 2017. Wooster, OH.

2016 “Are You Really Going to Eat That? The Causal Connection Between Perceived Eating Habits and Reference Groups.” Research Poster Presentation. Northeastern Ohio Undergraduate Sociological Symposium. March 12, 2016. Kent, OH.

GUEST LECTURER

F2023 “Using Sociological Methods to Research Health Disparities.” Spring 2023. Medical Anthropology, Grove City College. Virtual.

2022 “Professional Development Workshop: Applying to Graduate School.” With Tharuna Kalaivanan and Kellie Wilkerson. November 29, 2022. HNRS 131: Contemporary Social Issues, George Mason University. Virtual.

2022 “Using Sociological Methods to Research Health Disparities.” April 4, 2022. SOCI 101: Foundations of Sociology, Grove City College. Virtual.

2021 “Using Sociological Methods to Research Health Disparities.” November 9, 2021. SOCI 101: Foundations of Sociology, Grove City College. Virtual.

2020 “Opening the Black Box of the Hispanic Health Paradox: Social Determinants of Health and Hispanic Health Disparities.” With Ernesto Castañeda, Ph.D.,

Deziree Jackson, Sarah McCarthy, and Carina Cione. October 20, 2020. SOCY 620: Social Research Methods, American University. Virtual.

2017 — "Scheme (589), Secrets (596), Signal (600), and Spies: A Social Network Analysis of the Culper Spy Ring, 1778 to 1783." March 16, 2017. SOCI 101: Foundations of Sociology, Grove City College.

IN THE MEDIA

2021 — Housman, Patty. 2021. "Meet 10 Star Grad Student #Changemakers." *American University*. (https://www.american.edu/cas/news/meet-10-star-grad-student-changemakers.cfm).

PROFESSIONAL SERVICES

Manuscript Reviewer
Diaspora Studies; International Journal of Comparative Sociology; International Journal of Environmental Research and Public Health

PROFESSIONAL & ACADEMIC MEMBERSHIPS

Professional
American Sociological Association (ASA)

Academic
Alpha Kappa Delta; Pi Gamma Mu; Lambda Pi Eta; Omicron Delta Kappa
The Public Sociology Association at George Mason University
- President – May 2022 to May 2023
- Co-Chair – 2023 PSA Conference Planning Committee
- Member – September 2021 to present

SOFTWARE & RESEARCH SKILLS

IBM SPSS Statistics; MAXQDA; Microsoft Office; Zotero; SurveyMonkey; WordPress; Data Management; Variable Cleaning; Variable Coding; Coding Qualitative Data; Conducting Observations; Conducting Interviews; Composing Field Notes; Writing Literature Reviews

International Journal of *Environmental Research and Public Health*

MDPI

Article

The Implications of Health Disparities: A COVID-19 Risk Assessment of the Hispanic Community in El Paso

Carina Cione [1], Emma Vetter [2], Deziree Jackson [3], Sarah McCarthy [4] and Ernesto Castañeda [5,*]

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Abstract: Since the outbreak of the COVID-19 pandemic in the United States, Latinos have suffered from disproportionately high rates of hospitalization and death related to the virus. Health disparities based on race and ethnicity are directly associated with heightened mortality and burden of illness and act as underlying causes for the staggering impacts of COVID-19 in Latin communities in the United States. This is especially true in the city of El Paso, Texas, where over 82% of the population is Hispanic. To ascertain the level of danger that COVID-19 poses in El Paso, we constructed a point-in-time risk assessment of its Latin population and assessed a Latin individual's likelihood of hospitalization or death related to COVID-19 by comparing relevant health profiles with high-risk co-morbidities that the Centers for Disease Control (CDC) identified in 2020. Data for this risk assessment come from 1152 surveys conducted in El Paso. The assessment included comprehensive demographic, socioeconomic, and health data to analyze disparities across Hispanic sub-populations in the city. Results revealed that around 49.3% of Hispanics in the study had been previously diagnosed with a high-risk co-morbidity and therefore have an increased likelihood of hospitalization or death related to COVID-19. Additional factors that led to increased risk included low income, homelessness, lack of U.S. citizenship, and being insured. The findings from this study additionally demonstrate that structural inequality in the U.S. must be addressed, and preventive measures must be taken at local and state levels to decrease the mortality of pandemics. Baseline population health data can help with both of these goals.

Keywords: health equity; COVID pandemic; Hispanic health; immigrant; minority health

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1. Introduction

Existing health disparities have been exacerbated by COVID-19 [1,2]. Long before the pandemic, race and ethnicity were proven to be associated with life expectancy, mortality, and the burden of illness in the United States [3]. Communities of color consistently lack access to care, proper treatment, care provider diversity, and the resources that exist in high-income and White-populated areas of the country [3]. These disparities cause and prolong poor health in minority communities and result in higher-risk individuals with multiple risk factors beyond old age [2]. This is echoed by public health professionals who observe Black and Hispanic individuals die at higher rates because of an increased likelihood of underlying health conditions and structural barriers to healthcare [1]. Gaps in healthcare increase the vulnerability of groups of people, and their existence springs from discrimination, inequality, and structural racism.

Institutions that place lesser value on the lives of Black and Hispanic people not only turn a blind eye to health disparities but restrict minorities to riskier jobs where they work in dangerous conditions. Research in the United States, Canada, and Europe shows that

immigrants and other minority communities bear higher rates of work-related accidents, illnesses, and deaths because of their over-representation in high-risk occupations [4]. Because of these factors and being less likely to work remotely, they came into contact with COVID-19 before other racial groups and experienced its impacts earlier in the pandemic.

This article examines COVID-19 risk factors in the context of the Hispanic-majority border city of El Paso, Texas. To ascertain the level of danger that COVID-19 poses for the Hispanic community in El Paso, we constructed a point-in-time risk assessment of its Latin population. We assessed a Latin individual's likelihood of hospitalization or death related to COVID-19 by comparing relevant health profiles with high-risk co-morbidities that the Centers for Disease Control (CDC) identified in 2020 [5]. El Paso is an important research site on health disparities, as proven by prior research documenting that the border city's Hispanic population faces compounded structural inequalities, high risk of morality, and poor health outcomes [6,7].

Our study contributes to understanding how racial, ethnic, socioeconomic, and other intersectional experiences are predictive of health outcomes within regional and historical contexts. First, we provide a brief overview of how the COVID-19 pandemic has unfolded in El Paso and its "sister city" of Ciudad Juárez, Mexico. Then, we describe the methodology employed in gathering comprehensive survey data on Hispanics living in El Paso and compiling our risk assessment. The subsequent section analyzes significant demographic, socioeconomic, and health factors that encompass essential determinants of health and risk associated with COVID-19. These measures allowed us to predict Hispanic El Pasoans' high risks of hospitalization and death related to COVID-19 before the pandemic struck El Paso, and thus demonstrate the foreseen impact of COVID-19 on the Latin community in the U.S. [8–11]. In doing so, we also acknowledge and explore structural forms of discrimination and violence against communities of color, particularly Latinos, that contribute to health disparities.

In the early months of 2020, cities and entire regions around the world declared public health emergencies while COVID-19, also known as coronavirus, stole millions of lives and disabled many more [12]. Its arrival in the United States was swift. Former President Donald Trump, who dissolved the White House pandemic response team in 2018, assumed a perilously disinterested approach to information about the virus spreading in Asia. Reuters estimated a COVID-19 death count of at least 69,457 in the United States on 5 May 2020 [13]. This number continued to rise, reaching 92,038 on 20 May. This marked the United States as the country with the highest COVID-19 death toll in the world [13]. The number of lives lost to COVID-19 exceeded that of the United Kingdom, then the country with the second-highest mortality rate, by over 57,000 [13]. In 2020, the total estimated number of cases in the U.S. was also the highest across the globe at 1,189,198, outnumbering China by more than 1 million cases, despite China's population being approximately four times larger [13]. However, not all geographical areas were impacted at the same time. For example, the pandemic reached New York City many months before El Paso, Texas.

The great loss that the U.S. experienced in 2020 was also reflected in local cities' rates of hospitalization and death related to COVID-19, which tracked demographic data and allowed researchers to glimpse the differences in rates across ethno-racial groups. In New York, the Bureau of Communicable Disease Surveillance System reported that, as of 16 April 2020, the death rates for Blacks were 92.3 per 100,000 people, and 74.3 per 100,000 for Latinos [14]. In comparison, the White and Asian death rates were 45.2 and 34.5 per 100,000 people, respectively [14]. Just two months later, the mortality and infection rates skyrocketed. At least 5322 Latinos had died from COVID-19, the majority of whom were ages 65 and above [15]. This was the highest number of lab-confirmed deaths of a racial group in New York City, exceeding that of the White population by almost 1000 [15]. Even so, these numbers were understood to be low estimates since the data cover only lab-confirmed cases, effectively excluding asymptomatic and non-lab-confirmed cases.

As the COVID-19 pandemic continued to unfold and healthcare workers fought to save lives, a familiar pattern arose that concerned researchers and advocates: Black and Hispanic

individuals were not only suffering from more infections but also dying at incredibly higher rates than White and Asian people [14,15].

2. El Paso, Texas

El Paso is city in the western corner of Texas, bordering Las Cruces, New Mexico, and directly to the south, Ciudad Juarez, Mexico. El Paso City's population was around 649,000 in 2010 and 679,000 in 2020 and El Paso County has over 800,000 residents. El Paso is around 83% Hispanic. El Paso is a majority Latin city, with over 24% of the population being foreign-born [16]. It also includes Hispanics who have been in the area for decades and many generations, thus making it a great place to study the impact of health disparities within the same ethno-racial category. Poverty is directly related to health; this is visible in the U.S.–Mexico border [17].

El Paso experienced mounting pressure as time passed in the first months of the pandemic. Sixty-five people were hospitalized in El Paso in the first week of May 2020, and 17 were put on ventilators [18]. Local public health officials worried El Paso would suffer from limited resources, as the county only had 285 licensed ICU hospital beds [18]. Unfortunately, the City Director of Public Health, Robert Resendes, resigned on 4 May, and his replacement had not been selected at the time of his departure. The city insisted that his resignation would not negatively impact preventative action since the Office of Emergency Management handles public health crises, but the community continued to buzz with concern given that Texas was one of the top ten most infected states, with over 32,954 cases in 2020 [19,20].

Ciudad Juárez, which sits on the Mexican side of the border right next to El Paso, was also grappling with an upward trajectory of COVID-19 cases. El Paso and Ciudad Juárez are sister cities that are economically and socially intertwined. The first case of COVID-19 in the Mexican state of Chihuahua was confirmed in Ciudad Juárez on 17 March 2020, not long after cities in the U.S. began issuing public health mandates, mandatory quarantines, and other lockdown procedures [21]. Since then, the official response paralleled somewhat that of the U.S. because of the lax approach that President Andrés Manuel López Obrador took to prepare for outbreaks. He refused to close the Mexican border to visitors, instead allowing Americans and foreign tourists into the country, even though the U.S. imposed major entry restrictions at its legal entry points [22].

The border cities of Tijuana and Juárez, where Mexican and U.S. nationals travel to and from every day, and the popular destination of Cancún, had the three highest rates of documented COVID-19 cases in Mexico between January and May 2020 [23]. Things grew so dire that Armando Cabada, mayor of Ciudad Juárez, wrote to the foreign affairs secretary to ask that they block Americans from filtering into the city and spreading the coronavirus [22]. Another significant factor that the Mexican government had to consider was the Migrant Protection Protocols, or "Remain-in-Mexico", U.S. program. As a result, Juárez served as a temporary shelter for more than 19,000 Central American and Mexican migrants awaiting decisions on their U.S. asylum applications [24–26]. The foreign affairs secretary, however, did not fulfill Cabada's wishes, and U.S. citizens continued to pass into Mexico. Consequently, hospitals saw a massive influx of patients. Cemeteries were hosting as many as six burials each day, and the cost to bury a loved one increased by some USD 600 [27]. Unlike in El Paso, people living on the urban periphery of Ciudad Juárez had limited access to clean water and could not practice as effectively the CDC-recommended hygienic practices to counter COVID-19 [21]. They also faced other health barriers, such as the lack of COVID-19 testing sites, which increased the number of cases and deaths in the region [22].

3. Data and Methods

The data used in this study were collected through ethno-surveys, which provided close-ended and open-ended data regarding health, employment, socioeconomic status, housing, transborder habits, and citizenship. These surveys were conducted in 2011–2012,

nine years before the start of the pandemic, as part of a study funded by the National Institutes for Health (NIH) conducted by Dr. Ernesto Castañeda and research teams who trained for several months as part of a research methods course. The sample consisted of 1152 Hispanic respondents aged 18 and over residing in El Paso, Texas. All surveys were conducted and recorded in Spanish and/or English (at the preference of the respondent) in a variety of locations in El Paso, such as at individual's homes, shelters, and workplaces. Only close-ended questions from the ethno-surveys are referenced in this study. All researchers who participated in data collection were certified to work with human subjects, and the project had IRB approval from the University of Texas, El Paso. The NIH's National Institute on Minority Health and Health Disparities further reviewed and approved the project before releasing funds.

The risk assessment comprises several analyses conducted using the IBM SPSS 27 statistical package. Notably, we used purposeful sampling techniques [28] that specifically considered the heterogeneity of respondents, such as education levels, profession, housing status, and age, to construct an adequate representation of El Paso's geographic neighborhoods. Furthermore, we stopped data collection when saturation of responses was reached and we had a sample large and diverse enough to generalize to the Hispanic population of the whole city. No exclusionary criteria were identified when recruiting participants beyond self-identification as Hispanic, Latino, Mexican American, Chicano, Mexican, or of Latin American or Caribbean origin [6].

Undocumented Hispanics and those experiencing housing insecurity were over-sampled because of their relative exclusion across census counts and research studies [29]. Therefore, to take these differential selection probabilities into account and adjust to the El Paso demographic, weighted data were utilized to account for this over-sampling in the dataset. Throughout the following sections, we provide descriptive analyses to present various differences in the distributions of citizenship status, social class, and medical insurance coverage, among other factors, across the sample of Hispanic El Pasoans. Pearson's chi-squared tests determined bivariate associations.

The data precede the COVID pandemic, but when we embarked on this analysis, we wondered whether they could be used as a baseline to calculate population risks before the pandemic struck El Paso. It is safe to assume that most of the people who participated in the survey still reside in El Paso and that the demographic and health profile has not changed much; if anything, it may have worsened as the people in the sample have aged, but this also depends on the health status of the younger generations for whom comparative data do not exist. Health data are seen as a personal attribute, and patients' data are protected by HIPA. Even if hospitals engage in big data analysis with their anonymized patient data, they do not have access to all types of populations in a city; thus, the importance of databases such as this.

4. Latinos and High-Risk Populations

4.1. Race and Ethnicity

Risk is not only related to physiological factors but also socioeconomic, cultural, racial, and ethnic ones. The CDC distinguishes racial and ethnic minorities, as well as people who are currently homeless, pregnant, and breastfeeding, as individuals who are "high-risk" for COVID-19 [5]. This is because Latin communities across the U.S. have suffered disproportionately high rates of hospitalization and death caused by the virus compared to other racial and ethnic groups. According to the City of New York and the CDC, Black and Latin communities had borne the brunt of virus-related deaths [14]. In a weekly report, the CDC revealed that although 18% of the U.S. population is Black, 33% of hospitalized COVID-19 cases were among Black people in May 2020 [14].

The Latin population in the United States has received relatively little attention in relation to the pandemic despite its vulnerability to COVID-19. This is especially true in the city of El Paso, Texas, where Hispanics constitute over 83% of the population and have suffered disproportionately from the pandemic's damage [16]. On 28 May 2020, the

city recorded 1029 cases and 22 deaths [18]. Over a year later, the cumulative number of infections surpassed 111,000 and the death toll across El Paso had skyrocketed to 1651 lives lost. Hispanic individuals comprised the vast majority of COVID-related deaths at this time, at 91.25% of the population [30].

4.2. Essential and Frontline Workers

The Hispanic community is an integral part of the U.S. labor force. In 2018, 17% of the national labor force was comprised of documented Hispanic citizens, 61% of whom were Mexican [31]. However, this percentage does not include undocumented workers, who constitute upwards of an estimated 5.1% of the U.S. workforce [32]. This is supported by our data gathered in El Paso, as reported in Table 1, which show that 53.5% of undocumented Hispanics in 2011 were employed. The way the data were obtained means that the unemployed may be students, homemakers, or retired.

Table 1. Employment by Citizenship Status among Hispanics in El Paso, TX in 2011–2012.

Status	Citizen	Resident	Undocumented	Visa	Total
Unemployed	33.6% 138,083	46.5% 36,477	46.5% 8232	19.2% 2530	35.6% 185,322
Employed	66.4% 273,471	53.5% 41,990	53.5% 9461	80.8% 10,655	64.4% 335,577

Note: $p < 0.001$.

Furthermore, the CDC reports that at least 25% of the Hispanic population in the U.S. is employed in the service industry, including hospitality, transportation/travel, delivery, food, healthcare, and education services [33]. Unfortunately, these industries severely struggled under COVID-19 restrictions and regulations, and nonessential businesses laid off millions of workers across the country as a result of forced closures [34]. This was particularly worrisome for undocumented immigrants because they could not file for unemployment insurance and did not qualify for Pandemic Unemployment Assistance (PUA), which was passed in the Coronavirus Aid, Relief, and Economic Security (CARES) Act [35].

Then, there are those who were considered "essential" employees, including people working in grocery stores, mail services, agriculture, city maintenance, and construction, in addition to the service industries mentioned earlier, who were legally required to work in person during the pandemic. Laws surrounding "essential and emergency employees" require that such employees continue working through national emergencies, including those who are immunocompromised or have pre-existing health conditions [36]. This makes it difficult for frontline workers to receive unemployment benefits if they prefer not to work because one must be fired or laid off in order to collect unemployment insurance [37]. Employees who quit during the pandemic were disqualified from unemployment claims, a policy that jeopardizes their financial stability for the sake of maintaining their health. Therefore, "essential" workers were forced to engage with customers and coworkers in close quarters, as before COVID-19 regulations, and thus ran a higher risk of contracting and spreading the virus.

4.3. Prison, Jail, and Juvenile Delinquent Centers

Incarcerated populations in prisons, jails, and juvenile delinquent centers are also at higher risk of severe illness related to COVID-19. The close quarters, shared spaces, and lack of comprehensive medical care in correctional institutions create a breeding ground for the virus. The Marshall Project reports that there were at least 9437 cases of positive COVID-19 diagnoses in state and federal prisons across the U.S. as of 25 April 2020 [38]. As a result, 131 incarcerated individuals and seven prison employees died [38]. The deaths of prisoners rapidly increased throughout the spring months, eventually amounting to 496 dead inmates by 4 June 2020 [39]. There was no testing protocol for individual states at

that time, and many refused to release information regarding the number of prisoners who were tested. The Federal Bureau of Prisons even went so far as to report lower numbers compared to state correctional facilities [40].

In the second year of the pandemic, the institution's reporting habits had not improved. The Federal Bureau released information indicating that 799 federal inmates tested positive for the virus, along with 319 staff members. Although no staff member was among the deceased, 27 inmates died from virus-related complications. Furthermore, three inmates died at Fort Worth Federal Medical Center alone, and all federal prisons in Texas currently had at least one positive diagnosis within the facility [40]. The Marshall Project, however, defines these numbers as "almost certainly an undercount" [38].

This puts racial and ethnic minorities at further risk, given the mass incarceration of communities of color. In the U.S., Hispanics are imprisoned at a rate 1.4 times higher than that of Whites [41]. In 2016, approximately 61% of state prisoners in New Mexico were Hispanic, although approximately 49.1% of people living in New Mexico were Hispanic [42]. The ratio of Black and Hispanic prisoners exceeds that of incarcerated Whites across the country, but the disparities are widest in Texas and other southern states. For example, ranking second only to the number of incarcerated Black individuals, 541 per 100,000 prisoners in Texas are Hispanic [41]. The state's ratio of Hispanic to White prisoners is 2:1, and its neighbor, Arizona, has the highest number of Hispanic prisoners in the U.S. [41].

Juvenile delinquent centers incarcerating children ages 10 to 17 share similar demographic trends with adult correctional institutions. The Department of Justice revealed that Latino youth in the U.S. have a 65% higher chance of being detained and incarcerated than their White counterparts [43]. This profound disparity also exists in Texas, where juvenile prisoners are 1.47 times more likely to be Latino than White [43]. Disproportionate imprisonment because of higher policing and stricter sentencing is also one of the reasons that Black, Hispanic, and other minority communities in the U.S. were contracting, spreading, and dying from COVID-19 at higher rates than White Americans.

4.4. Medical Insurance and Citizenship

Immigration status dramatically impacts an individual's access to healthcare and medical treatment. Our data revealed that the likelihood of being medically insured increased with the stability of immigration status, as detailed in Table 2. In 2011, 89.3% of undocumented Hispanics living in El Paso lacked medical insurance, followed by 66% of lawful permanent residents.

Table 2. Medical Insurance by Citizenship among Hispanics in El Paso, TX in 2011–2012.

Status	Citizen	Resident	Undocumented	Visa	Total
Does not have medical insurance	43.1% 177,533	66.0% 52,188	89.3% 15,792	40.2% 5046	48.0% 250,559
Has medical insurance	56.9% 234,673	34% 26,914	10.7% 1900	59.8% 7515	52% 271,002

Note: $p < 0.001$.

These data were obtained before the Affordable Care Act was passed. Still, the Affordable Care Act does not provide coverage for all immigrants and excludes the undocumented community from nonemergency services [44]. Recipients of Deferred Action for Childhood Arrivals (DACA) have been denied both Medicaid and ACA benefits since 2012, and children of undocumented parents must be lawful residents or citizens in order to qualify for Medicaid or Children's Health Insurance Program (CHIP) services [44]. Despite the implementation of the Affordable Care Act, undocumented individuals have not experienced any major improvement in access to healthcare, so it is unlikely that these figures have changed significantly as a result of the Act.

Upon assessment of Hispanics who fulfilled the CDC criteria for individuals at high risk of severe illness related to COVID-19, our data, as shown in Table 3, revealed that only those insured by Medicaid and Medicare were over-represented in the high-risk category.

Table 3. Health Insurance Plan and High Risk of COVID-19 Complications.

Health Insurance Type	Not at Risk for COVID	At Risk for COVID	Total
Private healthcare plan	51.9% 70,011	43.6% 60,104	47.7% 130,115
Medicaid	8.3% 11,254	12.3% 16,991	10.4% 28,245
Medicare	2.3% 3125	9.5% 13,134	6.0% 16,259
VA	0.9% 1250	2.3% 3135	1.6% 4385
Tricare	6.0% 8125	3.6% 5010	4.8% 13,135
Unspecified healthcare plan	28.7% 38,758	26.8% 36,985	27.8% 75,743
Government employee healthcare	0.9% 1250	0.5% 625	0.7% 1875
Foreign insurance	0.9% 1250	1.4% 1875	1.1% 3125

Note: $p < 0.001$.

4.5. Homelessness

The U.S. struggles to provide affordable housing and address homelessness. In 2019, over 500,000 people were estimated to have been homeless on any given night nationwide [45]. People experiencing homelessness are at high risk of severe illness related to COVID-19 for multiple reasons. There are almost no isolated or private spaces in shelters, encampments, and other congregate housing settings that homeless individuals occupy [46]. People are in close proximity to one another, which makes it challenging to maintain the six feet of distance that medical professionals recommend to inhibit the spread of COVID-19. The Council of Economic Advisers found that around 200,000 people sleep in unsheltered places, such as cars, parks, sidewalks, and abandoned buildings. Those who may not sleep in the presence of others must still interact with people at social service facilities [45].

People experiencing housing instability are also less likely to have access to masks, gloves, and other materials that prevent the spread of the virus. This also includes basic hygienic facilities and necessities, such as soap [46]. They can also rely on public transportation and facilities, such as bathrooms and water fountains. Interacting without precautionary measures increases the possibility of exposure to COVID-19. According to our data collected in El Paso, housing instability lessens the likelihood of having medical insurance. In 2011, only about one-quarter (24.7%) of homeless Hispanics in El Paso were medically insured, which is a much lower percentage than for those who were housed (see Table 2).

Additionally, Hispanics experiencing housing instability constituted only 0.3% of those with a high-risk medical condition. However, they are still considered particularly vulnerable because of their heightened likelihood of contracting COVID-19 and limited access to medical providers. Individuals and families experiencing homelessness who are uninsured have a decreased likelihood of being tested for COVID-19 and adequately treated for potentially fatal symptoms (see Table 4). Furthermore, people who have not sought a visit to a medical clinic or provider are unaware of their health status and may be living with an illness that has gone undiagnosed. So, although our data only show 1% of Hispanics experiencing homelessness as “high risk,” the reality is that unhoused people

may not know enough about their health to provide information that can assess their level of risk [6].

Table 4. Disease Prevalence among Hispanics Experiencing Homelessness.

Health Condition	Percent	*N*
Smoking	22.5%	469
Obesity	18.5%	438
High Blood Pressure	8.1%	219
High Cholesterol	4.3%	117
Diabetes	4.0%	107
Asthma	3.4%	92
Hepatitis or Cirrhosis	2.8%	76
Heart Attack/Stroke	1.9%	51
Kidney Disease	1.5%	31
Cancer	0.5%	10
Tuberculosis	0.5%	10
Emphysema	0.4%	10
HIV/AIDS	0.4%	10
		1640

Note: Unweighted data was used to include all of the oversampled unhoused respondents.

Altogether, experiencing homelessness can almost guarantee poorer health outcomes. Compared to housed individuals, people who have ever experienced homelessness are more likely to face health issues, have unmet healthcare needs, and be subject to accelerated health erosion [47–49]. Their obstructed access to basic hygienic amenities, isolated spaces, and medical care makes it challenging for homeless individuals to protect themselves from COVID-19.

4.6. Socioeconomic Status

Of the total sample, 52.1% could be classified as low-income and 7.1% as high-income. Racial and ethnic minorities who are low-income are at heightened risk of severe illness related to COVID-19. As shown in Table 5 below, Hispanics with a lower SES are more likely to have a pre-existing high-risk illness that renders them physiologically vulnerable to COVID-19.

Table 5. Hispanics with High-Risk Pre-Existing Health Conditions by Socioeconomic Status.

Socioeconomic Status	High-Risk
Low SES	53.8% 146,205
Medium SES	45.0% 95,793
High SES	37.4% 13,790

Note: $p < 0.001$.

It is vital to analyze the risks associated with socioeconomic status, race, ethnicity, and pre-existing health conditions because they are often co-occurring factors that influence an individual or community's well-being and life expectancy. Similarly, among immigrants, income and employment are intimately associated with citizenship, immigration status, and health insurance. The same is true for people experiencing homelessness, who are typically low-income and vulnerable to COVID-19 [46].

5. Latinos and High-Risk Pre-Existing Health Conditions

In May 2020, the CDC stated that "older adults and people of any age who have serious underlying medical conditions" are at highest risk of severe illness from COVID-19 [5]. It defines severe illness as "hospitalization, admission to the ICU, intubation or mechanical ventilation, or death" that is caused or exacerbated by the contraction of COVID-19 [50]. Furthermore, the umbrella term of "serious underlying medical conditions" refers to people with chronic lung diseases, severe asthma, heart conditions, obesity, diabetes, immunocompromising illnesses (including, but not limited to chemotherapy/radiation or organ/bone marrow transplantation, HIV/AIDS, or prolonged use of corticosteroids), liver disease, and those undergoing dialysis for chronic kidney disease [5]. The CDC Morbidity and Mortality Weekly Report released on 17 April 2020 disclosed that 89.3% of people hospitalized due to COVID-19 had at least one of the following underlying health conditions: hypertension (49.7%), obesity (48.3%), chronic lung disease (34.6%), type 2 diabetes mellitus (28.3%), or cardiovascular disease (27.8%) [51]. Table 6 shows the distribution of our sample according to our created risk categories.

Table 6. Number of Pre-Existing Health Conditions Associated with Severe Illness Related to COVID-19 among Hispanics in El Paso in 2011–2012.

Risk Assessment	Percent	*N*
No risk factors	50.70%	266,383
1 risk factor	31.90%	167,396
2 risk factors	15.50%	81,278
3 or more risk factors	2.00%	10,264
		525,321
Not at-risk	50.70%	266,383
At-risk	49.30%	258,938
		525,321
Deaths (as of 22 April 2021)		2506
El Paso County pop. 2019		839,238
Death rate	0.3% of the population	
U.S. Death rate	0.00%	
Global Death rate	~0.4%	

Sources: Reuters Graphics [12,13], U.S. Census Bureau [16].

In the section below, we outline a set of analyses that explore the prevalence of high-risk pre-existing health conditions as they relate to medical insurance status, socioeconomic status, medication, age, and homelessness. We included data on medical insurance, socioeconomic status, and age for all conditions. We included information on medication and homelessness only when the findings were at least statistically significant at $p < 0.01$ or significantly exceeding the average percentage of the sample population.

Table 7 below reflects the prevalence of high-risk health conditions and diseases in the Hispanic community of El Paso in 2011–2012.

Two variables were created to paint a clearer picture of Hispanics' COVID-19 risk profiles. Individuals who had been diagnosed with one or more of the above diseases were categorized into an "at-risk" group, and then further sorted according to their pre-existing condition. Those with two or more, as well as three or more, conditions were grouped into their respective categories because of their compounded physiological vulnerabilities to severe illness related to COVID-19. Emphysema, tuberculosis, and HIV/AIDS were not included in these variables, and because their prevalence is very low, this does not have a significant effect on the results. The table below outlines the percentage of the Hispanic population of El Paso in 2011–2012 that is considered high-risk according to an individual's number of pre-existing conditions (see Table 8).

Table 7. High-Risk Illness and Disease Prevalence among Hispanics in El Paso.

Health Condition	Percent	*N*
Obesity	26.2%	95,818
Smoking	17.7%	92,989
High Blood Pressure	16.0%	83,980
High Cholesterol	12.9%	67,629
Asthma	7.6%	40,100
Diabetes	7.3%	38,235
Heart Attack/Stroke	2.6%	13,810
Kidney Disease	2.3%	11,905
Hepatitis or Cirrhosis	2.2%	11,326
Cancer	1.4%	7510
Emphysema	1.3%	6885
Homelessness	0.5%	2707
Tuberculosis	0.2%	1260
HIV/AIDS	<0.1%	10

Table 8. High-Risk Pre-Existing Health Conditions Associated with Severe Illness Related to COVID-19 Among Hispanics.

Health Condition	Percent	*N*
Obesity (only)	17.4%	45,000
High Blood Pressure (only)	11.3%	29,389
Diabetes (only)	3.9%	9999
Asthma (only)	7.2%	18,754
Heart Attack/Stroke (only)	0.7%	1875
Kidney Disease (only)	0.7%	1875
Cancer (only)	0.5%	1250
Smoking (only)	21.3%	55,043
Homelessness (only)	1.6%	4203
2 of the above	31.4%	81,278
3 or more	4.0%	10,264

Obesity, hypertension, asthma, and type 2 diabetes were the most common illnesses to render Hispanics at high risk. Most notably, however, is that the majority of Hispanic individuals had been diagnosed with one or more health conditions that put them at risk of dying from COVID. Altogether, those with compounded risk comprised about one-third of the total Hispanic population of El Paso at the time that the survey was taken. This indicates poor widespread health outcomes in the community overall and the importance of extreme public health precautions in dealing with respiratory pandemics.

Additionally, differences in disease prevalence arose when risk was cross-analyzed with place of birth. In Table 9, those with at least one pre-existing health condition were considered higher risk, and those with no pre-existing health condition were categorized as lower risk. Native-born Hispanics made up a slightly smaller portion of high-risk individuals, revealing a lesser likelihood of being diagnosed with a high-risk pre-existing health condition if they had been born in the U.S. These data suggest that birthplace is statistically associated with an individual's risk of contracting COVID-19. Hispanic immigrants in El Paso showed a collectively higher risk profile.

Table 9. Hispanics Diagnosed with High-Risk Pre-Existing Health Conditions by Birthplace.

At Risk for COVID-19	Born in the U.S.	Foreign Born	Total
Higher risk	47.4% 146,417	52.0% 112,521	50.7% 266,383
Lower risk	52.6% 162,588	48.0% 103,795	49.3% 258,893

Note: $p < 0.001$.

These disparate health outcomes were more closely examined by separating each specific illness according to individuals' birthplaces, shown below in Table 10. Hispanics born outside of the U.S. bore the brunt of type 2 diabetes, hypertension, kidney disease, and cancer diagnoses. Foreign-born Hispanics were also slightly more likely to have two high-risk pre-existing health conditions. On the other hand, U.S.-born individuals reported higher rates of asthma and smoking, indicating that immigrant Hispanics and U.S.-born Hispanics struggle with different health concerns in El Paso.

Table 10. Pre-Existing Health Conditions Associated with High Risk of Severe Illness Related to COVID-19, According to Birthplace.

Health Condition	Born in the U.S.	Foreign-Born
Obesity (only)	18.4%	16.1%
High Blood Pressure (only)	11.1%	11.7%
Diabetes (only)	2.1%	6.1%
Asthma (only)	9.4%	4.4%
Heart Attack/Stroke (only)	0.4%	1.1%
Kidney Disease (only)	0.0%	1.7%
Cancer (only)	0.0%	1.1%
Smoking (only)	22.6%	19.5%
Homelessness (only)	1.0%	2.4%
2 of the above	30.5%	32.5%
3 or more	4.4%	3.4%

Note: $p < 0.001$.

These findings challenge previous research on what scholars have labeled the "Immigrant Paradox". A close cousin of the Hispanic Health Paradox, this contradiction arose when researchers began seeing an unexpected pattern in the health outcomes of foreign-born people in the U.S. In general, the Paradox asserts that immigrants exhibit significantly better physical and mental health compared to their native-born counterparts, even within racial and ethnic subgroups of the country's population [52–55]. Our data, however, reflect the opposite: Hispanic immigrants were more likely than those born on U.S. soil to be diagnosed with a range and multiplicity of chronic illnesses, all of which are associated with severe sickness upon contraction of COVID-19.

5.1. High Blood Pressure

In El Paso, 16.0% of Hispanics reported a high blood pressure diagnosis, and 59.5% of them were low-income. High blood pressure, also known as hypertension, has been coined the "silent killer" given the absence of symptoms that accompany it. Many people go unaware of their high blood pressure, which can lead to the development of kidney disease, cardiovascular diseases, or fatal cardiac events, such as heart attack or stroke [56]. According to our data, 23.2% of adult Hispanics had never had their blood pressure checked. These numbers are concerning because the contraction of COVID-19 is especially dangerous for people with hypertension. The CDC reported that 49.7% of people hospitalized due to virus-related complications had hypertension in March 2020 [51]. Given the high number of those who had never checked their blood pressure, this analysis only accounted for Latin individuals who were aware of their blood pressure status, in addition to a large subsample whose blood pressure was measured as part of the study, as we discuss elsewhere [6].

Although high blood pressure is a cause of serious health conditions, medical coverage varied greatly among those with diagnoses. Our analysis revealed that 33.7% of Hispanics were aware of their high blood pressure but were not medically insured. Even though these

individuals knew of their diagnosis, they either chose not to enroll in medical insurance or could not because of cost or citizenship status.

5.2. Cholesterol

High cholesterol was almost equally as common as hypertension within our sample, as 12.9% of Hispanics reported being diagnosed by a health professional. Similar to high blood pressure, people are often unaware of their cholesterol levels until a serious or fatal event occurs. High cholesterol is a predicting factor of heart disease, hypertension, and type 2 diabetes [57]. Low-lipid cholesterols increase plaque growth in the arteries that flow to the brain and heart, eventually accumulating to the point where blood struggles to pass [58]. Heart attack (myocardial infarction) and stroke occur when plaque buildup has completely obstructed the blood from flowing through the arteries [57]. Both are extremely dangerous health conditions that exhibit little to no symptoms, and the lack of knowledge regarding residents' blood pressure and cholesterol status might render them especially susceptible to health complications caused by COVID-19.

This analysis showed that 28.8% of those diagnosed with high cholesterol did not have medical insurance at the time. More than half (52.8%) of those who had been diagnosed were low-income, whereas 10.2% were high-income. Because of these disparate figures, it is possible that socioeconomic status plays a role in the stress and diet, both of which impact cholesterol levels of Hispanic El Pasoans. Age was also an important factor in analyzing cholesterol, as the majority of cases occurred among people between the ages of 46 and 65.

5.3. Asthma

The study revealed that 7.6% of Hispanics reported asthma diagnoses. When treated and closely monitored, asthma is not life-threatening. However, if someone with asthma has an asthma attack and lacks access to an inhaler or ventilator, then it can be fatal. An attack is caused by severe inflammation that constricts and narrows the air passages that lead to the lungs [59]. Communicable diseases, such as the flu or an upper respiratory infection, can trigger an asthma attack [59]. It is dangerous to be unaware of the condition because those with asthma are at higher risk of complications or death after contracting a communicable illness. Although it is unknown whether COVID-19 induces asthma attacks, shortness of breath and dry cough are common symptoms of the virus that alter the flow of breath through the airways [60]. Severe symptoms and difficulty breathing might trigger an asthma attack, so medical professionals warn individuals with asthma to take caution. Nonetheless, there has been no information that distinguishes asthma attacks from common symptoms of COVID-19. Because of this, virus-related symptoms may be mistaken as a routine asthma attack and deter individuals with asthma from seeking medical attention.

Out of this portion of the Hispanic population in El Paso, approximately half (51.7%) did not have medical insurance to help them manage their asthma diagnosis prior to the Affordable Care Act. An individual's socioeconomic status also informed the likelihood of receiving an asthma diagnosis, given that 56.3% of Hispanic residents with asthma were low-income and 42.1% middle-income.

5.4. Heart Attack/Stroke

A small percentage (2.6%) of Latin individuals in El Paso reported a previous heart attack or stroke. Given the significance of socioeconomic status and medical insurance in the previous analyses, it is perhaps unsurprising that 27.4% were not medically insured, and an overwhelming percentage (72.8%) were low-income. Socioeconomic status was also associated with the use of medication to treat heart attack or stroke, as half (50.2%) of low-income Latin individuals who received this diagnosis reported being on medication compared to 83.2% of middle-class Hispanics.

When examining the age groups most affected by these conditions, our data showed that 27.2% of heart attacks or strokes were reported by people between the ages of 60 and 80. Deaths caused by COVID-19 are highest among those over the age of 64, so Latin individuals

in this age group who have suffered a heart attack or stroke have compounded risk factors that render them disproportionately vulnerable to COVID-19-related complications [61].

Heart attack and stroke are often caused by high cholesterol, as the low-lipid cholesterols create buildups of plaque that block proper blood flow to the heart and brain [57]. A heart attack is defined as a form of cardiovascular disease by itself, but it may also be an indicator of heart diseases such as arteriosclerosis, diabetes, or coronary artery disease [57]. Further, the CDC reported that 27.8% of COVID-related hospitalizations were among people with cardiovascular disease [51]. Heart attack and stroke are both potentially fatal health events that affect an individual for the rest of their life. For example, Cione's father experienced three heart attacks before receiving a diagnosis of arteriosclerosis. He was prescribed multiple pharmaceuticals that altered his metabolism, sleep quality, mood, energy levels, and ability to eat. His diet changed drastically, and he must regulate his consumption of cholesterol-rich foods for the remainder of his life.

The physiological processes leading to stroke are similar to those that result in heart attacks, although the life-long impacts may differ greatly. Depending on the part of the brain that was depleted of blood, stroke can cause paralysis, memory loss, changes in behavior, speech issues, and/or vision impairment. In extreme cases, individuals lose entirely the ability to speak or move their body [62]. Those who are medically uninsured and have experienced one or both of these health events are at higher risk of other health complications, such as an additional heart attack or stroke, if they do not receive proper follow-up care.

5.5. Emphysema

A minority (1.3%) of survey participants had received an emphysema diagnosis. Emphysema is a chronic lung disease that heightens one's susceptibility to severe illness [51]. Smoking tobacco is the most common cause of emphysema, but air pollution and respiratory infections can also cause or aggravate it. It is defined as a chronic obstructive pulmonary disease (COPD), and people can live with emphysema for years before symptoms develop [63]. Medical treatment typically involves medications, surgery, and oxygen therapy, but it is typical for those with emphysema to forgo these costly treatments [63,64].

Our data revealed that about one-quarter (27.4%) of those who were diagnosed with emphysema was not medically insured. Furthermore, emphysema was associated with lower socioeconomic status, as 54.5% of those with emphysema were low-income, whereas none were high-income. Regarding age, emphysema most commonly affected people ages 60–85, an age group that has been classified as particularly susceptible to severe illness or death related to COVID-19 [5].

5.6. Hepatitis or Cirrhosis

A total of 2.2% of the Hispanic population of El Paso reported a diagnosis of hepatitis, cirrhosis, or both. All hepatitis infections (A, B, C, D, and E) are inflammatory and occur in the liver, as well as cirrhosis, as cirrhosis is technically the progression of any liver disease [65]. Hepatitis B and C are the most common causes of cirrhosis, and those who are most at risk of contracting B, C, and D are injection drug users and those who practice unsafe sex [65]. While Hepatitis A is curable, all its other types are not [65]. Injection drug use and unsafe sex are risk factors also associated with the contraction of HIV, and any HIV-positive person who contracts hepatitis is at severe risk of health complications [66].

Of those who received a diagnosis, 33.6% are not medically insured. This diagnosis was distributed unequally across socioeconomic classes, given that low-income Hispanics once again constituted the majority at 77.8%, which is also the highest percentage across the illnesses in this risk assessment. Clearly, hepatitis and cirrhosis diagnoses are impacted by an individual's financial and social standing. This diagnosis also happened to almost exclusively strike young people between the ages of 18 and 30, indicating that younger people may be more susceptible to contracting hepatitis or developing cirrhosis.

5.7. Kidney Disease

Around 2.3% of Hispanic study participants reported kidney disease, of whom 42.2% did not have medical insurance and therefore struggled to receive regular care. Many of those with kidney disease diagnoses were middle-income (52.8%) and low-income (41.3%). Kidney disease is an illness that does not exhibit symptoms until the occurrence of a potentially fatal event, such as kidney failure. It is intimately linked with heart disease, diabetes, high blood pressure, and certain forms of cardiovascular disease known to cause or evolve into kidney disease. Further, it is a chronic disease, meaning that the kidneys are permanently damaged and cannot properly filter blood. Unless the patient immediately changes their diet and seeks medical treatment, their condition will worsen with time [67]. A share of 36.4% of Hispanics in El Paso with kidney disease are above the age of 60, which adds another layer of risk in the case of a positive COVID-19 diagnosis.

5.8. Cancer

Those with cancer diagnoses amounted to 1.4% of the Hispanic population, which is approximately equal to the proportions of kidney disease and heart attack/stroke. The ethno-surveys also revealed that 16.8% of Hispanic residents of El Paso who had cancer were uninsured, one of the lowest rates of lacking medical insurance across this report. This could be because the culture surrounding cancer in the United States is serious and fearful, which encourages people to remain insured after a diagnosis. People who are nearing remission, are in remission, or may have been diagnosed as a child are also among those who are likely to be insured.

Approximately half of the Hispanic residents diagnosed with cancer at some point in the past are of low socioeconomic status (50.1%), whereas 40.9% are considered middle-class. However, the ages of people who reported cancer diagnoses at one point in their lives varied greatly: 8.3% were ages 18–25, 16.6% were ages 31–35, and 8.3% were ages 46–50. Ultimately, the highest rates were reported by people between the ages of 51 and 65, who constituted 58.2% of the diagnosed population. This is significant because people ages 65 and older are considered "high risk" by the CDC for COVID-19. Hispanics who also have cancer are more likely to be negatively impacted by COVID-19. Nonetheless, this overall assessment shows how uncommon it is for older Hispanic people in El Paso to have cancer.

5.9. HIV/AIDS

The unweighted sample with over-representation of people experiencing homelessness has a 0.2% HIV rate. In our survey, 100% of those with HIV/AIDS were homeless at the time of the survey. Given the high-risk status associated with being homeless and having a positive HIV/AIDS diagnosis, respectively, this portion of the Latin population is extremely vulnerable to health complications or death related to COVID-19.

The percentage of those with HIV/AIDS in our weighted data constitutes about 0.00002% of all Hispanics living in El Paso, which is significantly lower than the 2019 national percentage of 0.34% [66,68]. However, the stigma surrounding HIV/AIDS makes people wary of getting tested and learning about prevention methods. It is estimated that 1 in 7 people living with HIV/AIDS in the United States are unaware of their positive status [66]. Therefore, it is likely that there are other HIV/AIDS-positive Latin people living in the region.

None of the HIV/AIDS-positive Hispanic residents in the sample were medically insured. Although the number of HIV/AIDS-positive people in the data is small, it is nonetheless worrisome, considering that HIV/AIDS killed over 37,000 people in the U.S. in 2018 [69]. The year before, 53% of new known HIV cases were diagnosed in the South, 21% of which were among Hispanics/Latinos. Although numbers have gradually decreased over the past few years, the rate of new cases in Texas was 15.4 per 100,000 in 2019 [69]. Care for the HIV/AIDS-positive community in the region is also subpar. Recently, the U.S. South reported the lowest number of HIV-positive people who received medical care and had a suppressed viral load from being treated with antiretroviral therapy [69].

Similarly, according to our data, only half of the Hispanic residents with HIV/AIDS were on medication in 2011. Whether the medication being taken was antiretroviral therapy is unknown, so it is possible that even fewer were being treated for HIV/AIDS.

5.10. Tuberculosis

The rates of tuberculosis are falling 2% each year globally, but it is still one of the top 10 leading causes of death worldwide [70]. A quarter of the global population has the tuberculosis bacteria lying dormant in their system, so others in the Hispanic community in El Paso may have contracted the bacteria as well. Only 5–15% of these people are estimated to fall ill with tuberculosis, but those with compromised immune systems and pre-existing conditions are at high risk of developing the illness. For instance, HIV/AIDS-positive people are 19 times more likely to die from tuberculosis, which causes further concern that many HIV/AIDS-positive people lack medical insurance [70].

The prevalence of tuberculosis is low in the El Paso community. Only 0.2% of the Hispanic community of El Paso reported having tuberculosis at one point in their lives, approximately half (49.6%) of whom have medical insurance. This is concerning because all of the tuberculosis diagnoses occurred among Hispanic people of low socioeconomic status who might not be able to afford the proper treatment or medicines without pharmaceutical or medical insurance coverage. Individuals over the age of 45 recalled no previous bouts of tuberculosis—instead, almost half of the reported diagnoses occurred among people aged 18–25.

5.11. Diabetes

According to our survey data, 7.3% of Hispanics in El Paso reported a diabetes diagnosis, 60.1% and 3.3% of whom were low-income and high-income, respectively. More than half (65.5%) had medical insurance, but 34.5% were not insured. According to the CDC, diabetes puts one at considerably higher risk of severe health complications related to COVID-19 given that nearly half (49.7%) of people hospitalized with severe virus-related illness as of 30 March 2020 had a previous diabetes diagnosis [51].

Low insulin adherence, which puts individuals in danger of unregulated and dangerous blood sugar levels, can be attributed to multiple factors such as access, affordability, willingness, and guidance on self-administered injection. This was a concern with our sample because only 31.2% of Hispanics with diabetes took insulin at least once. Positive diabetes diagnoses varied considerably according to age, and Hispanics over the age of 60 constituted 29.3% of total cases. This presents evidence that an insulin adherence barrier affected multiple different age groups. Previous research has drawn connections between low insulin usage and depression, embarrassment, a busy schedule, and travel among people living with type 2 diabetes [71,72]. Patients have also reported fears associated with insulin-related weight gain and accidental hypoglycemia, or low blood sugar, induced by an overproduction or excessive dosage of insulin [73]. In a study conducted by Hu et al., Hispanic immigrants with type 2 diabetes conflated insulin therapy with a death sentence, calling it a "last resort" and expressing that they feared injections because the insulin itself might cause further damage [74]. Many participants, especially women, cited a lack of positive family support and access to syringes as barriers to proper insulin use [74].

The survey data draw awareness to a persistent problem affecting the Hispanic community's well-being. Individuals with diabetes who are not receiving proper insulin treatment, if receiving any at all, will likely be hit harder by a positive COVID-19 diagnosis than those who follow regular schedules and guidelines outlined by a health provider. These are significant findings that reveal the disproportionately poor health experienced by Hispanic individuals living with chronic diseases and inform us of who might be especially vulnerable to COVID-19.

5.12. Obesity

Just over one-quarter (26.2%) of survey participants were considered obese, of whom 3.4% were considered severely obese with a Body Mass Index (BMI) of 40 or higher [51]. Almost half of obese Hispanics lived without medical coverage, and 58.2% of those diagnosed as obese were low-income. Over one-third (38.3%) received a diagnosis between the ages of 18 and 30, although 10.8% of obese Hispanics were ages 61 and older.

Obesity, characterized by a body mass index of 30 or higher, increases a person's vulnerability to severe illness related to COVID-19 [51]. The CDC reported that 48.3% of individuals hospitalized for virus-related health complications were obese in March 2020 [51]. Before COVID-19, obesity was regarded as a public health issue for the U.S. Hispanic population. In 2019, an estimated 80.4% of Hispanics living in the United States were overweight or obese and were more likely to be obese than White adults [75,76]. These trends are concerning because obesity is associated with many health conditions, including type 2 diabetes, hypertension, stroke, coronary heart disease, sleep apnea, certain cancers, and gallbladder disease [77]. Some of these conditions, as previously discussed, increase the risk of complications from COVID-19.

6. Conclusions

Throughout this paper, we dissect the socioeconomic factors that tie into health and well-being and their detrimental effect on racial and ethnic minorities. The COVID-19 pandemic, albeit unexpected, further exposed and reproduced health disparities that were previously less discernible to the general public. The Hispanic community across the United States is already at higher risk of COVID-19 because of institutional discrimination across the sectors of employment, housing, and health. In El Paso, where more than half of Hispanics were of low socioeconomic status, and 48% lacked medical insurance a decade before, their chances of suffering from severe illness related to COVID-19 are even higher. This is particularly dangerous for those with pre-existing health conditions, such as type 2 diabetes, cardiovascular disease, HIV/AIDS, and cancer. It remains unclear whether more Hispanics living in the U.S. will die from COVID-19 than other racial and ethnic groups, as the pandemic has not run its full course. However, preventive measures must be taken in order to protect the Hispanic community in El Paso from tragedy, including the proper allocation of health resources and financial support for low-income, homeless, undocumented, and medically uninsured individuals.

Although discussion of racial disparities is critical, it is just the tip of the iceberg. Health disparities explain how communities of color disproportionately suffer from poor health, but not why state and federal institutions do not properly allocate health resources. The heart of the problem lies in systemic racism, discrimination, and state-sanctioned violence against minorities. Given that communities of color face many structural inequalities, such as poverty, residential segregation, racism, and access to healthcare, they are not to blame for pre-existing or virus-related health disparities [78]. We should take caution in our reporting of racial and ethnic inequities to ensure that data are contextualized within a critical understanding of structural factors that cause disproportionate COVID-19 rates among minority groups.

In this study, we have outlined how it is not a coincidence that infection and death rates of COVID-19 among Native American, Black, and Hispanic populations in the U.S. have been among the highest in the world since the beginning of the pandemic. Structural inequalities incurred by institutional racism have created, and continue to create, underlying medical conditions and enable increased exposure to the virus, which puts Native American, Black, and Hispanic citizens in far more vulnerable positions regarding COVID-19 than their non-Hispanic White counterparts. When assessing preventative and recovery measures, policymakers and public health officials should consider pre-existing health disparities and their heightened likelihood of working essential or frontline jobs [31,32]. Cities and towns with higher numbers of working-class Latin people should be prepared to conduct extensive community-based health education and outreach through *promotoras*

de salud and provide referrals to critical medical care for sub-populations at higher risk. In addition, further research should investigate the lasting effects of COVID-19 infection and "long-COVID" on these groups.

The dataset used to assess the risk that the population of a city had to COVID was collected much before the pandemic started. Nonetheless, this paper shows how similarly detailed data about a city or population can and should be used by public health officials in a preventive fashion to reduce deaths. Public health data should not be limited to prevalence rates, and epidemiology, but should also include social variables and cultural and sociological insights to include the role of beliefs and ideas in health-seeking behavior and the role of socioeconomic factors in producing different health outcomes between and among ethnic and racial groups. Migration and immigration status are essential determinants of health and well-being. Longitudinal health and social data of large and diverse samples that oversample minority, immigrant, and unhoused individuals are an important tool in creating a healthy population.

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References

1. Lovelace, B. White House Officials Worry the Coronavirus Is Hitting African Americans Worse than Others. Available online: https://www.cnbc.com/2020/04/07/white-house-officials-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html (accessed on 28 April 2021).
2. Nania, R. Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show. Available online: https://www.aarp.org/health/conditions-treatments/info-2020/minority-communities-covid-19.html (accessed on 28 April 2021).
3. Barr, D. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health*, 2nd ed.; Johns Hopkins University Press: Baltimore, MD, USA, 2014.
4. Premji, S.; Duguay, P.; Messing, K.; Lippel, K. Are Immigrants, Ethnic and Linguistic Minorities Over-Represented in Jobs with a High Level of Compensated Risk? Results from a Montréal, Canada Study Using Census and Workers' Compensation Data. *Am. J. Ind. Med.* **2010**, *53*, 875–885. [CrossRef] [PubMed]
5. Centers for Disease Control and Prevention. People at Increased Risk and Other People Who Need to Take Extra Precautions. Available online: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html (accessed on 28 April 2021).
6. Castañeda, E.; Smith, B.; Vetter, E. Hispanic Health Disparities and Housing: Comparing Measured and Self-Reported Health Metrics Among Housed and Homeless Latin Individuals. *J. Migr. Health* **2020**, *1–2*, 100008. [CrossRef] [PubMed]
7. Moya, E.M.; Zamore, C.; Perez, L.M.; Tellez, K.; Avila, A.; Aragones, A. COVID-19 Imperils Access to Health and Human Services in El Paso, Texas and New York City: Perspectives from Hispanic Parents. *J. Racial Ethn. Health Disparities* **2022**, *9*, 1024–1029. [CrossRef] [PubMed]

8. Castañeda, E. Latinos in El Paso at Risk from COVID-19. Available online: https://ernestoc.medium.com/latinos-in-el-paso-at-risk-from-covid-19-1c508c564d24 (accessed on 11 December 2022).
9. The High COVID-19 Death Toll in Texas-Mexico Border Towns. Available online: https://time.com/6074581/covid-19-deaths-texas-mexico-border/ (accessed on 11 December 2022).
10. Moore, R. A Year into the Pandemic, COVID-19 Has Ravaged El Paso. Available online: http://elpasomatters.org/2021/03/14/a-year-into-the-pandemic-covid-19-has-ravaged-el-paso/ (accessed on 11 December 2022).
11. Castañeda, E. Speaking about Health Disparities: A Teachable Moment about Structural Racism. Available online: https://ernestoc.medium.com/speaking-about-health-disparities-a-teachable-moment-about-structural-racism-2774dc5f44b (accessed on 11 December 2022).
12. Reuters Graphics. COVID-19 Global Tracker. Available online: https://graphics.reuters.com/world-coronavirus-tracker-and-maps/ (accessed on 28 April 2021).
13. Reuters Graphics. Tracking the Novel Coronavirus in the U.S. Available online: https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html (accessed on 28 April 2021).
14. Bureau of Communicable Disease Surveillance System. Age-Adjusted Rates of Lab Confirmed COVID-19. Available online: https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf (accessed on 16 April 2020).
15. NYC Health. COVID-19: Data, Details on Deaths. Available online: https://github.com/nychealth/coronavirus-data/blob/master/by-race.csv (accessed on 16 April 2020).
16. U.S. Census Bureau. U.S. Census Bureau QuickFacts: El Paso County, Texas. Available online: https://www.census.gov/quickfacts/fact/table/elpasocountytexas/PST045219? (accessed on 28 April 2021).
17. Lachica, J.; Castañeda, E.; McDonald, Y. (Eds.) *Poverty, Place, and Health along the US-Mexico Border*; Poverty and Health: A Crisis among America's Most Vulnerable. Volume 2: Place and Health among the Vulnerable; ABC-CLIO: Goleta, CA, USA, 2013.
18. KTSM Staff. El Paso COVID-19 Cases Surpass 1,000 Mark. Available online: https://www.ktsm.com/local/el-paso-news/el-paso-covid-19-cases-surpass-1000-mark/ (accessed on 28 April 2021).
19. Willard, K. Public Health Director in El Paso Resigns as City Response to COVID-19 Continues. Available online: https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues (accessed on 28 April 2021).
20. Coyne, M. The U.S. May Be Heading to A Second (or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means. Available online: https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/ (accessed on 28 April 2021).
21. Cervantes Holguín, E.; Gutiérrez Sandoval, P.R. Resistir la Covid-19. Intersecciones en la Educación de Ciudad Juárez, México. *RIEJS* **2020**, *9*, 7–23. [CrossRef]
22. Pane, L.M.; Coronado, A. Virus Pushes Twin Cities El Paso and Juarez to the Brink. Available online: https://apnews.com/article/business-virus-outbreak-family-gatherings-north-america-mexico-e066bb7aaf4ad1c2417254c24c0e835c (accessed on 28 April 2021).
23. Berumen, J.; Schmulson, M.; Alegre-Díaz, J.; Guerrero, G.; Larriva-Sahd, J.; Olaiz, G.; Wong-Chew, R.M.; Cantú, C.; Ochoa-Guzmán, A.; Garcilazo-Ávila, A.; et al. Risk of Infection and Hospitalization by Covid-19 in Mexico: A Case-Control Study. *medRxiv* **2020**. [CrossRef]
24. Navarrete, B.; Sanchez, G. Risks and Challenges to Migrants, Asylum Seekers and Refugees Living Under COVID-19 in Ciudad Juárez, Mexico. *Migr. Policy Pract.* **2020**, *10*, 48–53.
25. Kahn, C. "Remain in Mexico" Policy's End Brings Renewed Hope to Asylum Seekers. Available online: https://www.npr.org/2021/02/14/967807189/remain-in-mexico-policys-end-brings-renewed-hope-to-asylum-seekers (accessed on 28 April 2021).
26. Castañeda, E. Expulsión de Migrantes Como Oportunidad Perdida y Tarea Para Sísifo. *Rev. Mex. De Sociol.* **2023**, *85*, 229–238.
27. Martinez, V. "Every Day I See Death": Gravediggers in Juarez Perform Grim Labor as COVID-19 Death Toll Rises in Mexico. Available online: https://www.elpasotimes.com/in-depth/news/local/juarez/2020/11/19/coronavirus-juarez-mexico-death-toll-cemetery-workers-covid-19/6248165002/ (accessed on 28 April 2021).
28. Neuman, W.L. *Social Research Methods: Qualitative and Quantitative Approaches*; Allyn & Bacon: Boston, MA, USA, 2011.
29. O'Hare, W.P. *Differential Undercounts in the U.S. Census: Who Is Missed?* Springer Nature: Berlin/Heidelberg, Germany, 2019; ISBN 978-3-030-10973-8.
30. El Paso Strong. City of El Paso COVID-19 Cases. Available online: https://www.epstrong.org/results.php (accessed on 28 April 2021).
31. U.S. Bureau of Labor Statistics. *Labor Force Characteristics by Race and Ethnicity, 2018*; BLS Reports; U.S. Bureau of Labor Statistics: Washington, DC, USA, 2019; pp. 1–83.
32. Passel, J.; Cohn, D. Share of Unauthorized Immigrant Workers in Production, Construction Jobs Falls Since 2007. Available online: https://www.pewresearch.org/hispanic/2015/03/26/share-of-unauthorized-immigrant-workers-in-production-construction-jobs-falls-since-2007/ (accessed on 28 April 2021).
33. Centers for Disease Control and Prevention. Health Equity Considerations & Racial & Ethnic Minority Groups. Available online: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html (accessed on 28 April 2021).
34. Villa, L. Millions of Americans Have Been Laid off Amid the Coronavirus Outbreak. Here's What It's Like to Be One of Them. Available online: https://time.com/5812538/coronavirus-economic-damage-workers/ (accessed on 28 April 2021).

35. Smith, R. Fact Sheet: Immigrant Workers' Eligibility for Unemployment Insurance. Available online: https://www.nelp.org/publication/immigrant-workers-eligibility-unemployment-insurance/ (accessed on 28 April 2021).
36. District of Columbia Department of Human Resources. E-DPM Instruction No. 12-51. 2013. Available online: https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf (accessed on 28 April 2021).
37. Stewart, E. The Essential Worker Trap. Available online: https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state-reopening (accessed on 28 April 2021).
38. Park, K.; Meagher, T.; Li, W. Tracking the Spread of Coronavirus in Prisons. Available online: https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons (accessed on 28 April 2021).
39. The Marshall Project. A State-by-State Look at Coronavirus in Prisons. Available online: https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (accessed on 28 April 2021).
40. Federal Bureau of Prisons. BOP: COVID-19 Update. Available online: https://www.bop.gov/coronavirus/ (accessed on 28 April 2021).
41. Nellis, A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. Available online: https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/ (accessed on 28 April 2021).
42. Data USA. New Mexico. Available online: https://datausa.io/profile/geo/new-mexico (accessed on 28 April 2021).
43. The Sentencing Project. Latinx Disparities in Youth Incarceration. Available online: https://www.sentencingproject.org/publications/latino-disparities-youth-incarceration/ (accessed on 28 April 2021).
44. National Immigration Law Center. Immigrants and the Affordable Care Act (ACA). Available online: https://www.nilc.org/issues/health-care/immigrantshcr/ (accessed on 28 April 2021).
45. The Council of Economic Advisers. The State of Homelessness in America. Available online: https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf (accessed on 1 May 2021).
46. Tsai, J.; Wilson, M. COVID-19: A Potential Public Health Problem for Homeless Populations. *Lancet Public Health* **2020**, *5*, e186–e187. [CrossRef] [PubMed]
47. Lebrun-Harris, L.A.; Baggett, T.P.; Jenkins, D.M.; Sripipatana, A.; Sharma, R.; Hayashi, A.S.; Daly, C.A.; Ngo-Metzger, Q. Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey. *Health Serv. Res.* **2013**, *48*, 992–1017. [CrossRef] [PubMed]
48. Oppenheimer, S.C.; Nurius, P.S.; Green, S. Homelessness History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights from Population Data. *Fam. Soc.* **2016**, *97*, 230–242. [CrossRef] [PubMed]
49. Castañeda, E.; Klassen, J.D.; Smith, C. Hispanic and Non-Hispanic Homeless Populations in El Paso, Texas. *Hisp. J. Behav. Sci.* **2014**, *36*, 488–505. [CrossRef]
50. Centers for Disease Control and Prevention. Medical Conditions. Available online: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (accessed on 28 April 2021).
51. Garg, S. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID-NET, 14 States, March 1–30, 2020. *MMWR Morb. Mortal. Wkly. Rep.* **2020**, *69*, 458. [CrossRef] [PubMed]
52. Alegria, M.; Canino, G.; Shrout, P.E.; Woo, M.; Duan, N.; Vila, D.; Torres, M.; Chen, C.-N.; Meng, X.-L. Prevalence of Mental Illness in Immigrant and Non-Immigrant U.S. Latino Groups. *Am. J. Psychiatry* **2008**, *165*, 359–369. [CrossRef] [PubMed]
53. Palloni, A.; Arias, E. Paradox Lost: Explaining the Hispanic Adult Mortality Advantage. *Demography* **2004**, *41*, 385–415. [CrossRef] [PubMed]
54. Medina-Inojosa, J.; Jean, N.; Cortes-Bergoderi, M.; Lopez-Jimenez, F. The Hispanic Paradox in Cardiovascular Disease and Total Mortality. *Prog. Cardiovasc. Dis.* **2014**, *57*, 286–292. [CrossRef] [PubMed]
55. Crosnoe, R. Studying the Immigrant Paradox in the Mexican-Origin Population. In *The Immigrant Paradox in Children and Adolescents: Is Becoming American a Developmental Risk?* American Psychological Association: Washington, DC, USA, 2012; pp. 61–76. ISBN 978-1-4338-1053-4.
56. Centers for Disease Control and Prevention. High Blood Pressure Symptoms and Causes. Available online: https://www.cdc.gov/bloodpressure/about.htm (accessed on 28 April 2021).
57. Centers for Disease Control and Prevention. Know Your Risk for Heart Disease. Available online: https://www.cdc.gov/heartdisease/risk_factors.htm (accessed on 28 April 2021).
58. National Heart, Lung, and Blood Institute. Blood Cholesterol. Available online: https://www.nhlbi.nih.gov/health-topics/blood-cholesterol (accessed on 28 April 2021).
59. American College of Allergy, Asthma & Immunology. Asthma Attack. Available online: https://acaai.org/asthma/symptoms/asthma-attack (accessed on 28 April 2021).
60. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19)—Symptoms. Available online: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (accessed on 28 April 2021).
61. Centers for Disease Control and Prevention. COVID-19 Provisional Counts—Weekly Updates by Select Demographic and Geographic Characteristics. Available online: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#AgeAndSex (accessed on 28 April 2021).
62. American Stroke Association. Effects of Stroke. Available online: https://www.stroke.org/en/about-stroke/effects-of-stroke (accessed on 28 April 2021).

63. American Lung Association. Emphysema | American Lung Association. Available online: https://www.lung.org/lung-health-diseases/lung-disease-lookup/emphysema (accessed on 28 April 2021).
64. Boyles, S. COPD Care Suffers With High Insurance Deductibles. Available online: https://www.medpagetoday.com/meetingcoverage/ats/79988 (accessed on 28 April 2021).
65. World Health Organization. Hepatitis. Available online: https://www.who.int/news-room/q-a-detail/hepatitis (accessed on 28 April 2021).
66. HIV.gov. U.S. Statistics. Available online: https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics (accessed on 28 April 2021).
67. National Institute of Diabetes and Digestive and Kidney Diseases. What Is Chronic Kidney Disease? Available online: https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease (accessed on 28 April 2021).
68. U.S. Census Bureau. *Census Bureau Projects U.S. and World Populations on New Year's Day*. Available online: https://www.census.gov/newsroom/press-releases/2019/new-years-population.html (accessed on 28 April 2021).
69. Centers for Disease Control and Prevention. HIV in the United States by Region. Available online: https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html (accessed on 28 April 2021).
70. World Health Organization. Tuberculosis (TB). Available online: https://www.who.int/news-room/fact-sheets/detail/tuberculosis (accessed on 28 April 2021).
71. Kilbourne, A.M.; Reynolds, C.F.; Good, C.B.; Sereika, S.M.; Justice, A.C.; Fine, M.J. How Does Depression Influence Diabetes Medication Adherence in Older Patients? *Am. J. Geriatr. Psychiatry* **2005**, *13*, 202–210. [CrossRef] [PubMed]
72. Peyrot, M.; Barnett, A.H.; Meneghini, L.F.; Schumm-Draeger, P.-M. Insulin Adherence Behaviours and Barriers in the Multinational Global Attitudes of Patients and Physicians in Insulin Therapy Study. *Diabet. Med.* **2012**, *29*, 682–689. [CrossRef] [PubMed]
73. Ross, S.A.; Tildesley, H.D.; Ashkenas, J. Barriers to Effective Insulin Treatment: The Persistence of Poor Glycemic Control in Type 2 Diabetes. *Curr. Med. Res. Opin.* **2011**, *27* (Suppl. 3), 13–20. [CrossRef] [PubMed]
74. Hu, J.; Amirehsani, K.; Wallace, D.; Letvak, S. The Meaning of Insulin to Hispanic Immigrants with Type 2 Diabetes and Their Families. *Diabetes Educ.* **2012**, *38*, 263–270. [CrossRef] [PubMed]
75. Hales, C.M.; Carroll, M.; Fryar, C.; Ogden, C. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018. NCHS Data Brief; 2020. Available online: https://www.cdc.gov/nchs/products/databriefs/db360.htm (accessed on 1 May 2021).
76. National Center for Health Statistics. *Health, United States 2018*; Health; National Center for Health Statistics: Hyattsville, MD, USA, 2018; pp. 1–56.
77. Systematic Evidence Review from the Obesity Expert Panel, 2013; *Managing Overweight and Obesity in Adults*; NIH: National Heart, Lung, and Blood Institue: Bethesda, MD, USA, 2013; pp. 1–501.
78. Bailey, Z.; Krieger, N.; Agenor, M.; Graves, J.; Linos, N. Structural Racism and Health Inequities in the USA: Evidence and Interventions. *Lancet* **2017**, *389*, 1453–1463. [CrossRef] [PubMed]

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Article

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Article

The Implications of Health Disparities: A COVID-19 Risk Assessment of the Hispanic Community in El Paso

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Abstract: Since the outbreak of the COVID-19 pandemic in the United States, Latinos have suffered from disproportionately high rates of hospitalization and death related to the virus. Health disparities based on race and ethnicity are directly associated with heightened mortality and burden of illness and act as underlying causes for the staggering impacts of COVID-19 in Latin communities in the United States. This is especially true in the city of El Paso, Texas, where over 82% of the population is Hispanic. To ascertain the level of danger that COVID-19 poses in El Paso, we constructed a point-in-time risk assessment of its Latin population and assessed a Latin individual's likelihood of hospitalization or death related to COVID-19 by comparing relevant health profiles with high-risk co-morbidities that the Centers for Disease Control (CDC) identified in 2020. Data for this risk assessment come from 1152 surveys conducted in El Paso. The assessment included comprehensive demographic, socioeconomic, and health data to analyze disparities across Hispanic sub-populations in the city. Results revealed that around 49.3% of Hispanics in the study had been previously diagnosed with a high-risk co-morbidity and therefore have an increased likelihood of hospitalization or death related to COVID-19. Additional factors that led to increased risk included low income, homelessness, lack of U.S. citizenship, and being insured. The findings from this study additionally demonstrate that structural inequality in the U.S. must be addressed, and preventive measures must be taken at local and state levels to decrease the mortality of pandemics. Baseline population health data can help with both of these goals.

Keywords: health equity; COVID pandemic; Hispanic health; immigrant; minority health

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1. Introduction

Existing health disparities have been exacerbated by COVID-19 [1,2]. Long before the pandemic, race and ethnicity were proven to be associated with life expectancy, mortality, and the burden of illness in the United States [3]. Communities of color consistently lack access to care, proper treatment, care provider diversity, and the resources that exist in high-income and White-populated areas of the country [3]. These disparities cause and prolong poor health in minority communities and result in higher-risk individuals with multiple risk factors beyond old age [2]. This is echoed by public health professionals who observe Black and Hispanic individuals die at higher rates because of an increased likelihood of underlying health conditions and structural barriers to healthcare [1]. Gaps in healthcare increase the vulnerability of groups of people, and their existence springs from discrimination, inequality, and structural racism.

Institutions that place lesser value on the lives of Black and Hispanic people not only turn a blind eye to health disparities but restrict minorities to riskier jobs where they work in dangerous conditions. Research in the United States, Canada, and Europe shows that

immigrants and other minority communities bear higher rates of work-related accidents, illnesses, and deaths because of their over-representation in high-risk occupations [4]. Because of these factors and being less likely to work remotely, they came into contact with COVID-19 before other racial groups and experienced its impacts earlier in the pandemic.

This article examines COVID-19 risk factors in the context of the Hispanic-majority border city of El Paso, Texas. To ascertain the level of danger that COVID-19 poses for the Hispanic community in El Paso, we constructed a point-in-time risk assessment of its Latin population. We assessed a Latin individual's likelihood of hospitalization or death related to COVID-19 by comparing relevant health profiles with high-risk co-morbidities that the Centers for Disease Control (CDC) identified in 2020 [5]. El Paso is an important research site on health disparities, as proven by prior research documenting that the border city's Hispanic population faces compounded structural inequalities, high risk of morality, and poor health outcomes [6,7].

Our study contributes to understanding how racial, ethnic, socioeconomic, and other intersectional experiences are predictive of health outcomes within regional and historical contexts. First, we provide a brief overview of how the COVID-19 pandemic has unfolded in El Paso and its "sister city" of Ciudad Juárez, Mexico. Then, we describe the methodology employed in gathering comprehensive survey data on Hispanics living in El Paso and compiling our risk assessment. The subsequent section analyzes significant demographic, socioeconomic, and health factors that encompass essential determinants of health and risk associated with COVID-19. These measures allowed us to predict Hispanic El Pasoans' high risks of hospitalization and death related to COVID-19 before the pandemic struck El Paso, and thus demonstrate the foreseen impact of COVID-19 on the Latin community in the U.S. [8–11]. In doing so, we also acknowledge and explore structural forms of discrimination and violence against communities of color, particularly Latinos, that contribute to health disparities.

In the early months of 2020, cities and entire regions around the world declared public health emergencies while COVID-19, also known as coronavirus, stole millions of lives and disabled many more [12]. Its arrival in the United States was swift. Former President Donald Trump, who dissolved the White House pandemic response team in 2018, assumed a perilously disinterested approach to information about the virus spreading in Asia. Reuters estimated a COVID-19 death count of at least 69,457 in the United States on 5 May 2020 [13]. This number continued to rise, reaching 92,038 on 20 May. This marked the United States as the country with the highest COVID-19 death toll in the world [13]. The number of lives lost to COVID-19 exceeded that of the United Kingdom, then the country with the second-highest mortality rate, by over 57,000 [13]. In 2020, the total estimated number of cases in the U.S. was also the highest across the globe at 1,189,198, outnumbering China by more than 1 million cases, despite China's population being approximately four times larger [13]. However, not all geographical areas were impacted at the same time. For example, the pandemic reached New York City many months before El Paso, Texas.

The great loss that the U.S. experienced in 2020 was also reflected in local cities' rates of hospitalization and death related to COVID-19, which tracked demographic data and allowed researchers to glimpse the differences in rates across ethno-racial groups. In New York, the Bureau of Communicable Disease Surveillance System reported that, as of 16 April 2020, the death rates for Blacks were 92.3 per 100,000 people, and 74.3 per 100,000 for Latinos [14]. In comparison, the White and Asian death rates were 45.2 and 34.5 per 100,000 people, respectively [14]. Just two months later, the mortality and infection rates skyrocketed. At least 5322 Latinos had died from COVID-19, the majority of whom were ages 65 and above [15]. This was the highest number of lab-confirmed deaths of a racial group in New York City, exceeding that of the White population by almost 1000 [15]. Even so, these numbers were understood to be low estimates since the data cover only lab-confirmed cases, effectively excluding asymptomatic and non-lab-confirmed cases.

As the COVID-19 pandemic continued to unfold and healthcare workers fought to save lives, a familiar pattern arose that concerned researchers and advocates: Black and Hispanic

individuals were not only suffering from more infections but also dying at incredibly higher rates than White and Asian people [14,15].

2. El Paso, Texas

El Paso is city in the western corner of Texas, bordering Las Cruces, New Mexico, and directly to the south, Ciudad Juarez, Mexico. El Paso City's population was around 649,000 in 2010 and 679,000 in 2020 and El Paso County has over 800,000 residents. El Paso is around 83% Hispanic. El Paso is a majority Latin city, with over 24% of the population being foreign-born [16]. It also includes Hispanics who have been in the area for decades and many generations, thus making it a great place to study the impact of health disparities within the same ethno-racial category. Poverty is directly related to health; this is visible in the U.S.–Mexico border [17].

El Paso experienced mounting pressure as time passed in the first months of the pandemic. Sixty-five people were hospitalized in El Paso in the first week of May 2020, and 17 were put on ventilators [18]. Local public health officials worried El Paso would suffer from limited resources, as the county only had 285 licensed ICU hospital beds [18]. Unfortunately, the City Director of Public Health, Robert Resendes, resigned on 4 May, and his replacement had not been selected at the time of his departure. The city insisted that his resignation would not negatively impact preventative action since the Office of Emergency Management handles public health crises, but the community continued to buzz with concern given that Texas was one of the top ten most infected states, with over 32,954 cases in 2020 [19,20].

Ciudad Juárez, which sits on the Mexican side of the border right next to El Paso, was also grappling with an upward trajectory of COVID-19 cases. El Paso and Ciudad Juárez are sister cities that are economically and socially intertwined. The first case of COVID-19 in the Mexican state of Chihuahua was confirmed in Ciudad Juárez on 17 March 2020, not long after cities in the U.S. began issuing public health mandates, mandatory quarantines, and other lockdown procedures [21]. Since then, the official response paralleled somewhat that of the U.S. because of the lax approach that President Andrés Manuel López Obrador took to prepare for outbreaks. He refused to close the Mexican border to visitors, instead allowing Americans and foreign tourists into the country, even though the U.S. imposed major entry restrictions at its legal entry points [22].

The border cities of Tijuana and Juárez, where Mexican and U.S. nationals travel to and from every day, and the popular destination of Cancún, had the three highest rates of documented COVID-19 cases in Mexico between January and May 2020 [23]. Things grew so dire that Armando Cabada, mayor of Ciudad Juárez, wrote to the foreign affairs secretary to ask that they block Americans from filtering into the city and spreading the coronavirus [22]. Another significant factor that the Mexican government had to consider was the Migrant Protection Protocols, or "Remain-in-Mexico", U.S. program. As a result, Juárez served as a temporary shelter for more than 19,000 Central American and Mexican migrants awaiting decisions on their U.S. asylum applications [24–26]. The foreign affairs secretary, however, did not fulfill Cabada's wishes, and U.S. citizens continued to pass into Mexico. Consequently, hospitals saw a massive influx of patients. Cemeteries were hosting as many as six burials each day, and the cost to bury a loved one increased by some USD 600 [27]. Unlike in El Paso, people living on the urban periphery of Ciudad Juárez had limited access to clean water and could not practice as effectively the CDC-recommended hygienic practices to counter COVID-19 [21]. They also faced other health barriers, such as the lack of COVID-19 testing sites, which increased the number of cases and deaths in the region [22].

3. Data and Methods

The data used in this study were collected through ethno-surveys, which provided close-ended and open-ended data regarding health, employment, socioeconomic status, housing, transborder habits, and citizenship. These surveys were conducted in 2011–2012,

nine years before the start of the pandemic, as part of a study funded by the National Institutes for Health (NIH) conducted by Dr. Ernesto Castañeda and research teams who trained for several months as part of a research methods course. The sample consisted of 1152 Hispanic respondents aged 18 and over residing in El Paso, Texas. All surveys were conducted and recorded in Spanish and/or English (at the preference of the respondent) in a variety of locations in El Paso, such as at individual's homes, shelters, and workplaces. Only close-ended questions from the ethno-surveys are referenced in this study. All researchers who participated in data collection were certified to work with human subjects, and the project had IRB approval from the University of Texas, El Paso. The NIH's National Institute on Minority Health and Health Disparities further reviewed and approved the project before releasing funds.

The risk assessment comprises several analyses conducted using the IBM SPSS 27 statistical package. Notably, we used purposeful sampling techniques [28] that specifically considered the heterogeneity of respondents, such as education levels, profession, housing status, and age, to construct an adequate representation of El Paso's geographic neighborhoods. Furthermore, we stopped data collection when saturation of responses was reached and we had a sample large and diverse enough to generalize to the Hispanic population of the whole city. No exclusionary criteria were identified when recruiting participants beyond self-identification as Hispanic, Latino, Mexican American, Chicano, Mexican, or of Latin American or Caribbean origin [6].

Undocumented Hispanics and those experiencing housing insecurity were over-sampled because of their relative exclusion across census counts and research studies [29]. Therefore, to take these differential selection probabilities into account and adjust to the El Paso demographic, weighted data were utilized to account for this over-sampling in the dataset. Throughout the following sections, we provide descriptive analyses to present various differences in the distributions of citizenship status, social class, and medical insurance coverage, among other factors, across the sample of Hispanic El Pasoans. Pearson's chi-squared tests determined bivariate associations.

The data precede the COVID pandemic, but when we embarked on this analysis, we wondered whether they could be used as a baseline to calculate population risks before the pandemic struck El Paso. It is safe to assume that most of the people who participated in the survey still reside in El Paso and that the demographic and health profile has not changed much; if anything, it may have worsened as the people in the sample have aged, but this also depends on the health status of the younger generations for whom comparative data do not exist. Health data are seen as a personal attribute, and patients' data are protected by HIPA. Even if hospitals engage in big data analysis with their anonymized patient data, they do not have access to all types of populations in a city; thus, the importance of databases such as this.

4. Latinos and High-Risk Populations

4.1. Race and Ethnicity

Risk is not only related to physiological factors but also socioeconomic, cultural, racial, and ethnic ones. The CDC distinguishes racial and ethnic minorities, as well as people who are currently homeless, pregnant, and breastfeeding, as individuals who are "high-risk" for COVID-19 [5]. This is because Latin communities across the U.S. have suffered disproportionately high rates of hospitalization and death caused by the virus compared to other racial and ethnic groups. According to the City of New York and the CDC, Black and Latin communities had borne the brunt of virus-related deaths [14]. In a weekly report, the CDC revealed that although 18% of the U.S. population is Black, 33% of hospitalized COVID-19 cases were among Black people in May 2020 [14].

The Latin population in the United States has received relatively little attention in relation to the pandemic despite its vulnerability to COVID-19. This is especially true in the city of El Paso, Texas, where Hispanics constitute over 83% of the population and have suffered disproportionately from the pandemic's damage [16]. On 28 May 2020, the

city recorded 1029 cases and 22 deaths [18]. Over a year later, the cumulative number of infections surpassed 111,000 and the death toll across El Paso had skyrocketed to 1651 lives lost. Hispanic individuals comprised the vast majority of COVID-related deaths at this time, at 91.25% of the population [30].

4.2. Essential and Frontline Workers

The Hispanic community is an integral part of the U.S. labor force. In 2018, 17% of the national labor force was comprised of documented Hispanic citizens, 61% of whom were Mexican [31]. However, this percentage does not include undocumented workers, who constitute upwards of an estimated 5.1% of the U.S. workforce [32]. This is supported by our data gathered in El Paso, as reported in Table 1, which show that 53.5% of undocumented Hispanics in 2011 were employed. The way the data were obtained means that the unemployed may be students, homemakers, or retired.

Table 1. Employment by Citizenship Status among Hispanics in El Paso, TX in 2011–2012.

Status	Citizen	Resident	Undocumented	Visa	Total
Unemployed	33.6% 138,083	46.5% 36,477	46.5% 8232	19.2% 2530	35.6% 185,322
Employed	66.4% 273,471	53.5% 41,990	53.5% 9461	80.8% 10,655	64.4% 335,577

Note: $p < 0.001$.

Furthermore, the CDC reports that at least 25% of the Hispanic population in the U.S. is employed in the service industry, including hospitality, transportation/travel, delivery, food, healthcare, and education services [33]. Unfortunately, these industries severely struggled under COVID-19 restrictions and regulations, and nonessential businesses laid off millions of workers across the country as a result of forced closures [34]. This was particularly worrisome for undocumented immigrants because they could not file for unemployment insurance and did not qualify for Pandemic Unemployment Assistance (PUA), which was passed in the Coronavirus Aid, Relief, and Economic Security (CARES) Act [35].

Then, there are those who were considered "essential" employees, including people working in grocery stores, mail services, agriculture, city maintenance, and construction, in addition to the service industries mentioned earlier, who were legally required to work in person during the pandemic. Laws surrounding "essential and emergency employees" require that such employees continue working through national emergencies, including those who are immunocompromised or have pre-existing health conditions [36]. This makes it difficult for frontline workers to receive unemployment benefits if they prefer not to work because one must be fired or laid off in order to collect unemployment insurance [37]. Employees who quit during the pandemic were disqualified from unemployment claims, a policy that jeopardizes their financial stability for the sake of maintaining their health. Therefore, "essential" workers were forced to engage with customers and coworkers in close quarters, as before COVID-19 regulations, and thus ran a higher risk of contracting and spreading the virus.

4.3. Prison, Jail, and Juvenile Delinquent Centers

Incarcerated populations in prisons, jails, and juvenile delinquent centers are also at higher risk of severe illness related to COVID-19. The close quarters, shared spaces, and lack of comprehensive medical care in correctional institutions create a breeding ground for the virus. The Marshall Project reports that there were at least 9437 cases of positive COVID-19 diagnoses in state and federal prisons across the U.S. as of 25 April 2020 [38]. As a result, 131 incarcerated individuals and seven prison employees died [38]. The deaths of prisoners rapidly increased throughout the spring months, eventually amounting to 496 dead inmates by 4 June 2020 [39]. There was no testing protocol for individual states at

that time, and many refused to release information regarding the number of prisoners who were tested. The Federal Bureau of Prisons even went so far as to report lower numbers compared to state correctional facilities [40].

In the second year of the pandemic, the institution's reporting habits had not improved. The Federal Bureau released information indicating that 799 federal inmates tested positive for the virus, along with 319 staff members. Although no staff member was among the deceased, 27 inmates died from virus-related complications. Furthermore, three inmates died at Fort Worth Federal Medical Center alone, and all federal prisons in Texas currently had at least one positive diagnosis within the facility [40]. The Marshall Project, however, defines these numbers as "almost certainly an undercount" [38].

This puts racial and ethnic minorities at further risk, given the mass incarceration of communities of color. In the U.S., Hispanics are imprisoned at a rate 1.4 times higher than that of Whites [41]. In 2016, approximately 61% of state prisoners in New Mexico were Hispanic, although approximately 49.1% of people living in New Mexico were Hispanic [42]. The ratio of Black and Hispanic prisoners exceeds that of incarcerated Whites across the country, but the disparities are widest in Texas and other southern states. For example, ranking second only to the number of incarcerated Black individuals, 541 per 100,000 prisoners in Texas are Hispanic [41]. The state's ratio of Hispanic to White prisoners is 2:1, and its neighbor, Arizona, has the highest number of Hispanic prisoners in the U.S. [41].

Juvenile delinquent centers incarcerating children ages 10 to 17 share similar demographic trends with adult correctional institutions. The Department of Justice revealed that Latino youth in the U.S. have a 65% higher chance of being detained and incarcerated than their White counterparts [43]. This profound disparity also exists in Texas, where juvenile prisoners are 1.47 times more likely to be Latino than White [43]. Disproportionate imprisonment because of higher policing and stricter sentencing is also one of the reasons that Black, Hispanic, and other minority communities in the U.S. were contracting, spreading, and dying from COVID-19 at higher rates than White Americans.

4.4. Medical Insurance and Citizenship

Immigration status dramatically impacts an individual's access to healthcare and medical treatment. Our data revealed that the likelihood of being medically insured increased with the stability of immigration status, as detailed in Table 2. In 2011, 89.3% of undocumented Hispanics living in El Paso lacked medical insurance, followed by 66% of lawful permanent residents.

Table 2. Medical Insurance by Citizenship among Hispanics in El Paso, TX in 2011–2012.

Status	Citizen	Resident	Undocumented	Visa	Total
Does not have medical insurance	43.1% 177,533	66.0% 52,188	89.3% 15,792	40.2% 5046	48.0% 250,559
Has medical insurance	56.9% 234,673	34% 26,914	10.7% 1900	59.8% 7515	52% 271,002

Note: $p < 0.001$.

These data were obtained before the Affordable Care Act was passed. Still, the Affordable Care Act does not provide coverage for all immigrants and excludes the undocumented community from nonemergency services [44]. Recipients of Deferred Action for Childhood Arrivals (DACA) have been denied both Medicaid and ACA benefits since 2012, and children of undocumented parents must be lawful residents or citizens in order to qualify for Medicaid or Children's Health Insurance Program (CHIP) services [44]. Despite the implementation of the Affordable Care Act, undocumented individuals have not experienced any major improvement in access to healthcare, so it is unlikely that these figures have changed significantly as a result of the Act.

Upon assessment of Hispanics who fulfilled the CDC criteria for individuals at high risk of severe illness related to COVID-19, our data, as shown in Table 3, revealed that only those insured by Medicaid and Medicare were over-represented in the high-risk category.

Table 3. Health Insurance Plan and High Risk of COVID-19 Complications.

Health Insurance Type	Not at Risk for COVID	At Risk for COVID	Total
Private healthcare plan	51.9% 70,011	43.6% 60,104	47.7% 130,115
Medicaid	8.3% 11,254	12.3% 16,991	10.4% 28,245
Medicare	2.3% 3125	9.5% 13,134	6.0% 16,259
VA	0.9% 1250	2.3% 3135	1.6% 4385
Tricare	6.0% 8125	3.6% 5010	4.8% 13,135
Unspecified healthcare plan	28.7% 38,758	26.8% 36,985	27.8% 75,743
Government employee healthcare	0.9% 1250	0.5% 625	0.7% 1875
Foreign insurance	0.9% 1250	1.4% 1875	1.1% 3125

Note: $p < 0.001$.

4.5. Homelessness

The U.S. struggles to provide affordable housing and address homelessness. In 2019, over 500,000 people were estimated to have been homeless on any given night nationwide [45]. People experiencing homelessness are at high risk of severe illness related to COVID-19 for multiple reasons. There are almost no isolated or private spaces in shelters, encampments, and other congregate housing settings that homeless individuals occupy [46]. People are in close proximity to one another, which makes it challenging to maintain the six feet of distance that medical professionals recommend to inhibit the spread of COVID-19. The Council of Economic Advisers found that around 200,000 people sleep in unsheltered places, such as cars, parks, sidewalks, and abandoned buildings. Those who may not sleep in the presence of others must still interact with people at social service facilities [45].

People experiencing housing instability are also less likely to have access to masks, gloves, and other materials that prevent the spread of the virus. This also includes basic hygienic facilities and necessities, such as soap [46]. They can also rely on public transportation and facilities, such as bathrooms and water fountains. Interacting without precautionary measures increases the possibility of exposure to COVID-19. According to our data collected in El Paso, housing instability lessens the likelihood of having medical insurance. In 2011, only about one-quarter (24.7%) of homeless Hispanics in El Paso were medically insured, which is a much lower percentage than for those who were housed (see Table 2).

Additionally, Hispanics experiencing housing instability constituted only 0.3% of those with a high-risk medical condition. However, they are still considered particularly vulnerable because of their heightened likelihood of contracting COVID-19 and limited access to medical providers. Individuals and families experiencing homelessness who are uninsured have a decreased likelihood of being tested for COVID-19 and adequately treated for potentially fatal symptoms (see Table 4). Furthermore, people who have not sought a visit to a medical clinic or provider are unaware of their health status and may be living with an illness that has gone undiagnosed. So, although our data only show 1% of Hispanics experiencing homelessness as "high risk," the reality is that unhoused people

may not know enough about their health to provide information that can assess their level of risk [6].

Table 4. Disease Prevalence among Hispanics Experiencing Homelessness.

Health Condition	Percent	N
Smoking	22.5%	469
Obesity	18.5%	438
High Blood Pressure	8.1%	219
High Cholesterol	4.3%	117
Diabetes	4.0%	107
Asthma	3.4%	92
Hepatitis or Cirrhosis	2.8%	76
Heart Attack/Stroke	1.9%	51
Kidney Disease	1.5%	31
Cancer	0.5%	10
Tuberculosis	0.5%	10
Emphysema	0.4%	10
HIV/AIDS	0.4%	10
		1640

Note: Unweighted data was used to include all of the oversampled unhoused respondents.

Altogether, experiencing homelessness can almost guarantee poorer health outcomes. Compared to housed individuals, people who have ever experienced homelessness are more likely to face health issues, have unmet healthcare needs, and be subject to accelerated health erosion [47–49]. Their obstructed access to basic hygienic amenities, isolated spaces, and medical care makes it challenging for homeless individuals to protect themselves from COVID-19.

4.6. Socioeconomic Status

Of the total sample, 52.1% could be classified as low-income and 7.1% as high-income. Racial and ethnic minorities who are low-income are at heightened risk of severe illness related to COVID-19. As shown in Table 5 below, Hispanics with a lower SES are more likely to have a pre-existing high-risk illness that renders them physiologically vulnerable to COVID-19.

Table 5. Hispanics with High-Risk Pre-Existing Health Conditions by Socioeconomic Status.

Socioeconomic Status	High-Risk
Low SES	53.8% 146,205
Medium SES	45.0% 95,793
High SES	37.4% 13,790

Note: $p < 0.001$.

It is vital to analyze the risks associated with socioeconomic status, race, ethnicity, and pre-existing health conditions because they are often co-occurring factors that influence an individual or community's well-being and life expectancy. Similarly, among immigrants, income and employment are intimately associated with citizenship, immigration status, and health insurance. The same is true for people experiencing homelessness, who are typically low-income and vulnerable to COVID-19 [46].

5. Latinos and High-Risk Pre-Existing Health Conditions

In May 2020, the CDC stated that "older adults and people of any age who have serious underlying medical conditions" are at highest risk of severe illness from COVID-19 [5]. It defines severe illness as "hospitalization, admission to the ICU, intubation or mechanical ventilation, or death" that is caused or exacerbated by the contraction of COVID-19 [50]. Furthermore, the umbrella term of "serious underlying medical conditions" refers to people with chronic lung diseases, severe asthma, heart conditions, obesity, diabetes, immunocompromising illnesses (including, but not limited to chemotherapy/radiation or organ/bone marrow transplantation, HIV/AIDS, or prolonged use of corticosteroids), liver disease, and those undergoing dialysis for chronic kidney disease [5]. The CDC Morbidity and Mortality Weekly Report released on 17 April 2020 disclosed that 89.3% of people hospitalized due to COVID-19 had at least one of the following underlying health conditions: hypertension (49.7%), obesity (48.3%), chronic lung disease (34.6%), type 2 diabetes mellitus (28.3%), or cardiovascular disease (27.8%) [51]. Table 6 shows the distribution of our sample according to our created risk categories.

Table 6. Number of Pre-Existing Health Conditions Associated with Severe Illness Related to COVID-19 among Hispanics in El Paso in 2011–2012.

Risk Assessment	Percent	*N*
No risk factors	50.70%	266,383
1 risk factor	31.90%	167,396
2 risk factors	15.50%	81,278
3 or more risk factors	2.00%	10,264
		525,321
Not at-risk	50.70%	266,383
At-risk	49.30%	258,938
		525,321
Deaths (as of 22 April 2021)		2506
El Paso County pop. 2019		839,238
Death rate	0.3% of the population	
U.S. Death rate	0.00%	
Global Death rate	~0.4%	

Sources: Reuters Graphics [12,13], U.S. Census Bureau [16].

In the section below, we outline a set of analyses that explore the prevalence of high-risk pre-existing health conditions as they relate to medical insurance status, socioeconomic status, medication, age, and homelessness. We included data on medical insurance, socioeconomic status, and age for all conditions. We included information on medication and homelessness only when the findings were at least statistically significant at $p < 0.01$ or significantly exceeding the average percentage of the sample population.

Table 7 below reflects the prevalence of high-risk health conditions and diseases in the Hispanic community of El Paso in 2011–2012.

Two variables were created to paint a clearer picture of Hispanics' COVID-19 risk profiles. Individuals who had been diagnosed with one or more of the above diseases were categorized into an "at-risk" group, and then further sorted according to their pre-existing condition. Those with two or more, as well as three or more, conditions were grouped into their respective categories because of their compounded physiological vulnerabilities to severe illness related to COVID-19. Emphysema, tuberculosis, and HIV/AIDS were not included in these variables, and because their prevalence is very low, this does not have a significant effect on the results. The table below outlines the percentage of the Hispanic population of El Paso in 2011–2012 that is considered high-risk according to an individual's number of pre-existing conditions (see Table 8).

Table 7. High-Risk Illness and Disease Prevalence among Hispanics in El Paso.

Health Condition	Percent	*N*
Obesity	26.2%	95,818
Smoking	17.7%	92,989
High Blood Pressure	16.0%	83,980
High Cholesterol	12.9%	67,629
Asthma	7.6%	40,100
Diabetes	7.3%	38,235
Heart Attack/Stroke	2.6%	13,810
Kidney Disease	2.3%	11,905
Hepatitis or Cirrhosis	2.2%	11,326
Cancer	1.4%	7510
Emphysema	1.3%	6885
Homelessness	0.5%	2707
Tuberculosis	0.2%	1260
HIV/AIDS	<0.1%	10

Table 8. High-Risk Pre-Existing Health Conditions Associated with Severe Illness Related to COVID-19 Among Hispanics.

Health Condition	Percent	*N*
Obesity (only)	17.4%	45,000
High Blood Pressure (only)	11.3%	29,389
Diabetes (only)	3.9%	9999
Asthma (only)	7.2%	18,754
Heart Attack/Stroke (only)	0.7%	1875
Kidney Disease (only)	0.7%	1875
Cancer (only)	0.5%	1250
Smoking (only)	21.3%	55,043
Homelessness (only)	1.6%	4203
2 of the above	31.4%	81,278
3 or more	4.0%	10,264

Obesity, hypertension, asthma, and type 2 diabetes were the most common illnesses to render Hispanics at high risk. Most notably, however, is that the majority of Hispanic individuals had been diagnosed with one or more health conditions that put them at risk of dying from COVID. Altogether, those with compounded risk comprised about one-third of the total Hispanic population of El Paso at the time that the survey was taken. This indicates poor widespread health outcomes in the community overall and the importance of extreme public health precautions in dealing with respiratory pandemics.

Additionally, differences in disease prevalence arose when risk was cross-analyzed with place of birth. In Table 9, those with at least one pre-existing health condition were considered higher risk, and those with no pre-existing health condition were categorized as lower risk. Native-born Hispanics made up a slightly smaller portion of high-risk individuals, revealing a lesser likelihood of being diagnosed with a high-risk pre-existing health condition if they had been born in the U.S. These data suggest that birthplace is statistically associated with an individual's risk of contracting COVID-19. Hispanic immigrants in El Paso showed a collectively higher risk profile.

Table 9. Hispanics Diagnosed with High-Risk Pre-Existing Health Conditions by Birthplace.

At Risk for COVID-19	Born in the U.S.	Foreign Born	Total
Higher risk	47.4% 146,417	52.0% 112,521	50.7% 266,383
Lower risk	52.6% 162,588	48.0% 103,795	49.3% 258,893

Note: $p < 0.001$.

These disparate health outcomes were more closely examined by separating each specific illness according to individuals' birthplaces, shown below in Table 10. Hispanics born outside of the U.S. bore the brunt of type 2 diabetes, hypertension, kidney disease, and cancer diagnoses. Foreign-born Hispanics were also slightly more likely to have two high-risk pre-existing health conditions. On the other hand, U.S.-born individuals reported higher rates of asthma and smoking, indicating that immigrant Hispanics and U.S.-born Hispanics struggle with different health concerns in El Paso.

Table 10. Pre-Existing Health Conditions Associated with High Risk of Severe Illness Related to COVID-19, According to Birthplace.

Health Condition	Born in the U.S.	Foreign-Born
Obesity (only)	18.4%	16.1%
High Blood Pressure (only)	11.1%	11.7%
Diabetes (only)	2.1%	6.1%
Asthma (only)	9.4%	4.4%
Heart Attack/Stroke (only)	0.4%	1.1%
Kidney Disease (only)	0.0%	1.7%
Cancer (only)	0.0%	1.1%
Smoking (only)	22.6%	19.5%
Homelessness (only)	1.0%	2.4%
2 of the above	30.5%	32.5%
3 or more	4.4%	3.4%

Note: $p < 0.001$.

These findings challenge previous research on what scholars have labeled the "Immigrant Paradox". A close cousin of the Hispanic Health Paradox, this contradiction arose when researchers began seeing an unexpected pattern in the health outcomes of foreign-born people in the U.S. In general, the Paradox asserts that immigrants exhibit significantly better physical and mental health compared to their native-born counterparts, even within racial and ethnic subgroups of the country's population [52–55]. Our data, however, reflect the opposite: Hispanic immigrants were more likely than those born on U.S. soil to be diagnosed with a range and multiplicity of chronic illnesses, all of which are associated with severe sickness upon contraction of COVID-19.

5.1. High Blood Pressure

In El Paso, 16.0% of Hispanics reported a high blood pressure diagnosis, and 59.5% of them were low-income. High blood pressure, also known as hypertension, has been coined the "silent killer" given the absence of symptoms that accompany it. Many people go unaware of their high blood pressure, which can lead to the development of kidney disease, cardiovascular diseases, or fatal cardiac events, such as heart attack or stroke [56]. According to our data, 23.2% of adult Hispanics had never had their blood pressure checked. These numbers are concerning because the contraction of COVID-19 is especially dangerous for people with hypertension. The CDC reported that 49.7% of people hospitalized due to virus-related complications had hypertension in March 2020 [51]. Given the high number of those who had never checked their blood pressure, this analysis only accounted for Latin individuals who were aware of their blood pressure status, in addition to a large subsample whose blood pressure was measured as part of the study, as we discuss elsewhere [6].

Although high blood pressure is a cause of serious health conditions, medical coverage varied greatly among those with diagnoses. Our analysis revealed that 33.7% of Hispanics were aware of their high blood pressure but were not medically insured. Even though these

individuals knew of their diagnosis, they either chose not to enroll in medical insurance or could not because of cost or citizenship status.

5.2. Cholesterol

High cholesterol was almost equally as common as hypertension within our sample, as 12.9% of Hispanics reported being diagnosed by a health professional. Similar to high blood pressure, people are often unaware of their cholesterol levels until a serious or fatal event occurs. High cholesterol is a predicting factor of heart disease, hypertension, and type 2 diabetes [57]. Low-lipid cholesterols increase plaque growth in the arteries that flow to the brain and heart, eventually accumulating to the point where blood struggles to pass [58]. Heart attack (myocardial infarction) and stroke occur when plaque buildup has completely obstructed the blood from flowing through the arteries [57]. Both are extremely dangerous health conditions that exhibit little to no symptoms, and the lack of knowledge regarding residents' blood pressure and cholesterol status might render them especially susceptible to health complications caused by COVID-19.

This analysis showed that 28.8% of those diagnosed with high cholesterol did not have medical insurance at the time. More than half (52.8%) of those who had been diagnosed were low-income, whereas 10.2% were high-income. Because of these disparate figures, it is possible that socioeconomic status plays a role in the stress and diet, both of which impact cholesterol levels of Hispanic El Pasoans. Age was also an important factor in analyzing cholesterol, as the majority of cases occurred among people between the ages of 46 and 65.

5.3. Asthma

The study revealed that 7.6% of Hispanics reported asthma diagnoses. When treated and closely monitored, asthma is not life-threatening. However, if someone with asthma has an asthma attack and lacks access to an inhaler or ventilator, then it can be fatal. An attack is caused by severe inflammation that constricts and narrows the air passages that lead to the lungs [59]. Communicable diseases, such as the flu or an upper respiratory infection, can trigger an asthma attack [59]. It is dangerous to be unaware of the condition because those with asthma are at higher risk of complications or death after contracting a communicable illness. Although it is unknown whether COVID-19 induces asthma attacks, shortness of breath and dry cough are common symptoms of the virus that alter the flow of breath through the airways [60]. Severe symptoms and difficulty breathing might trigger an asthma attack, so medical professionals warn individuals with asthma to take caution. Nonetheless, there has been no information that distinguishes asthma attacks from common symptoms of COVID-19. Because of this, virus-related symptoms may be mistaken as a routine asthma attack and deter individuals with asthma from seeking medical attention.

Out of this portion of the Hispanic population in El Paso, approximately half (51.7%) did not have medical insurance to help them manage their asthma diagnosis prior to the Affordable Care Act. An individual's socioeconomic status also informed the likelihood of receiving an asthma diagnosis, given that 56.3% of Hispanic residents with asthma were low-income and 42.1% middle-income.

5.4. Heart Attack/Stroke

A small percentage (2.6%) of Latin individuals in El Paso reported a previous heart attack or stroke. Given the significance of socioeconomic status and medical insurance in the previous analyses, it is perhaps unsurprising that 27.4% were not medically insured, and an overwhelming percentage (72.8%) were low-income. Socioeconomic status was also associated with the use of medication to treat heart attack or stroke, as half (50.2%) of low-income Latin individuals who received this diagnosis reported being on medication compared to 83.2% of middle-class Hispanics.

When examining the age groups most affected by these conditions, our data showed that 27.2% of heart attacks or strokes were reported by people between the ages of 60 and 80. Deaths caused by COVID-19 are highest among those over the age of 64, so Latin individuals

in this age group who have suffered a heart attack or stroke have compounded risk factors that render them disproportionately vulnerable to COVID-19-related complications [61].

Heart attack and stroke are often caused by high cholesterol, as the low-lipid cholesterols create buildups of plaque that block proper blood flow to the heart and brain [57]. A heart attack is defined as a form of cardiovascular disease by itself, but it may also be an indicator of heart diseases such as arteriosclerosis, diabetes, or coronary artery disease [57]. Further, the CDC reported that 27.8% of COVID-related hospitalizations were among people with cardiovascular disease [51]. Heart attack and stroke are both potentially fatal health events that affect an individual for the rest of their life. For example, Cione's father experienced three heart attacks before receiving a diagnosis of arteriosclerosis. He was prescribed multiple pharmaceuticals that altered his metabolism, sleep quality, mood, energy levels, and ability to eat. His diet changed drastically, and he must regulate his consumption of cholesterol-rich foods for the remainder of his life.

The physiological processes leading to stroke are similar to those that result in heart attacks, although the life-long impacts may differ greatly. Depending on the part of the brain that was depleted of blood, stroke can cause paralysis, memory loss, changes in behavior, speech issues, and/or vision impairment. In extreme cases, individuals lose entirely the ability to speak or move their body [62]. Those who are medically uninsured and have experienced one or both of these health events are at higher risk of other health complications, such as an additional heart attack or stroke, if they do not receive proper follow-up care.

5.5. Emphysema

A minority (1.3%) of survey participants had received an emphysema diagnosis. Emphysema is a chronic lung disease that heightens one's susceptibility to severe illness [51]. Smoking tobacco is the most common cause of emphysema, but air pollution and respiratory infections can also cause or aggravate it. It is defined as a chronic obstructive pulmonary disease (COPD), and people can live with emphysema for years before symptoms develop [63]. Medical treatment typically involves medications, surgery, and oxygen therapy, but it is typical for those with emphysema to forgo these costly treatments [63,64].

Our data revealed that about one-quarter (27.4%) of those who were diagnosed with emphysema was not medically insured. Furthermore, emphysema was associated with lower socioeconomic status, as 54.5% of those with emphysema were low-income, whereas none were high-income. Regarding age, emphysema most commonly affected people ages 60–85, an age group that has been classified as particularly susceptible to severe illness or death related to COVID-19 [5].

5.6. Hepatitis or Cirrhosis

A total of 2.2% of the Hispanic population of El Paso reported a diagnosis of hepatitis, cirrhosis, or both. All hepatitis infections (A, B, C, D, and E) are inflammatory and occur in the liver, as well as cirrhosis, as cirrhosis is technically the progression of any liver disease [65]. Hepatitis B and C are the most common causes of cirrhosis, and those who are most at risk of contracting B, C, and D are injection drug users and those who practice unsafe sex [65]. While Hepatitis A is curable, all its other types are not [65]. Injection drug use and unsafe sex are risk factors also associated with the contraction of HIV, and any HIV-positive person who contracts hepatitis is at severe risk of health complications [66].

Of those who received a diagnosis, 33.6% are not medically insured. This diagnosis was distributed unequally across socioeconomic classes, given that low-income Hispanics once again constituted the majority at 77.8%, which is also the highest percentage across the illnesses in this risk assessment. Clearly, hepatitis and cirrhosis diagnoses are impacted by an individual's financial and social standing. This diagnosis also happened to almost exclusively strike young people between the ages of 18 and 30, indicating that younger people may be more susceptible to contracting hepatitis or developing cirrhosis.

5.7. Kidney Disease

Around 2.3% of Hispanic study participants reported kidney disease, of whom 42.2% did not have medical insurance and therefore struggled to receive regular care. Many of those with kidney disease diagnoses were middle-income (52.8%) and low-income (41.3%). Kidney disease is an illness that does not exhibit symptoms until the occurrence of a potentially fatal event, such as kidney failure. It is intimately linked with heart disease, diabetes, high blood pressure, and certain forms of cardiovascular disease known to cause or evolve into kidney disease. Further, it is a chronic disease, meaning that the kidneys are permanently damaged and cannot properly filter blood. Unless the patient immediately changes their diet and seeks medical treatment, their condition will worsen with time [67]. A share of 36.4% of Hispanics in El Paso with kidney disease are above the age of 60, which adds another layer of risk in the case of a positive COVID-19 diagnosis.

5.8. Cancer

Those with cancer diagnoses amounted to 1.4% of the Hispanic population, which is approximately equal to the proportions of kidney disease and heart attack/stroke. The ethno-surveys also revealed that 16.8% of Hispanic residents of El Paso who had cancer were uninsured, one of the lowest rates of lacking medical insurance across this report. This could be because the culture surrounding cancer in the United States is serious and fearful, which encourages people to remain insured after a diagnosis. People who are nearing remission, are in remission, or may have been diagnosed as a child are also among those who are likely to be insured.

Approximately half of the Hispanic residents diagnosed with cancer at some point in the past are of low socioeconomic status (50.1%), whereas 40.9% are considered middle-class. However, the ages of people who reported cancer diagnoses at one point in their lives varied greatly: 8.3% were ages 18–25, 16.6% were ages 31–35, and 8.3% were ages 46–50. Ultimately, the highest rates were reported by people between the ages of 51 and 65, who constituted 58.2% of the diagnosed population. This is significant because people ages 65 and older are considered "high risk" by the CDC for COVID-19. Hispanics who also have cancer are more likely to be negatively impacted by COVID-19. Nonetheless, this overall assessment shows how uncommon it is for older Hispanic people in El Paso to have cancer.

5.9. HIV/AIDS

The unweighted sample with over-representation of people experiencing homelessness has a 0.2% HIV rate. In our survey, 100% of those with HIV/AIDS were homeless at the time of the survey. Given the high-risk status associated with being homeless and having a positive HIV/AIDS diagnosis, respectively, this portion of the Latin population is extremely vulnerable to health complications or death related to COVID-19.

The percentage of those with HIV/AIDS in our weighted data constitutes about 0.00002% of all Hispanics living in El Paso, which is significantly lower than the 2019 national percentage of 0.34% [66,68]. However, the stigma surrounding HIV/AIDS makes people wary of getting tested and learning about prevention methods. It is estimated that 1 in 7 people living with HIV/AIDS in the United States are unaware of their positive status [66]. Therefore, it is likely that there are other HIV/AIDS-positive Latin people living in the region.

None of the HIV/AIDS-positive Hispanic residents in the sample were medically insured. Although the number of HIV/AIDS-positive people in the data is small, it is nonetheless worrisome, considering that HIV/AIDS killed over 37,000 people in the U.S. in 2018 [69]. The year before, 53% of new known HIV cases were diagnosed in the South, 21% of which were among Hispanics/Latinos. Although numbers have gradually decreased over the past few years, the rate of new cases in Texas was 15.4 per 100,000 in 2019 [69]. Care for the HIV/AIDS-positive community in the region is also subpar. Recently, the U.S. South reported the lowest number of HIV-positive people who received medical care and had a suppressed viral load from being treated with antiretroviral therapy [69].

Similarly, according to our data, only half of the Hispanic residents with HIV/AIDS were on medication in 2011. Whether the medication being taken was antiretroviral therapy is unknown, so it is possible that even fewer were being treated for HIV/AIDS.

5.10. Tuberculosis

The rates of tuberculosis are falling 2% each year globally, but it is still one of the top 10 leading causes of death worldwide [70]. A quarter of the global population has the tuberculosis bacteria lying dormant in their system, so others in the Hispanic community in El Paso may have contracted the bacteria as well. Only 5–15% of these people are estimated to fall ill with tuberculosis, but those with compromised immune systems and pre-existing conditions are at high risk of developing the illness. For instance, HIV/AIDS-positive people are 19 times more likely to die from tuberculosis, which causes further concern that many HIV/AIDS-positive people lack medical insurance [70].

The prevalence of tuberculosis is low in the El Paso community. Only 0.2% of the Hispanic community of El Paso reported having tuberculosis at one point in their lives, approximately half (49.6%) of whom have medical insurance. This is concerning because all of the tuberculosis diagnoses occurred among Hispanic people of low socioeconomic status who might not be able to afford the proper treatment or medicines without pharmaceutical or medical insurance coverage. Individuals over the age of 45 recalled no previous bouts of tuberculosis—instead, almost half of the reported diagnoses occurred among people aged 18–25.

5.11. Diabetes

According to our survey data, 7.3% of Hispanics in El Paso reported a diabetes diagnosis, 60.1% and 3.3% of whom were low-income and high-income, respectively. More than half (65.5%) had medical insurance, but 34.5% were not insured. According to the CDC, diabetes puts one at considerably higher risk of severe health complications related to COVID-19 given that nearly half (49.7%) of people hospitalized with severe virus-related illness as of 30 March 2020 had a previous diabetes diagnosis [51].

Low insulin adherence, which puts individuals in danger of unregulated and dangerous blood sugar levels, can be attributed to multiple factors such as access, affordability, willingness, and guidance on self-administered injection. This was a concern with our sample because only 31.2% of Hispanics with diabetes took insulin at least once. Positive diabetes diagnoses varied considerably according to age, and Hispanics over the age of 60 constituted 29.3% of total cases. This presents evidence that an insulin adherence barrier affected multiple different age groups. Previous research has drawn connections between low insulin usage and depression, embarrassment, a busy schedule, and travel among people living with type 2 diabetes [71,72]. Patients have also reported fears associated with insulin-related weight gain and accidental hypoglycemia, or low blood sugar, induced by an overproduction or excessive dosage of insulin [73]. In a study conducted by Hu et al., Hispanic immigrants with type 2 diabetes conflated insulin therapy with a death sentence, calling it a “last resort” and expressing that they feared injections because the insulin itself might cause further damage [74]. Many participants, especially women, cited a lack of positive family support and access to syringes as barriers to proper insulin use [74].

The survey data draw awareness to a persistent problem affecting the Hispanic community’s well-being. Individuals with diabetes who are not receiving proper insulin treatment, if receiving any at all, will likely be hit harder by a positive COVID-19 diagnosis than those who follow regular schedules and guidelines outlined by a health provider. These are significant findings that reveal the disproportionately poor health experienced by Hispanic individuals living with chronic diseases and inform us of who might be especially vulnerable to COVID-19.

5.12. Obesity

Just over one-quarter (26.2%) of survey participants were considered obese, of whom 3.4% were considered severely obese with a Body Mass Index (BMI) of 40 or higher [51]. Almost half of obese Hispanics lived without medical coverage, and 58.2% of those diagnosed as obese were low-income. Over one-third (38.3%) received a diagnosis between the ages of 18 and 30, although 10.8% of obese Hispanics were ages 61 and older.

Obesity, characterized by a body mass index of 30 or higher, increases a person's vulnerability to severe illness related to COVID-19 [51]. The CDC reported that 48.3% of individuals hospitalized for virus-related health complications were obese in March 2020 [51]. Before COVID-19, obesity was regarded as a public health issue for the U.S. Hispanic population. In 2019, an estimated 80.4% of Hispanics living in the United States were overweight or obese and were more likely to be obese than White adults [75,76]. These trends are concerning because obesity is associated with many health conditions, including type 2 diabetes, hypertension, stroke, coronary heart disease, sleep apnea, certain cancers, and gallbladder disease [77]. Some of these conditions, as previously discussed, increase the risk of complications from COVID-19.

6. Conclusions

Throughout this paper, we dissect the socioeconomic factors that tie into health and well-being and their detrimental effect on racial and ethnic minorities. The COVID-19 pandemic, albeit unexpected, further exposed and reproduced health disparities that were previously less discernible to the general public. The Hispanic community across the United States is already at higher risk of COVID-19 because of institutional discrimination across the sectors of employment, housing, and health. In El Paso, where more than half of Hispanics were of low socioeconomic status, and 48% lacked medical insurance a decade before, their chances of suffering from severe illness related to COVID-19 are even higher. This is particularly dangerous for those with pre-existing health conditions, such as type 2 diabetes, cardiovascular disease, HIV/AIDS, and cancer. It remains unclear whether more Hispanics living in the U.S. will die from COVID-19 than other racial and ethnic groups, as the pandemic has not run its full course. However, preventive measures must be taken in order to protect the Hispanic community in El Paso from tragedy, including the proper allocation of health resources and financial support for low-income, homeless, undocumented, and medically uninsured individuals.

Although discussion of racial disparities is critical, it is just the tip of the iceberg. Health disparities explain how communities of color disproportionately suffer from poor health, but not why state and federal institutions do not properly allocate health resources. The heart of the problem lies in systemic racism, discrimination, and state-sanctioned violence against minorities. Given that communities of color face many structural inequalities, such as poverty, residential segregation, racism, and access to healthcare, they are not to blame for pre-existing or virus-related health disparities [78]. We should take caution in our reporting of racial and ethnic inequities to ensure that data are contextualized within a critical understanding of structural factors that cause disproportionate COVID-19 rates among minority groups.

In this study, we have outlined how it is not a coincidence that infection and death rates of COVID-19 among Native American, Black, and Hispanic populations in the U.S. have been among the highest in the world since the beginning of the pandemic. Structural inequalities incurred by institutional racism have created, and continue to create, underlying medical conditions and enable increased exposure to the virus, which puts Native American, Black, and Hispanic citizens in far more vulnerable positions regarding COVID-19 than their non-Hispanic White counterparts. When assessing preventative and recovery measures, policymakers and public health officials should consider pre-existing health disparities and their heightened likelihood of working essential or frontline jobs [31,32]. Cities and towns with higher numbers of working-class Latin people should be prepared to conduct extensive community-based health education and outreach through *promotoras*

de salud and provide referrals to critical medical care for sub-populations at higher risk. In addition, further research should investigate the lasting effects of COVID-19 infection and "long-COVID" on these groups.

The dataset used to assess the risk that the population of a city had to COVID was collected much before the pandemic started. Nonetheless, this paper shows how similarly detailed data about a city or population can and should be used by public health officials in a preventive fashion to reduce deaths. Public health data should not be limited to prevalence rates, and epidemiology, but should also include social variables and cultural and sociological insights to include the role of beliefs and ideas in health-seeking behavior and the role of socioeconomic factors in producing different health outcomes between and among ethnic and racial groups. Migration and immigration status are essential determinants of health and well-being. Longitudinal health and social data of large and diverse samples that oversample minority, immigrant, and unhoused individuals are an important tool in creating a healthy population.

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References

1. Lovelace, B. White House Officials Worry the Coronavirus Is Hitting African Americans Worse than Others. Available online: https://www.cnbc.com/2020/04/07/white-house-officials-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html (accessed on 28 April 2021).
2. Nania, R. Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show. Available online: https://www.aarp.org/health/conditions-treatments/info-2020/minority-communities-covid-19.html (accessed on 28 April 2021).
3. Barr, D. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health*, 2nd ed.; Johns Hopkins University Press: Baltimore, MD, USA, 2014.
4. Premji, S.; Duguay, P.; Messing, K.; Lippel, K. Are Immigrants, Ethnic and Linguistic Minorities Over-Represented in Jobs with a High Level of Compensated Risk? Results from a Montréal, Canada Study Using Census and Workers' Compensation Data. *Am. J. Ind. Med.* **2010**, *53*, 875–885. [CrossRef] [PubMed]
5. Centers for Disease Control and Prevention. People at Increased Risk and Other People Who Need to Take Extra Precautions. Available online: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html (accessed on 28 April 2021).
6. Castañeda, E.; Smith, B.; Vetter, E. Hispanic Health Disparities and Housing: Comparing Measured and Self-Reported Health Metrics Among Housed and Homeless Latin Individuals. *J. Migr. Health* **2020**, *1–2*, 100008. [CrossRef] [PubMed]
7. Moya, E.M.; Zamore, C.; Perez, L.M.; Tellez, K.; Avila, A.; Aragones, A. COVID-19 Imperils Access to Health and Human Services in El Paso, Texas and New York City: Perspectives from Hispanic Parents. *J. Racial Ethn. Health Disparities* **2022**, *9*, 1024–1029. [CrossRef] [PubMed]

8. Castañeda, E. Latinos in El Paso at Risk from COVID-19. Available online: https://ernestoc.medium.com/latinos-in-el-paso-at-risk-from-covid-19-1c508c564d24 (accessed on 11 December 2022).
9. The High COVID-19 Death Toll in Texas-Mexico Border Towns. Available online: https://time.com/6074581/covid-19-deaths-texas-mexico-border/ (accessed on 11 December 2022).
10. Moore, R. A Year into the Pandemic, COVID-19 Has Ravaged El Paso. Available online: http://elpasomatters.org/2021/03/14/a-year-into-the-pandemic-covid-19-has-ravaged-el-paso/ (accessed on 11 December 2022).
11. Castañeda, E. Speaking about Health Disparities: A Teachable Moment about Structural Racism. Available online: https://ernestoc.medium.com/speaking-about-health-disparities-a-teachable-moment-about-structural-racism-2774dc5f44b (accessed on 11 December 2022).
12. Reuters Graphics. COVID-19 Global Tracker. Available online: https://graphics.reuters.com/world-coronavirus-tracker-and-maps/ (accessed on 28 April 2021).
13. Reuters Graphics. Tracking the Novel Coronavirus in the U.S. Available online: https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html (accessed on 28 April 2021).
14. Bureau of Communicable Disease Surveillance System. Age-Adjusted Rates of Lab Confirmed COVID-19. Available online: https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf (accessed on 16 April 2020).
15. NYC Health. COVID-19: Data, Details on Deaths. Available online: https://github.com/nychealth/coronavirus-data/blob/master/by-race.csv (accessed on 16 April 2020).
16. U.S. Census Bureau. U.S. Census Bureau QuickFacts: El Paso County, Texas. Available online: https://www.census.gov/quickfacts/fact/table/elpasocountytexas/PST045219? (accessed on 28 April 2021).
17. Lachica, J.; Castañeda, E.; McDonald, Y. (Eds.) *Poverty, Place, and Health along the US-Mexico Border*; Poverty and Health: A Crisis among America's Most Vulnerable. Volume 2: Place and Health among the Vulnerable; ABC-CLIO: Goleta, CA, USA, 2013.
18. KTSM Staff. El Paso COVID-19 Cases Surpass 1,000 Mark. Available online: https://www.ktsm.com/local/el-paso-news/el-paso-covid-19-cases-surpass-1000-mark/ (accessed on 28 April 2021).
19. Willard, K. Public Health Director in El Paso Resigns as City Response to COVID-19 Continues. Available online: https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues (accessed on 28 April 2021).
20. Coyne, M. The U.S. May Be Heading to A Second (or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means. Available online: https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/ (accessed on 28 April 2021).
21. Cervantes Holguín, E.; Gutiérrez Sandoval, P.R. Resistir la Covid-19. Intersecciones en la Educación de Ciudad Juárez, México. *RIEJS* **2020**, *9*, 7–23. [CrossRef]
22. Pane, L.M.; Coronado, A. Virus Pushes Twin Cities El Paso and Juarez to the Brink. Available online: https://apnews.com/article/business-virus-outbreak-family-gatherings-north-america-mexico-e066bb7aaf4ad1c2417254c24c0e835c (accessed on 28 April 2021).
23. Berumen, J.; Schmulson, M.; Alegre-Díaz, J.; Guerrero, G.; Larriva-Sahd, J.; Olaiz, G.; Wong-Chew, R.M.; Cantú, C.; Ochoa-Guzmán, A.; Garcilazo-Ávila, A.; et al. Risk of Infection and Hospitalization by Covid-19 in Mexico: A Case-Control Study. *medRxiv* **2020**. [CrossRef]
24. Navarrete, B.; Sanchez, G. Risks and Challenges to Migrants, Asylum Seekers and Refugees Living Under COVID-19 in Ciudad Juárez, Mexico. *Migr. Policy Pract.* **2020**, *10*, 48–53.
25. Kahn, C. "Remain in Mexico" Policy's End Brings Renewed Hope to Asylum Seekers. Available online: https://www.npr.org/2021/02/14/967807189/remain-in-mexico-policys-end-brings-renewed-hope-to-asylum-seekers (accessed on 28 April 2021).
26. Castañeda, E. Expulsión de Migrantes Como Oportunidad Perdida y Tarea Para Sísifo. *Rev. Mex. De Sociol.* **2023**, *85*, 229–238.
27. Martinez, V. "Every Day I See Death": Gravediggers in Juarez Perform Grim Labor as COVID-19 Death Toll Rises in Mexico. Available online: https://www.elpasotimes.com/in-depth/news/local/juarez/2020/11/19/coronavirus-juarez-mexico-death-toll-cemetery-workers-covid-19/6248165002/ (accessed on 28 April 2021).
28. Neuman, W.L. *Social Research Methods: Qualitative and Quantitative Approaches*; Allyn & Bacon: Boston, MA, USA, 2011.
29. O'Hare, W.P. *Differential Undercounts in the U.S. Census: Who Is Missed?* Springer Nature: Berlin/Heidelberg, Germany, 2019; ISBN 978-3-030-10973-8.
30. El Paso Strong. City of El Paso COVID-19 Cases. Available online: https://www.epstrong.org/results.php (accessed on 28 April 2021).
31. U.S. Bureau of Labor Statistics. *Labor Force Characteristics by Race and Ethnicity, 2018*; BLS Reports; U.S. Bureau of Labor Statistics: Washington, DC, USA, 2019; pp. 1–83.
32. Passel, J.; Cohn, D. Share of Unauthorized Immigrant Workers in Production, Construction Jobs Falls Since 2007. Available online: https://www.pewresearch.org/hispanic/2015/03/26/share-of-unauthorized-immigrant-workers-in-production-construction-jobs-falls-since-2007/ (accessed on 28 April 2021).
33. Centers for Disease Control and Prevention. Health Equity Considerations & Racial & Ethnic Minority Groups. Available online: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html (accessed on 28 April 2021).
34. Villa, L. Millions of Americans Have Been Laid off Amid the Coronavirus Outbreak. Here's What It's Like to Be One of Them. Available online: https://time.com/5812538/coronavirus-economic-damage-workers/ (accessed on 28 April 2021).

35. Smith, R. Fact Sheet: Immigrant Workers' Eligibility for Unemployment Insurance. Available online: https://www.nelp.org/publication/immigrant-workers-eligibility-unemployment-insurance/ (accessed on 28 April 2021).
36. District of Columbia Department of Human Resources. E-DPM Instruction No. 12-51. 2013. Available online: https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf (accessed on 28 April 2021).
37. Stewart, E. The Essential Worker Trap. Available online: https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state-reopening (accessed on 28 April 2021).
38. Park, K.; Meagher, T.; Li, W. Tracking the Spread of Coronavirus in Prisons. Available online: https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons (accessed on 28 April 2021).
39. The Marshall Project. A State-by-State Look at Coronavirus in Prisons. Available online: https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (accessed on 28 April 2021).
40. Federal Bureau of Prisons. BOP: COVID-19 Update. Available online: https://www.bop.gov/coronavirus/ (accessed on 28 April 2021).
41. Nellis, A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. Available online: https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/ (accessed on 28 April 2021).
42. Data USA. New Mexico. Available online: https://datausa.io/profile/geo/new-mexico (accessed on 28 April 2021).
43. The Sentencing Project. Latinx Disparities in Youth Incarceration. Available online: https://www.sentencingproject.org/publications/latino-disparities-youth-incarceration/ (accessed on 28 April 2021).
44. National Immigration Law Center. Immigrants and the Affordable Care Act (ACA). Available online: https://www.nilc.org/issues/health-care/immigrantshcr/ (accessed on 28 April 2021).
45. The Council of Economic Advisers. The State of Homelessness in America. Available online: https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf (accessed on 1 May 2021).
46. Tsai, J.; Wilson, M. COVID-19: A Potential Public Health Problem for Homeless Populations. *Lancet Public Health* **2020**, *5*, e186–e187. [CrossRef] [PubMed]
47. Lebrun-Harris, L.A.; Baggett, T.P.; Jenkins, D.M.; Sripipatana, A.; Sharma, R.; Hayashi, A.S.; Daly, C.A.; Ngo-Metzger, Q. Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey. *Health Serv. Res.* **2013**, *48*, 992–1017. [CrossRef] [PubMed]
48. Oppenheimer, S.C.; Nurius, P.S.; Green, S. Homelessness History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights from Population Data. *Fam. Soc.* **2016**, *97*, 230–242. [CrossRef] [PubMed]
49. Castañeda, E.; Klassen, J.D.; Smith, C. Hispanic and Non-Hispanic Homeless Populations in El Paso, Texas. *Hisp. J. Behav. Sci.* **2014**, *36*, 488–505. [CrossRef]
50. Centers for Disease Control and Prevention. Medical Conditions. Available online: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (accessed on 28 April 2021).
51. Garg, S. Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID-NET, 14 States, March 1–30, 2020. *MMWR Morb. Mortal. Wkly. Rep.* **2020**, *69*, 458. [CrossRef] [PubMed]
52. Alegria, M.; Canino, G.; Shrout, P.E.; Woo, M.; Duan, N.; Vila, D.; Torres, M.; Chen, C.-N.; Meng, X.-L. Prevalence of Mental Illness in Immigrant and Non-Immigrant U.S. Latino Groups. *Am. J. Psychiatry* **2008**, *165*, 359–369. [CrossRef] [PubMed]
53. Palloni, A.; Arias, E. Paradox Lost: Explaining the Hispanic Adult Mortality Advantage. *Demography* **2004**, *41*, 385–415. [CrossRef] [PubMed]
54. Medina-Inojosa, J.; Jean, N.; Cortes-Bergoderi, M.; Lopez-Jimenez, F. The Hispanic Paradox in Cardiovascular Disease and Total Mortality. *Prog. Cardiovasc. Dis.* **2014**, *57*, 286–292. [CrossRef] [PubMed]
55. Crosnoe, R. Studying the Immigrant Paradox in the Mexican-Origin Population. In *The Immigrant Paradox in Children and Adolescents: Is Becoming American a Developmental Risk?* American Psychological Association: Washington, DC, USA, 2012; pp. 61–76. ISBN 978-1-4338-1053-4.
56. Centers for Disease Control and Prevention. High Blood Pressure Symptoms and Causes. Available online: https://www.cdc.gov/bloodpressure/about.htm (accessed on 28 April 2021).
57. Centers for Disease Control and Prevention. Know Your Risk for Heart Disease. Available online: https://www.cdc.gov/heartdisease/risk_factors.htm (accessed on 28 April 2021).
58. National Heart, Lung, and Blood Institute. Blood Cholesterol. Available online: https://www.nhlbi.nih.gov/health-topics/blood-cholesterol (accessed on 28 April 2021).
59. American College of Allergy, Asthma & Immunology. Asthma Attack. Available online: https://acaai.org/asthma/symptoms/asthma-attack (accessed on 28 April 2021).
60. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19)—Symptoms. Available online: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html (accessed on 28 April 2021).
61. Centers for Disease Control and Prevention. COVID-19 Provisional Counts—Weekly Updates by Select Demographic and Geographic Characteristics. Available online: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#AgeAndSex (accessed on 28 April 2021).
62. American Stroke Association. Effects of Stroke. Available online: https://www.stroke.org/en/about-stroke/effects-of-stroke (accessed on 28 April 2021).

63. American Lung Association. Emphysema | American Lung Association. Available online: https://www.lung.org/lung-health-diseases/lung-disease-lookup/emphysema (accessed on 28 April 2021).
64. Boyles, S. COPD Care Suffers With High Insurance Deductibles. Available online: https://www.medpagetoday.com/meetingcoverage/ats/79988 (accessed on 28 April 2021).
65. World Health Organization. Hepatitis. Available online: https://www.who.int/news-room/q-a-detail/hepatitis (accessed on 28 April 2021).
66. HIV.gov. U.S. Statistics. Available online: https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics (accessed on 28 April 2021).
67. National Institute of Diabetes and Digestive and Kidney Diseases. What Is Chronic Kidney Disease? Available online: https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease (accessed on 28 April 2021).
68. U.S. Census Bureau. *Census Bureau Projects U.S. and World Populations on New Year's Day*. Available online: https://www.census.gov/newsroom/press-releases/2019/new-years-population.html (accessed on 28 April 2021).
69. Centers for Disease Control and Prevention. HIV in the United States by Region. Available online: https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html (accessed on 28 April 2021).
70. World Health Organization. Tuberculosis (TB). Available online: https://www.who.int/news-room/fact-sheets/detail/tuberculosis (accessed on 28 April 2021).
71. Kilbourne, A.M.; Reynolds, C.F.; Good, C.B.; Sereika, S.M.; Justice, A.C.; Fine, M.J. How Does Depression Influence Diabetes Medication Adherence in Older Patients? *Am. J. Geriatr. Psychiatry* **2005**, *13*, 202–210. [CrossRef] [PubMed]
72. Peyrot, M.; Barnett, A.H.; Meneghini, L.F.; Schumm-Draeger, P.-M. Insulin Adherence Behaviours and Barriers in the Multinational Global Attitudes of Patients and Physicians in Insulin Therapy Study. *Diabet. Med.* **2012**, *29*, 682–689. [CrossRef] [PubMed]
73. Ross, S.A.; Tildesley, H.D.; Ashkenas, J. Barriers to Effective Insulin Treatment: The Persistence of Poor Glycemic Control in Type 2 Diabetes. *Curr. Med. Res. Opin.* **2011**, *27* (Suppl. 3), 13–20. [CrossRef] [PubMed]
74. Hu, J.; Amirehsani, K.; Wallace, D.; Letvak, S. The Meaning of Insulin to Hispanic Immigrants with Type 2 Diabetes and Their Families. *Diabetes Educ.* **2012**, *38*, 263–270. [CrossRef] [PubMed]
75. Hales, C.M.; Carroll, M.; Fryar, C.; Ogden, C. Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018. NCHS Data Brief; 2020. Available online: https://www.cdc.gov/nchs/products/databriefs/db360.htm (accessed on 1 May 2021).
76. National Center for Health Statistics. *Health, United States 2018*; Health; National Center for Health Statistics: Hyattsville, MD, USA, 2018; pp. 1–56.
77. Systematic Evidence Review from the Obesity Expert Panel, 2013; *Managing Overweight and Obesity in Adults*; NIH: National Heart, Lung, and Blood Institue: Bethesda, MD, USA, 2013; pp. 1–501.
78. Bailey, Z.; Krieger, N.; Agenor, M.; Graves, J.; Linos, N. Structural Racism and Health Inequities in the USA: Evidence and Interventions. *Lancet* **2017**, *389*, 1453–1463. [CrossRef] [PubMed]

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Article

Symptoms of PTSD and Depression among Central American Immigrant Youth

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Abstract: The aim of this paper is to explore the mental health challenges that Central American immigrant youth face before and after arriving in the United States. This population is hard to reach, marginalized, and disproportionately exposed to trauma from a young age. This paper investigates the mental health stressors experienced by Central American immigrant youth and asylum seekers, including unaccompanied minors, surveyed in the U.S. in 2017. This mixed methods study uses qualitative data from interviews along with close-ended questions and the validated PHQ-8 Questionnaire and the Child PTSD Symptom Scale (CPSS). These new migrants face numerous challenges to mental health, increased psychopathological risk exacerbated by high levels of violence and low state-capacity in their countries of origin, restrictive immigration policies, the fear of deportation for themselves and their family members, and the pressure to integrate once in the U.S. We find that Central American youth have seen improvements in their self-reported mental health after migrating to the U.S., but remain at risk of further trauma exposure, depression, and PTSD. We find that they exhibit a disproportionate likelihood of having lived through traumatizing experiences that put them at higher risk for psychological distress and disorders that may create obstacles to integration. These can, in turn, create new stressors that exacerbate PTSD, depression, and anxiety. These conditions can be minimized through programs that aid immigrant integration and mental health.

Keywords: trauma; unaccompanied minors; migration; Central American youth; transnational families; generational trauma; immigrant integration; social determinants of mental health

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1. Introduction

Central American youth emigrating to escape violence, poverty, family separation, and abuse may have a high risk for developing mental health issues such as anxiety, depression, and post-traumatic stress disorder. Upon settling in their new community, immigrants grapple with cultural, social, and economic challenges. They must find housing, learn a new language, earn money, navigate prejudice, and establish a social support network. They are thrown into an acculturation process, defined by Alegría et al. as "the acquisition of the cultural elements of the dominant society," which include norms, values, ideas, and behaviors [1]. The relative success of this acculturation process, in turn, shapes immigrants' mental health, their ability to integrate, and how they are perceived by their new society [1]. During the transition, one may accumulate acculturative stress, or the stress of trying to integrate into a new country's culture while seeking to retain one's values, traditions, and beliefs derived from home country experiences [2]. This unique type of stress that

immigrants face upon their arrival can be more difficult to manage by those who have already experienced trauma. Post-migration stressors may inhibit immigrants' recovery from pre-migration trauma, which prolongs and worsens mental health problems [3]. Therefore, the challenges that Central American immigrants face prior to and after arriving in the U.S. will shape their mental health status, vulnerability to further trauma, and integration experience.

Immigrant youth experience major stressors and traumas in their country of origin. Families often separate for economic reasons, having their children stay with a relative while the parents live and work in the U.S. The separation of the family across physical borders is defined as a transnational household [4–6]. Many women immigrants take care of other children abroad while being away from their own children [7]. Despite the distance, many parents still attempt to fulfill familial obligations through remittances: the money and gifts sent back to support their children and express their love and sacrifice [4]. Even though the parents may become stable providers of money, clothes, food, and toys, children are still often unable to comprehend parental separation as anything other than abandonment [8]. Even though children may eventually reunite with their parents in the U.S., feelings of resentment and abandonment may linger [4,8]. Despite the best intentions of the parents, the children left behind often struggle to form close and trusting relationships in their adult lives, including with partners and children [4]. The experience of long-term separation, hardships in their country of origin, and their own migration journey will weigh on their mental health status post-migration. Taking a sociological approach to the social determinants of health [3,9], this paper argues that the migration and integration processes present unique stressors that mold mental health outcomes.

1.1. Traumatic Stressors

Driving factors for emigration from Central America include political instability, crime, violence, and low state capacity that deprives populations of access to education, health care, and other services. Migration is one mode of escaping from these hardships. Trauma is defined as "actual or threatened death, serious injury, or sexual violence" [10]. Surviving a trauma is not only stressful, but it may create long-term sequelae, and in some cases, develop into a chronic stressor such as PTSD. Immigrants may experience trauma at different points of their migration process: pre-migration traumas in their home country, traumas on the migratory journey, and a hostile environment in the new country [11]. Common forms of pre-migration trauma include natural disasters, war, gang violence, victimization, witnessing a crime, physical and sexual abuse, or attacks based on their sexual orientation or gender identity. Migrant youth traveling alone face an increased risk of undernutrition, dehydration, assault, kidnapping, and others forms of violence [12–15]. These traumatic experiences put migrants at higher risk for psychological distress and disorders that may also create obstacles to integration that create new stressors that accumulate into compounded traumas [11].

There are different pathways that shape the lives of migrant families and their children. While qualified workers, refugees, and asylum seekers are often allowed to immigrate as family units, most often families are separated as a result of migration. For example: immigrating without a child due to limited options for legal migration, forced separation that occurs either after arriving or during their time in the U.S., and the migration by unaccompanied minors. Often, migrants must make the journey to the U.S. without their children so as not to expose them to the perils of traveling or because they plan to work abroad temporarily to send remittances [16]. Other families are forcibly separated upon arriving at the U.S. border or after they have made it across and established their new lives. These parents who leave their children behind are operating under structurally constrained choices and are forced to sacrifice present needs for their children's future economic security [17,18]. When limited options force families to separate, their decision is contingent upon what the family believes to be most beneficial in the long run [19]. Parents

may view immigrating to the United States as a means to achieve economic stability for the family [19]. Nonetheless, children left behind may feel abandoned and resentful [4,6,20].

Often looking to reunite with parents, minors who arrive at the border without any adult family members are designated by U.S. authorities as "unaccompanied alien children" (UACs) and are subject to additional legal protections. However, legal representation is not guaranteed, and the "fast-track court hearings" [11] that follow their arrival limit opportunities to develop legal claims for immigrant youth. Once in the United States, immigrant children face additional risks for mental health disorders due to poor living conditions, lack of opportunities, discrimination, limited access to federal resources, and fear of deportation [11].

Children from families divided across borders have a higher likelihood of experiencing separation anxiety, ongoing grief, and low self-worth [4,8]. Familial cohesion and stability play a role in behavioral outcomes among immigrant youth [21]. Those who are cared for by their parents or relatives have better behavioral outcomes than those who do not experience familial supervision or guidance [21]. In addition, a caregiver's documentation status affects the well-being of the youth in their care. Immigrant youth who live with undocumented caregivers are more likely to be stressed [21].

Young immigrants may have a heightened vulnerability to post-traumatic stress disorder (PTSD) [22]. Asylum seekers and immigrant youth may have higher rates of PTSD [23–26]. Immigrant youth may be at an increased risk for PTSD due to (1) pre-migration trauma; (2) traumatic migration experiences; (3) migrating unaccompanied; (4) experiencing higher acculturation stress if migrating at an older age; (5) experiencing prolonged family separation; (6) threats of deportation and forced separation; and (7) discrimination and hate crimes [27]. Furthermore, they may struggle to maintain healthy adult relationships in the future [4]. In this way, migration can be understood as a social determinant of mental health among immigrant youth and adults.

The mental health of immigrants is not only connected to the trauma they face prior to arriving in the U.S. but also to U.S. government policies, which have a long history of excluding Latin people (we use Latin as a gender-neutral adjective, we also use Hispanic as synonymous, when used by the authors cited) [28], and which have become increasingly restrictive since the 1990s. Immigrants and their children often face a hostile and xenophobic social and political environment. The changes in policy over the past three decades primarily targeted undocumented immigrants who had previously managed to fly under the radar [29]. The Illegal Immigrant Reform and Immigration Responsibility Act of 1996 (IIRIRA) established a "bar of inadmissibility" for five to ten years for undocumented immigrants who overstayed their visas and allowed for deportation without counsel or legal representation [11,29]. Additionally, the IIRIRA increased resources for immigration enforcement agencies such as Customs and Border Patrol. The IIRIRA was not the only discriminatory policy passed at this time. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) restricted undocumented immigrants' rights to social services, including access to food stamps, healthcare, and Social Security [29]. These acts removed the federal government's responsibility to grant aid to immigrants and allowed state governments to limit or exclude immigrants from federal and state programs with the belief that they had not been in the United States long enough to be entitled to such services [29]. These policies played a critical role in subjecting immigrant children to a higher risk of mental health disorders that included PTSD, anxiety, and depression by restricting access to mental health care.

In addition to IIRIRA and PRWORA, state laws such as Arizona's Support Our Law Enforcement and Safe Neighborhoods Act (SB 1070) subjected immigrants to additional perils. SB 1070 gave law enforcement agencies the ability to detain anyone who was suspected of being an undocumented immigrant. Anyone who was not carrying a legal residency document would be charged with a misdemeanor. The primary goal of SB 1070 was to reduce the number of undocumented immigrants in the U.S., to encourage self-deportation, and to discourage new immigrants from entering the country. In practice,

this law criminalizes people simply for appearing to be Hispanic and thus assumed to be undocumented [30]. Another study showed the unfavorable impacts of racial profiling on high school-age Hispanics, who showed a higher probability than Black and white students to report feeling sad. Hispanic students were also slightly more likely to have suicidal thoughts and attempts than others [31].

In this way, pre-existing traumas and subsequent mental health struggles influence immigrants' psychological well-being and integration experience in the U.S. A different study reported that female immigrants from Latin America experienced high levels of trauma from domestic, community, emotional, physical, and sexual violence. Some girls experienced abuse at the hands of relatives with whom their parents had left them after migrating. A minor could be subjected to emotional violence by being left behind and forced to deal with neglectful or abusive caretakers. In addition to experiencing childhood violence, women dealt with physical violence from their domestic partners. Sometimes, physical violence was considered normal, and family members encouraged women to stay in the relationship [32]. Furthermore, sexual abuse is underreported by males [33].

This is not to say that every migrant goes through traumatic experiences. For example, some immigrants make the journey by plane and enter the U.S. with immigrant visa or as tourists, so they experience less violence and trauma on the journey. However, those without prior legal recourse to family reunification often complete the journey over land, becoming exposed to life-threatening incidents with gangs, thieves, or human smugglers [32]. After arriving in the U.S., many experience sexual and physical violence but feel they cannot report it to authorities due to their immigration status [32]. This shows the mental health advantages of providing administrative avenues for immigration and family reunification, as it would make migration a safer experience for all. Racist immigration policies that increase animosity against immigrants have heightened the fear of deportation and worsened immigrants' mental health [11,28].

1.2. Mental Health among Immigrants

After arriving in the United States, many immigrants experience challenges associated with language, economic hardships, and discrimination. The demands created by mainstream society and the lack of social support can contribute further to acculturative stress [1,34,35], migration-related stressors [36,37], and psychiatric disorders [35]. A study by Finch and Vega found that as someone born outside the United States acclimates to their new home, their perception of discrimination slowly increases as they learn English and become familiarized with their environs [38]. This increased awareness of discrimination and acculturation stress led the researchers to find a significant correlation between acculturation and depression. With Latin youth populations being at the highest risk for depression among multiple ethnic groups [39], it is not surprising that the perception of discrimination among migrants leads to a significant decrease in self-esteem [40]. In multiethnic states like Florida and California, 55% of adolescent Latin individuals have experienced at least one form of discrimination [40]. Central American immigrants with high levels of acculturative stress are more likely to experience depression, suicidal ideation, and anxiety [41,42]. Hovey concluded that this might be because they feel caught between two different cultures [34]. However, Dunn and O'Brien report that Latin immigrants feel the pressure to learn English quickly but experience lower stress levels assimilating into American society compared to other groups [43].

Factors that protect immigrants from mental health disorders, such as family cohesion, may erode over time due to the labor market demands and the challenges of having to negotiate between two cultures. According to Cook et al., Latin immigrants, who have lived in the United States for less than ten years, experience lower rates of psychiatric and depressive disorders. Conversely, Latin immigrants living in the U.S. for over twenty-one years are more likely to have a psychiatric disorder than their U.S.-born counterparts [35].

Recently arrived immigrants often lack opportunities to secure medical insurance and therefore cannot access mental health services. In addition to lack of insurance, other

barriers to accessing mental healthcare are distrust of the medical system, lack of childcare or transportation, and unfamiliarity with mental healthcare. In the United States, only some immigrants access mental health services to potentially mediate or lessen symptoms of PTSD, depression, and anxiety. Only about a third of Latina immigrants referred to mental health services receive therapy or psychiatric consultation; younger Latinas and those experiencing only anxiety use mental health services less frequently [44]. Immigrants who experience longer elapsed time between the referral and the intake appointment are less likely to use such services. Houchasen and co-authors argue that this may be due to the lack of providers, the unavailability of appointments, clients not understanding or agreeing to referrals, although case managers are key in helping immigrants receive professional mental healthcare [44].

2. Materials and Methods

The project from which this paper derives, "Household Contexts and School Integration of Resettled Migrant Youth," included: semi-structured interviews with 23 social service providers, school staff, and community experts in the metropolitan Washington, D.C. region; a structured interview with 41 parents or sponsors of minors who arrived in the region; as well as a structured interview with closed- and open-ended questions and two mental health symptom scales applied to 58 Central American participants who arrived in the United States as minors a few years before the time of the interview (2017). We conducted interviews with sponsors and experts to triangulate our qualitative findings. For reasons of length, in this paper, we mainly report the findings directly from youth respondents; however, many of the youth statements were further substantiated by some of the sponsors and service providers.

Unaccompanied minors from Central America have been a frequent topic of discussion in the news since at least the so-called border crisis of 2014 [13,45], but with few exceptions, their voices are rarely heard. These exceptions include a few journalistic snippets, *testimonios* (first-person accounts) [46], interviews of detainees [47,48], or consideration of art they produce during detention [49]. Children have agency and their own way of processing and understanding their experiences and conditions [17], and the best way to understand their mental health outside of a clinical setting is through interviewing and assessing them directly.

Unaccompanied minors and recently arrived immigrant youth constitute a subpopulation that is vulnerable and hard to reach. Therefore, our sampling methods included recruitment through after-school programs, advocacy and legal services, non-profit agencies, and snowball sampling. Participants were paid $25 USD for their participation. Interviewers were certified in human subject ethics training and trained in trauma-informed interviewing. The Institutional Review Board of American University approved the study [IRB-2016-227]. The PIs had previous experience working with undocumented, homeless, disabled, and vulnerable populations. We made clear that we were not working for the government and were not lawyers or journalists. All the PIs and research assistants spoke Spanish. Many of the interviewers were Hispanic and some Central American. They were often immigrants or children of immigrants. Most interviewers were female. The interviewing team included undergraduates and masters level students, so establishing rapport with the interviewees was relatively easy, and it was possible to gain a certain level of trust and confidence.

The survey instrument gathered demographic information as well as details regarding dangers in the youths' home countries, migration journeys, family dynamics, U.S. sponsors, and the youths' experiences with immigration courts and schools in the United States. Youth were also asked whether they had spent time in a detention center, shelter, health clinic, or rehabilitation center over the past six months. Self-reported mental health status, PTSD symptoms, and depressive symptoms were assessed using the Child PTSD Symptom Scale (CPSS) and the Patient Health Questionnaire (PHQ-8) scales. The interviews were

wide-ranging. Some questions were open-ended, whereas others invited simple yes or no answers, and others entailed scale-ranking.

Mixed method studies involve using different approaches to collect or analyze data to increase confidence in the findings [50–54]. We designed this to be a mixed methods study using closed-ended quantifiable questions and open-ended questions that would elicit narrative responses. The purpose was to triangulate the qualitative and quantitative responses collected simultaneously from the same respondents during the same point in time.

Our goal was to explore the mental health challenges that Central American immigrant youth face before and after arriving in the United States. A mixed methods approach provided us with the opportunity to bring forward the voices of this vulnerable and hard to reach population with confidence, points of comparison, and verification to make up for the sample size. The point of the mixed methods design and asking similar questions in different ways was to enable us not to take any answer at face value but to compare answers given by the same respondent.

On average, interviews lasted between 60 and 90 min. All interviews were conducted in Spanish and transcribed in-house, and the narrative sections selected as representing important trends and cases were translated to use in English-language publications after the coding and analyses were done. This ensured that the text remained faithful to the original meaning. Interviews were recorded, transcribed, entered into Qualtrics to analyze responses to the same answer, and coded in NVivo using spelled-out coding trees to bring together themes brought up by participants at any point during the interview. We analyzed quantitative variables on SPSS, thus allowing for the triangulation of both qualitative data and descriptive quantitative statistics.

Thirty-seven youth reported El Salvador as their country of origin, followed by Honduras and Guatemala with 16 and 5 interviewees, respectively (see Table 1). Age at the time of migration ranged from 8 to 20, with only two participants reporting more than 18 years (19 and 20). We decided to include them because their experiences were very similar to those 14 or 16 who already saw themselves as of working age [55]. Interviews took place when youth were at a minimum of 10 years old and a maximum of 22 years old, and the average age at the time of the interview was 16. At the time of their arrival at the border, 34 were unaccompanied, and 24 were accompanied. Additionally, nine arrived with documentation, and 49 minors were undocumented. When interviewed, 22 participants resided in Prince George's County, Maryland, USA, 24 in Montgomery County, Maryland, USA, and 12 in Fairfax County, Virginia, USA, all of which are core jurisdictions in the Washington, D.C. metropolitan area.

Because the survey was comprehensive and asked questions about minors' lives in their home countries, in the United States, and during their migration journeys, we anticipated that there would be changes in youths' mental and physical health statuses post-migration. To track this, question 8 of the survey asked respondents to "Describe your health status prior to migration" by checking "yes" or "no" to the following mental health-related conditions: "Constant Stress," "Anxiety (unease or excessive concern)," and "Depression." Respondents were given these options in Spanish: "Estrés constante," "Ansiedad (intranquilidad o preocupación excesiva)," and "Tristeza." At the end of the survey, they were asked the same question about their health after migration.

Respondents filled out a PHQ-9 modified for teens in Spanish to screen for depression symptoms minus the questions related to suicidal ideation, also known as PHQ-8 [56,57]. This scale has been validated in English and Spanish and is often used by psychologists and clinicians internationally [58,59]. The instrument asks if respondents had experienced individual depression symptoms in the previous two weeks on the scale of (0) "None" (Ninguno), (1) "Various days" (Varios días), (2) "More than Half" (Mas de la mitad de los días"), or (3) "Almost every day" ("Casi todos los días"). We scored as follows in Table 2.

Table 1. Descriptive statistics among immigrant minors in the D.C. metropolitan area (n = 58).

	Overall n	**Years/%**
Average age at time of arrival	58	14
Average age at time of interview	58	16
Gender	58	
Male	31	53.5%
Female	26	44.8%
Non-binary	1	1.7%
U.S. legal citizenship status at time of arrival	58	
Documented	9	15.5%
Undocumented	49	84.5%
Country of origin	58	
El Salvador	37	63.8%
Honduras	16	27.6%
Guatemala	5	8.6%
Jurisdiction within DC metropolitan area	58	
Prince George's County	22	37.9%
Montgomery County	24	41.4%
Fairfax County	12	20.7%
Accompaniment status at the border	58	
Accompanied	34	58.6%
Unaccompanied	24	41.4%

Table 2. PHQ-8 scoring guide.

SCORING	**SEVERITY**
0–4	No or minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–24	Severe depression

Source: [60].

Respondents filled out a Spanish version of the Child PTSD Symptom Scale (CPSS), a version of the PCL-5 used by the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) designed to screen for PTSD in children and adolescents [61]. The instrument is routinely used to provide services and was translated by the Los Angeles Unified School District. It is a self-reporting checklist assessment utilizing the DSM-4′s definition of symptoms apparent in those suffering from post-traumatic stress disorder (PTSD). The CPSS assesses PTSD symptoms and diagnoses in children ranging from ages 8 to 18 based on three items: reexperiencing trauma, avoidance, and arousal [62]. The 17-question assessment asked respondents to report and rate symptoms they experienced in the past two weeks. They were asked to choose how often they experienced symptoms by selecting (0) "Not at all" (Nunca), (1) "Once in a while" (Ocasionalmente), (2) "Half the time" (El 50% del tiempo), or (3) "Almost always" (Prácticamente en todo momento). Following CBITS scoring guidelines, we used a cutoff of 14 points or higher to indicate moderate to severe symptoms of PTSD (see Table 3). This study purposely did not use a checklist of traumatic experiences to avoid triggering study participants, and thus making participation itself traumatic. Respondents were invited to talk about feelings and symptoms, self-report mental health conditions, and self-disclose traumatic experiences, if they felt comfortable.

Table 3. Child PTSD Symptom Scale scoring guide.

	Add the Number of Points Endorsed Per Question, Where
1	not at all = 0 points, once in a while = 1 point, half the time = 2 points, and almost always = 3 points.
2	Tally all points for each of the 17 questions to obtain a total score.
3	Total scores of 14 points or higher indicate moderate to severe PTSD.

Source: [62].

3. Results

3.1. Traumatic Experiences

Most of the youth and adolescents we interviewed had previous traumatic experiences. Some youth shared that they had seen loved ones killed in front of them and personally experienced violence and abuse. Here, we present three excerpts of participant narratives as examples of some of the experiences that youth shared. These narratives point to stressors that youth experience before, during, and after migration.

3.1.1. Carlos

Carlos, who was 15 when interviewed, briefly described his life in El Salvador, which often felt indirectly dictated by the gangs:

> "They wanted to force me to join the Maras. And that is why you can't study: because I was scared to leave the house . . . to go to school."

Death threats were also common if youths did not want to join the gangs. Carlos continued:

> "They only followed me once, but they didn't get me. I headed home. If someone doesn't join the Maras, they kill you, young. There are no options. If you don't join the Maras, they kill you. I felt a lot of pressure."

For Carlos, coming to the United States and joining his father, already living there, was his preferred option over death or joining a gang. He spoke with his family, and then his father arranged for and paid for him to travel north. When asked why he migrated, he responded:

> "Fleeing the Maras. It was my idea to come . . . My dad paid so that they [the coyotes] could bring me. From El Salvador, I went to Guatemala; from Guatemala, I took a bus. I got off, took another bus, got off. At night the buses ran . . . I must've taken around twenty buses from Guatemala to Mexico. From Mexico to the United States, I went by bus and by taxi. I crossed the border and was walking when they detained me. They took me to Immigration; they interviewed me. I explained my case, why I came . . . I was at the center for minors for about half a month. I played there, they had classes, and from there I went with my dad. The trip took around three months . . . I was in a migration center, but not the Court. I understood the rules: I shouldn't miss school, I shouldn't work . . . mostly that . . . In the center for minors, they treated me well. In the immigration center, they speak very angrily to you. I felt nervous because they spoke to me very angrily."

Overall, youth understood that they were under strict watch while their cases were being processed. For Carlos, age 15, he had to attend school, not work, and stay out of trouble—anything that he did, he was told could be used against him in immigration proceedings. Carlos said the lawyer, "didn't help us that much . . . I don't know anything regarding the decision on my case."

3.1.2. Diana

Diana's story is emblematic of the stressors that many like her experience. The words of Diana, 16, from El Salvador, echoed those of Carlos about confidence in the lawyers and courtrooms that they had to experience.

> "No, we go to the court, and then, they don't tell us anything. The lawyer said that they weren't going to give us anything, that I mean, we didn't have hopes that they would give us, I don't know, a permit [to stay]."

She explained why she wanted to leave El Salvador—she was only 13 when she left.

> "I came from El Salvador because I wanted to study more. I want to be a doctor. Where I was living then, the schools aren't great. Well, they don't teach a lot of things, like math, or things like that. They only taught us math twice a week, for 30 min. Same with science. So, my parents wanted me to come here to study, and I also wanted to study, but where I lived, I couldn't study what I wanted to study."

She felt more able to attain those goals in the United States than in El Salvador. She continued:

> "Here I think when I'm 22, or when I'm no longer a minor, I'll be going to university. I want to study. And where I used to live was very dangerous, and there are no opportunities to pursue higher education. Most people in my country only study up to high school and stop there. It is very rare that someone makes it to university."

Diana spoke about her scary, confusing, and dislocating experience crossing the border and being kept in Customs and Border Protection (CBP) custody:

> "We were in a house, and then a man told us that he was going to leave us in a forest. There was a forest, and you could hear a river. And we were on a rock with some other men, who were also with the man who brought us. And you could hear animal noises, and they were very scary. We were scared. It was around 5 in the morning, and we were there for around two hours waiting for the man who was supposed to guide us across. We passed the river once, but then that was when we were going to walk along in the desert. Then we came back and did another loop because the man made a mistake, and he said that we were going to pass through there to Mexico. So, then we came back to go through the United States, and the man was mistaken again. So, then we came back to Mexico, and then the next time we crossed it was where cotton was being grown, and then we walked a lot, a lot to get to a big, black gate where there was an immigration van waiting, and they detained us. They asked our names, and they loaded us in their car, and took us to a little house where there were only around 15 girls. They gave me a blanket, around, well it must've already been nighttime by then. They took us to shower, because our clothes were all [dirty], and they gave us [new] clothes. The next day they took us to the detention center."

Diana described that at first, she struggled in school and felt like she did not know any of the course content because of inadequate schooling in El Salvador. She was nervous that there would not be anyone she could relate to in school. But she found people to help her academically, and she was able to make friends:

> "It was very taxing. At first, I did not want to go out. I was afraid of people who I thought did not speak Spanish. I don't know, I thought they would say go, you aren't from here, things like that. And I didn't want to go to school, I felt sad. But after the first day I went to school, I made friends and then I didn't even want there to be a weekend. I only wanted to be in school. Because we played. And although some classes/subjects were difficult for me, like math, because let me tell you, in El Salvador, they barely had taught me how to add. I didn't know how to multiply, I didn't know how to divide, I didn't know anything! I

> only knew how to read, but I didn't read very well. And here they taught me in Spanish. They are teaching me how to read better. And I am interested in school here. They have a lot of programs to help us, for the students at our school."

3.1.3. Samantha

Samantha, who was 15 and from Honduras, explained how her group was held up near the Guatemala-Mexico border by gangs with firearms threatening to light her group's buses on fire, with everyone inside, unless they all paid a fee. She had to sleep in a field for four nights while the coyotes arranged with the gang to let them pass:

> "And they went around in cars too, with firearms and all that. They would go in front of cars and wouldn't let them pass. Supposedly, that post is controlled by them. *In which country was this?* Guatemala, and I think it was on the border with Mexico. And if you didn't pay them a certain quantity of money, they wouldn't let you through. Supposedly, they were going to set the buses on fire because they were locked from the outside. I mean, no one from the inside could open the doors or anything. The others couldn't open them or anything. *How was this problem resolved?* I don't know how they resolved it. They, I think they went back to where they came from. We were left at that sports field, that I told you about. We slept and spent around four days there, sleeping in the cold and everything. They made an agreement with them. And they gave them, the people that had to give them money, I believe a week. And if not, well that they'd do away with us. Uh-huh, and I think they were able to get it and afterwards we were let free. And we left."

As Samantha continued, she recounted that she only got to eat food once a day during the trip and would otherwise drink water. Traveling through Mexico was not easy.

Samantha described how she had not seen her mom in years and was very little when she left for the U.S. The first year in the U.S. was hard for Samantha because she missed her grandmother and sister, who had felt like her mom more than anyone else when she was still living in Honduras. Other youth, including Melissa, age 14, David, age 13, and Sarah, age 18, also reported that one of the more challenging parts of coming to the U.S. was leaving other relatives, particularly their grandmothers.

3.2. Self-Reported Mental Health

In each mental health "yes" or "no" question in our survey, our respondents by-and-large stated that they did not experience "mental health problems" ("*problemas de salud mental*") before or after migrating to the United States, with only 3 out of 58 responding "yes" (Figure 1). However, many reported having experienced feelings of sadness, worry, and restlessness. About sixty percent of youth reported feeling sad before and after migration. While there was a slight decrease in feelings of sadness post-migration, the change was less than three percent. About one-third of youth reported that they had feelings of anxiety, worry, and restlessness both before and after moving to the United States. Additionally, after immigrating, some reported a decrease in constant stress. This implies that either living in their home countries, making the migration journey, or both situations put a disproportionate amount of stress on the Central American immigrant youth in our sample. Furthermore, many had traumatic experiences. We do not display this data to show population prevalence rates but to report results from our sample and to contrast the mental health self-reported by participant minors with the results from both the scales and the traumatic experiences shared during the same meetings.

The individuals answering in the affirmative for any of these conditions were not always the same pre- and post-migration. There were no statistically significant differences in these self-reported concerns before migrating (through recollection) and at the time of the interview. No statistically significant differences were found based on gender. However, the three individuals noting mental health problems before migrating are all males. The self-reported mental health of our participants slightly improved after migration.

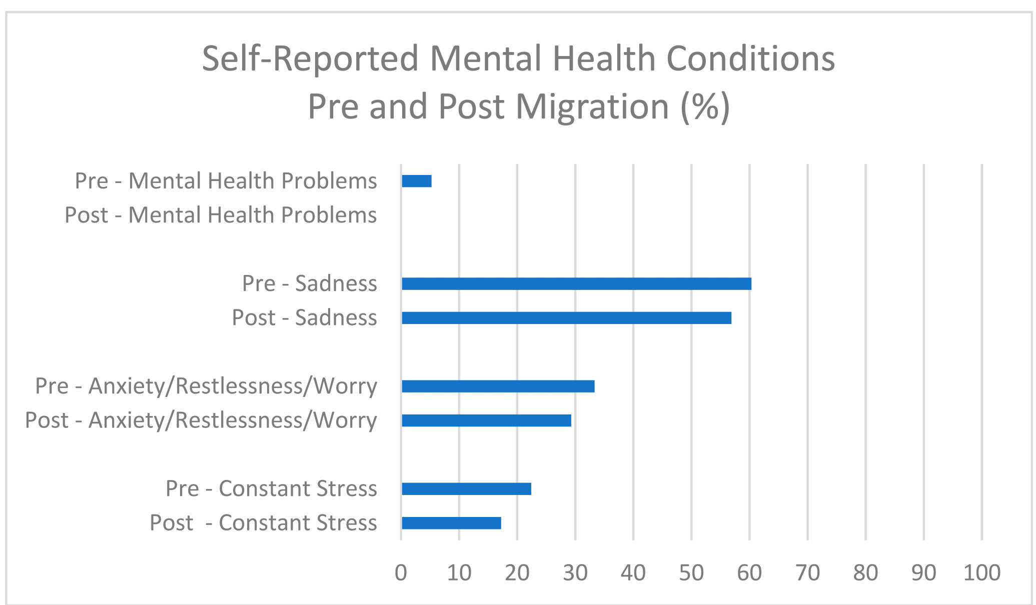

Figure 1. Self-reported mental health pre- and post-migration.

3.3. Mental Health Conditions Pre- and Post-Migration

In the open-ended and follow-up questions, the participants talked more about their sources of worry before and after migration. Table 4 summarizes the types of responses most often given.

3.4. PHQ-9 Modified for Teens

Using the modified PHQ-9 for teens, referred to here as PHQ-8, we were able to examine the severity of depressive symptoms among participants. While 31% of participants reported that they had not struggled with any depressive symptoms within the last two weeks, 79.3% scored between 0 and 4 in the PH8-scale, indicating no or minimal depression, and around 20% exhibited symptoms of mild or moderate depression (Table 5). In one of the follow-up questions, not to be used for scoring, respondents were asked if they felt sad or depressed most days in the last year. Contrary to their other answers, 38% of them responded "yes." We did not ask for suicidal ideation or follow up with a formal diagnosis by a clinician, so the depression scores are on the conservative side.

3.5. Child PTSD Symptoms Scale

Based on the Child PTSD Symptom Scale, 66.7% of youth showed low to no symptoms of PTSD. However, 33.3% of youth did show symptoms that could indicate moderate to severe symptoms of PTSD. Although answers to this assessment would not be used as stand-alone criteria to measure or diagnose PTSD, they do allow researchers to assess individuals preliminarily, monitor present symptoms, and examine whether symptoms indicate a PTSD diagnosis.

The results shown in Table 6 are heterogenous: 12.3% reported no symptoms of PTSD; 54% reported a few symptoms; and 33% scored above the cutoff of 14 points. However, 11 participants, of the 47 that answered the scale, scored between 20 and 28. It is noteworthy that two individuals had very high scores, 42, and 45, close to the maximum possible score of 51.

Table 4. Mental Health Worries and Stressors Pre- and Post-Migration.

	Reasons before Migration	Reasons after Migration
Constant stress	• Want to see and reunite with parent(s) • Gang presence • Living alone • Planning the trip	• Having to stay indoors and being bored • Work
Anxiety	• Future dreams; the trip • Violence affecting friends • Gangs • Needed parent • Could not afford school supplies • Could not study around delinquency • Payment to gangs or coyotes	• Missed and worried about family in home country • New U.S. president • Possible family deportation • Future life • Exploitation at work • Bullying
Sadness	• Leaving friends and family • Could not get out with gangs • Lacking things that others had • Missing parent • Mother: not knowing her, wanting to meet her • Death of grandmother • Death or disappearance of friends • Alcoholic father	• Family separation • Missed friends
Mental health problems	• Frustration • Aggression • Headaches	• None

Table 5. Symptoms of depression from the PHQ-8.

	N	Percent
No or minimal	46	79.3
Mild	8	13.8
Moderate	4	6.9
n	58	100

Table 6. Symptoms of PTSD from the Child PTSD Symptom Scale.

	N	Percent
Zero	7	12.3
Low	31	54.4
Moderate to Severe	19	33.3
n	57	100

4. Discussion

4.1. Traumatic Experiences

Carlos discussed how the gang violence in his home community inhibited his ability to study, move around, or take advantage of opportunities outside of school. Once he was settled in the D.C. area, he said that he felt very safe and that his father kept a close eye on him and his siblings—he felt cared for. Uncertainty of whether Carlos will be allowed to stay with his father in the D.C. area or instead be sent back to El Salvador, where he

has nowhere safe to stay, is a persistent source of anxiety, as is the case with liminal legal status [63,64].

He described having difficulty in school due to language barriers; however, like other youth in our study he was able to develop friendships when he found classmates who were also still learning English. Importantly, now he can imagine doing more than he could when he was in El Salvador. He described not being able to leave the house in El Salvador; now he feels he can join a soccer team in the short term, and in the long term, attend university to become a lawyer. By being taken care of by his father, he was able to start seeing the possibility of a better life for himself [21]. This underscores the importance of family reunification for mental health and the role that family support plays in youth integration.

The trauma of witnessing or being surrounded by violence in migrant-sending communities, family separation, and a notoriously dangerous journey North can last far longer than is clearly visible. For instance, multiple participants reported that one or both of their parents were killed by gangs in their sending communities when they were very young. The other struggles described above, some but not all involving violence, can play into different forms of mental strife as well.

The mental health findings in our sample are mixed. While some mental health measures were positive within the sample, others were negative even with the same individual. One minor, Diana, reported that she wanted to come to the U.S. because she knew that the educational opportunities were better, and she was determined to become a doctor and return to El Salvador. However, she also reported that she sometimes felt isolated and sad. She felt as though her dreams might never be achieved, despite the strong support system of faculty and peers at her school. Another interviewee, Samantha, spoke about how she felt safer in the U.S. than in Honduras. However, she also experienced the loneliness that Diana described, as well as background feelings of tiredness and not having the energy to go about anything beyond the minimum of everyday life. Her mental strife could stem from the fact that she seldom felt safe in Honduras and that she experienced constant fear for her immediate physical safety on the journey from Honduras to the U.S. As demonstrated here, Diana and Samantha both have experienced complex traumatic situations and subsequent feelings of isolation.

These feelings of loneliness may also be due to prior trauma, such as being left behind when their parents migrated to the United States. The parents often have attempted to compensate for this sense of abandonment through "teleparenting" and by sending advice, admonitions, money, clothes, and toys from afar [8]. Yet many children reported feeling ungrateful for what parents understand to have been sacrifices made for the benefit of their offspring. Immigration leaves both the child and the parents sad and uncertain about the future [8].

4.2. Self-Reported Mental Health

Figure 1 shows how many of our respondents reported sadness, anxiety, and/or stress as well as traumatic events but did not consider themselves as "having mental health problems." This could be framed as resilience or as a reflection of their understandings about mental illness. However, an important finding from the triangulation is the discrepancy in self-reporting between "mental health problems" and other mental health aspects. Youth may not consider their anxiety, depression, or constant stress to be a mental health problem. Our findings related to symptoms of PTSD also tell us that more of our sample may be experiencing mental health problems but simply not conceptualizing these symptoms as part of a larger whole. One potential reason for this discrepancy may be the widespread stigma around mental health [65,66]. Additionally, adolescents generally have a harder time understanding their emotions and identifying healthy adaptive emotion regulation strategies than adults [67,68]. A lack of emotional awareness, coping skills, and mental health information might account for participants' tendencies to report negative emotions

but not mental health problems. By using the term "mental health problems," the study addresses issues that have not been formally diagnosed by a mental health professional.

Our qualitative survey results also tell us that our sample had many challenges to confront, often throughout their lives. Children and parents often struggle to understand one another after reuniting physically in the United States, there can remain unsaid tension, recurrent feelings of abandonment, and struggles getting to know one another (again or for the first time). Youth reported that getting used to the relationship with their parents or other sponsors was hard, though it improved over time. Often there are new stepfamilies in addition to the blood relatives of the children, and the dwellings that house immigrant families may be small, cramped, and offer little privacy or space.

4.3. Mental Health Pre- and Post-Migration

Children are likely to be safer in the United States than they were in their country of origin. However, preoccupations about documentation status and deportation impact their mental health [21,69]. Immigration status can contribute to anxieties about immigration authorities and being sent back to an unsafe environment in their home countries. Children fear making friends because no one will understand their situation or, in a worst-case scenario, notify authorities of their presence [28]. Their feelings of abandonment, the separation from their parents, and the possibility of being turned over to the authorities are all potential contributors to feelings of isolation.

For Central American minors who were forcefully separated from their parents at the border, this experience may contribute to the mental health difficulties that these children experience. When children see their parents being torn away from them by border patrol agents, immigration judges, or prison guards, they witness those they love the most being humiliated, and taken away. These experiences likely have a profound and enduring impact that will last a lifetime because they watched those who made them feel safe become impotent when they were forcibly separated. Similarly, the later deportation of a parent can further lead the child to experience depression, insecurity, and loneliness [70]. Table 4 shows that there are worries and stressors both before and after migrating.

4.4. PHQ-8

Depression was also found to be disproportionately high within our sample, with routinely more than 20% of respondents on each question stating that they felt a depressive symptom at least some of the time in the last two weeks and, in other categories, much more frequently. In the last year, almost 40% of the respondents answered "yes" to the question, "Have you felt depressed or sad in the past year most days, even when you feel good sometimes?" These results support our key finding that one-third of our sample may be struggling with moderate to severe PTSD, as depression is a common PTSD comorbidity [62].

4.5. Child PTSD Symptoms Scale

One-third of respondents had moderate to severe symptoms of PTSD. Meanwhile, 12% of respondents reported no symptoms of PTSD as assessed by this scale. Those who reported no symptoms may actually have extremely intense symptoms that they cope with by disassociating. A dissociative state is caused by denial and avoidance and is part of the trauma sequelae of PTSD [62]. Part of surviving trauma is often forgetting [71]. Nevertheless, the results show how the lives of Central Americans cannot be reduced to possibly traumatic experiences. Some individuals may have no PTSD symptoms at all, many young immigrants may have some, and a few of them may have many symptoms, and they can be helped by adequate and accessible mental health services and a network of non-profits providing help to this population as they often do in the D.C. metropolitan region.

5. Limitations

The youth that participated in the study made it to the border and were placed with a sponsor. Therefore, our sample includes relatively privileged individuals in comparison with those who could not make or complete the trip, or the ones who were returned at the border. Because of our partial recruitment through afterschool programs, counselors, and social and legal service providers, our sample was privileged: interviewees were more likely to be enrolled in school than the overall Central American youth population in the Washington, D.C. metro area. Other qualitative findings in the study show that schools were instrumental to youth in developing friendships. Coupled with an *n* of 58, this probably understates the pressures faced by the larger population under study. However, our data about immigrant youth are insightful. Little is known about recent cohorts of unaccompanied Central American youth, and our survey data and instruments can be used for an individual-level analysis.

Given the self-reported format of the survey, these results may be underreporting negative mental health outcomes. Vocabulary related to mental health conditions used in the survey may have been unfamiliar to some of our respondents or understood differently in Spanish than in English [72]. There are cultural differences in interpretations and stigmas concerning mental health, which might have caused respondents to downplay, exaggerate, or altogether hide information or experiences [48,49]. Indeed, studies on mental health stigma and self-concealment have documented how some cultural elements in Latin communities make individuals wary of disclosing their mental health status or seeking out services [65,73–75]. Latin Americans with mental and/or psychosocial disabilities may experience employment discrimination; therefore, someone's willingness to conceal their mental health problems can impact their finances [76]. Furthermore, youth who had not thought or spoken openly about their feelings, especially those who were younger, may have misinterpreted or struggled to understand the survey questions.

Emblematic of possible underreporting, most of our respondents answered in the negative when asked if they struggled with "mental health problems." Nonetheless, many reported that they suffered from anxiety, depression, constant stress, or sadness. While negatively perceived emotions and stress cannot alone necessarily be defined as "mental health problems," they could be indicative of other mental health disorders [77–79]. These responses are especially important when considered alongside the finding from the Child PTSD Symptoms Scale that one-third of Central American minors may be struggling with moderate to severe PTSD. This grants us reason to believe that the actual values are much higher for both our sample and the Central American immigrant youth population at large.

Another limitation was that the answers regarding pre-migration circumstances were based on recollection rather than two different measurements in a longitudinal study. These findings further show the limits of self-reported physical and mental health data, particularly for people with little access to healthcare [80]. They also show the importance of conducting direct measurements during the study and of triangulating self-reported questions, validated scales, and open-ended questions, and the qualitative data that they generate.

The study respondents do not come from a probability random sample because this is a vulnerable and hard-to-reach population. There is no equivalent of a census, phonebook, or neighborhood to create a randomizing sample strategy: the study's recruitment strategy utilized non-profit organizations, law offices, and snowball sampling. Many respondents were found through schools, especially in Montgomery County. Thus, we do not have the stories of those who may have dropped out of school and who may report different experiences due to being embedded in the community in ways other than school. Another consideration is that the bulk of interviews were conducted during the first six months of 2017, namely, before the Trump administration enacted many of its immigration policies and practices, before they took effect, or before they came to public light. The 2016 election and the Trump administration's immigration policies and directives changed the conversation about Latino immigrants, Central America, and intercultural and community violence in several ways. Even so, our data provide a strong benchmark for how youth

fared before 2016. Finally, only a small proportion (15%) of the youth were undocumented, and legal papers are noted as a key determinant of whether an immigrant will integrate well. It is important to note that most UACs approach immigration authorities at the border and ask for asylum and family reunification due to their status as minors. This study only addresses those who were not sent back after turning themselves in to Customs and Border Protection. This study predates the Remain in Mexico program started by the Trump administration and its policy of family separation after detention or asylum application. It also predates the COVID 19 pandemic, which created higher economic and psychological stress for Central American immigrants. Therefore, the results presented here undoubtedly understate the situation of young migrants between 2018 and 2021.

Given the conditions in the countries of origin at the root of migration, the hard passage through Mexico and militarized international borders, and the criminalization of immigration and asylum-seeking, we assumed that all participants had exposure to many or at least one traumatic event during their lifetimes. We did not verify through a trauma exposure checklist because this could have been too upsetting to complete.

6. Conclusions: The Social Determinants of Mental Health

The youth we interviewed often perceived that they had little or no opportunities in their sending communities, whether due to the power and violence of gangs or the inadequacies of schooling and labor markets. Leaving the only home an individual has ever known, the notoriously dangerous journey to the United States, and the challenges of their circumstances upon arriving in the United States are all possible sources of PTSD symptoms [11].

While self-reported mental health measures are not iron-clad ways of understanding an individual's feelings, there is a clear trend. Each measure improved slightly after migration. Being in the United States improved mental well-being perceptions for some, but not all. In other words, mental health concerns did not worsen post-migration in any of the scales or questions used. For participants, emigration reduced some risks but brought many new challenges around familial and societal integration.

This paper shows the complex situations faced by immigrants after arrival in the U.S. [36]. Even if outcomes improved when coming to the U.S., these vignettes support our findings that a third of the respondents may be suffering from PTSD or depression. In line with the literature, we conclude that changes that allow for better access to social services, education, healthcare, and employment are needed to improve Central American youth and their families' mental health outcomes and prevent further trauma exposure. Mental health is not the simple result of individual-level experiences or pre-determined neurochemistry alone but is deeply affected by environmental factors that include poverty, inequality, and immigration policies.

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References

1. Alegria, M.; Shrout, P.E.; Woo, M.; Guarnaccia, P.; Sribney, W.; Vila, D.; Polo, A.; Cao, Z.; Mulvaney-Day, N.; Torres, M.; et al. Understanding Differences in Past Year Psychiatric Disorders for Latinos Living in the US. *Soc. Sci. Med.* **2007**, *65*, 214–230. [CrossRef]
2. Cervantes, R.C.; Gattamorta, K.A.; Berger-Cardoso, J. Examining Difference in Immigration Stress, Acculturation Stress and Mental Health Outcomes in Six Hispanic/Latino Nativity and Regional Groups. *J. Immigr. Minority Health* **2019**, *21*, 14–20. [CrossRef]
3. Hynie, M. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *Can. J. Psychiatry* **2018**, *63*, 297–303. [CrossRef]
4. Castaneda, E.; Buck, L. A Family of Strangers: Transnational Parenting and the Consquences of Family Separation Due to Undocumented Migration. In *Hidden Lives and Human Rights in the United States: Understanding the Controversies and Tragedies of Undocumented Immigration*; Lorentzen, L.A., Ed.; Praeger, an imprint of ABC-CLIO, LLC: Santa Barbara, CA, USA, 2014; Volume 2, pp. 175–201. ISBN 978-1-4408-2847-8.
5. Abrego, L.J. *Sacrificing Families: Navigating Laws, Labor, and Love Across Borders*; Stanford University Press: Stanford, CA, USA, 2014; ISBN 978-0-8047-9057-4.
6. Oliveira, G. *Motherhood Across Borders: Immigrants and Their Children in Mexico and New York*; NYU Press: New York, NY, USA, 2018; ISBN 978-1-4798-7462-0.
7. Parreñas, R.S. Migrant Filipina Domestic Workers and the International Division of Reproductive Labor. *Gend. Soc.* **2000**, *14*, 560–580. [CrossRef]
8. Castañeda, E.; Buck, L. Remittances, Transnational Parenting, and the Children Left Behind: Economic and Psychological Implications. *Lat. Am.* **2011**, *55*, 85–110. [CrossRef]
9. Alegría, M.; NeMoyer, A.; Falgas, I.; Wang, Y.; Alvarez, K. Social Determinants of Mental Health: Where We Are and Where We Need to Go. *Curr. Psychiatry Rep.* **2018**, *20*, 95. [CrossRef]
10. Pai, A.; Suris, A.M.; North, C.S. Posttraumatic Stress Disorder in the DSM-5: Controversy, Change, and Conceptual Considerations. *Behav. Sci.* **2017**, *7*, 7. [CrossRef] [PubMed]
11. Torres, S.A.; Santiago, C.D.; Walts, K.K.; Richards, M.H. Immigration Policy, Practices, and Procedures: The Impact on the Mental Health of Mexican and Central American Youth and Families. *Am. Psychol.* **2018**, *73*, 843–854. [CrossRef]
12. Berger Cardoso, J.; Brabeck, K.; Stinchcomb, D.; Heidbrink, L.; Price, O.A.; Gil-García, Ó.F.; Crea, T.M.; Zayas, L.H. Integration of Unaccompanied Migrant Youth in the United States: A Call for Research. *J. Ethn. Migr. Stud.* **2019**, *45*, 273–292. [CrossRef] [PubMed]
13. Stinchcomb, D.; Hershberg, E. *Unaccompanied Migrant Children from Central America: Context, Causes, and Responses*; Social Science Research Network: Rochester, NY, USA, 2014.
14. Semple, K. Migrants in Mexico Face Kidnappings and Violence While Awaiting Immigration Hearings in U.S. The New York Times 2019. Available online: https://www.nytimes.com/2019/07/12/world/americas/mexico-migrants.html (accessed on 30 March 2021).
15. Chomsky, A. *Undocumented: How Immigration Became Illegal*; Beacon Press: Boston, MA, USA, 2014.
16. Castañeda, E. Living in Limbo: Transnational Households, Remittances and Development. *Int. Migr.* **2013**, *51*, 13–35. [CrossRef]
17. Dreby, J. *Divided by Borders: Mexican Migrants and Their Children*; University of California Press: Berkeley, CA, USA, 2010; ISBN 9780520266605.
18. Parreñas, R.S. *Children of Global Migration: Transnational Families and Gendered Woes*; Stanford University Press: Stanford, CA, USA, 2005; ISBN 0804749442.
19. Dreby, J. U.S. Immigration Policy and Family Separation: The Consequences for Children's Well-Being. *Soc. Sci. Med.* **2015**, *132*, 245–251. [CrossRef]
20. Deparle, J. *A Good Provider Is One Who Leaves: One Family and Migration in the 21st Century*; Penguin Publishing Group: New York, NY, USA, 2020; ISBN 978-0-14-311119-1.

21. Walker, J.; Venta, A.; Galicia, B. Who Is Taking Care of Central American Immigrant Youth? Preliminary Data on Caregiving Arrangements and Emotional-Behavioral Symptoms Post-Migration. *Child. Psychiatry Hum. Dev.* **2020**. [CrossRef]
22. Venta, A.C.; Mercado, A. Trauma Screening in Recently Immigrated Youth: Data from Two Spanish-Speaking Samples. *J. Child. Fam Stud.* **2019**, *28*, 84–90. [CrossRef]
23. Breslau, J.; Borges, G.; Tancredi, D.; Saito, N.; Kravitz, R.; Hinton, L.; Vega, W.; Medina-Mora, M.E.; Aguilar-Gaxiola, S. Migration from Mexico to the United States and Subsequent Risk for Depressive and Anxiety Disorders: A Cross-National Study. *Arch. Gen. Psychiatry* **2011**, *68*, 428–433. [CrossRef]
24. Jamil, H.; Farrag, M.; Hakim-Larson, J.; Kafaji, T.; Abdulkhaleq, H.; Hammad, A. Mental Health Symptoms in Iraqi Refugees: Posttraumatic Stress Disorder, Anxiety, and Depression. *J. Cult. Divers.* **2007**, *14*, 19–25. [PubMed]
25. Park, J.; Elbert, T.; Kim, S.J.; Park, J. The Contribution of Posttraumatic Stress Disorder and Depression to Insomnia in North Korean Refugee Youth. *Front. Psychiatry* **2019**, *10*, 211. [CrossRef]
26. Reavell, J.; Fazil, Q. The Epidemiology of PTSD and Depression in Refugee Minors Who Have Resettled in Developed Countries. *J. Ment. Health* **2017**, *26*, 74–83. [CrossRef]
27. Perreira, K.M.; Ornelas, I. Painful Passages: Traumatic Experiences and Post-Traumatic Stress among U.S. Immigrant Latino Adolescents and Their Primary Caregivers. *Int. Migr. Rev.* **2013**, *47*, 976–1005. [CrossRef]
28. Castañeda, E. *Building Walls: Excluding Latin People in the United States*; Lexington: Lanham, MD, USA, 2019.
29. Androff, D.K.; Ayon, C.; Becerra, D.; Gurrola, M. U.S. Immigration Policy and Immigrant Children's Well-Being: The Impact of Policy Shifts. *J. Soc. Soc. Welf.* **2011**, *38*, 77–98.
30. Romero, M. Are Your Papers in Order: Racial Profiling, Vigilantes, and America's Toughest Sheriff. *Harv. Lat. L. Rev.* **2011**, *14*, 337.
31. Luo, T.; Escalante, C.L. Stringent Immigration Enforcement and the Mental Health and Health-Risk Behaviors of Hispanic Adolescent Students in Arizona. *Health Econ.* **2021**, *30*, 86–103. [CrossRef] [PubMed]
32. Kaltman, S.; de Mendoza, A.H.; Gonzales, F.A.; Serrano, A.; Guarnaccia, P.J. Contextualizing the Trauma Experience of Women Immigrants from Central America, South America, and Mexico. *J. Trauma. Stress* **2011**, *24*, 635–642. [CrossRef] [PubMed]
33. Holmes, W.C.; Slap, G.B. Sexual Abuse of Boys: Definition, Prevalence, Correlates, Sequelae, and Management. *JAMA* **1998**, *280*, 1855–1862. [CrossRef]
34. Hovey, J.D. Acculturative Stress, Depression, and Suicidal Ideation among Central American Immigrants. *Suicide Life Threat. Behav.* **2000**, *30*, 125–139.
35. Cook, B.; Alegría, M.; Lin, J.Y.; Guo, J. Pathways and Correlates Connecting Latinos' Mental Health With Exposure to the United States. *Am. J. Public Health* **2009**, *99*, 2247–2254. [CrossRef] [PubMed]
36. Moya, E.M.; Chávez-Baray, S.M.; Esparza, O.A.; Chelius, L.C.; Castañeda, E.; Villalobos, G.; Eguiluz, I.; Martínez, E.A.; Herrera, K.; Llamas, T.; et al. Ulysses Syndrome in Economical and Political Migrants in Mexico and the United States. *EHQUIDAD Rev. Int. De Políticas De Bienestar Y Trab. Soc.* **2016**, *5*, 11–50. [CrossRef]
37. Achotegui, J. *How to Assess. Stress and Migratory Mourning: Scales of Risk Factors in Mental Health*; Ediciones El Mundo de la Mente: Llançà, España, 2011.
38. Finch, B.K.; Kolody, B.; Vega, W.A. Perceived Discrimination and Depression among Mexican-Origin Adults in California. *J. Health Soc. Behav.* **2000**, *41*, 295. [CrossRef] [PubMed]
39. Umaña-Taylor, A.J.; Updegraff, K.A. Latino Adolescents' Mental Health: Exploring the Interrelations among Discrimination, Ethnic Identity, Cultural Orientation, Self-Esteem, and Depressive Symptoms. *J. Adolesc.* **2007**, *30*, 549–567. [CrossRef]
40. Szalacha, L.A.; Erkut, S.; Coll, C.G.; Alarcón, O.; Fields, J.P.; Ceder, I. Discrimination and Puerto Rican Children's and Adolescents' Mental Health. *Cult. Divers. Ethn. Minority Psychol.* **2003**, *9*, 141–155. [CrossRef]
41. Leong, F.; Park, Y.S.; Kalibatseva, Z. Disentangling Immigrant Status in Mental Health: Psychological Protective and Risk Factors among Latino and Asian American Immigrants. *Am. J. Orthopsychiatry* **2013**, *83*, 361–371. [CrossRef]
42. Arbona, C.; Olvera, N.; Rodriguez, N.; Hagan, J.; Linares, A.; Wiesner, M. Acculturative Stress Among Documented and Undocumented Latino Immigrants in the United States. *Hisp J. Behav Sci* **2010**, *32*, 362–384. [CrossRef]
43. Dunn, M.G.; O'Brien, K.M. Psychological Health and Meaning in Life: Stress, Social Support, and Religious Coping in Latina/Latino Immigrants. *Hisp. J. Behav. Sci.* **2009**, *31*, 204–227. [CrossRef]
44. Hochhausen, L.; Le, H.; Perry, D.F. Community-Based Mental Health Service Utilization Among Low-Income Latina Immigrants. *Community Ment. Health J.* **2011**, *47*, 14–23. [CrossRef] [PubMed]
45. Castañeda, E. There is No Immigration Security Threat That Reform with an Earned Path to Citizenship Cannot Address. Available online: https://scholars.org/there-no-immigration-security-threat-reform-earned-path-citizenship-cannot-address (accessed on 14 October 2020).
46. Mangual Figueroa, A.; Barrales, W. Testimonio and Counterstorytelling by Immigrant-Origin Children and Youth: Insights That Amplify Immigrant Subjectivities. *Societies* **2021**, *11*, 38. [CrossRef]
47. Boehm, D.A.; Terrio, S.J. *Illegal Encounters: The Effect of Detention and Deportation on Young People*; NYU Press: New York, NY, USA, 2019; ISBN 978-1-4798-0591-4.
48. Terrio, S.J. *Whose Child. Am. I? Unaccompanied, Undocumented Children in U.S. Immigration Custody*; University of California Press: Oakland, CA, USA, 2015; ISBN 978-0-520-28149-3.
49. Rung, D.L. Processes of Sub-Citizenship: Neoliberal Statecrafting 'Citizens,' 'Non-Citizens,' and Detainable 'Others'. *Soc. Sci.* **2020**, *9*, 30. [CrossRef]

50. Small, M.L. How to Conduct a Mixed Methods Study: Recent Trends in a Rapidly Growing Literature. *Annu. Rev. Sociol.* **2011**, *37*, 57–86. [CrossRef]
51. Creswell, J.W.; Clark-Plano, V.L. Choosing a Mixed Methods Design. In *Designing and Conducting: Mixed Methods Research*; SAGE Publications: Thousand Oaks, CA, USA, 2007; pp. 58–88.
52. Rumbaut, R.G. Sites of Belonging: Acculturation, Discrimination, and Ethnic Identity Among Children of Immigrants. In *Discovering Successful Pathways in Children's Development: Mixed Methods in the Study of Childhood and Family Life*; Weiner, T.S., Ed.; University of Chicago Press: Chicago, IL, USA, 2005; pp. 111–164.
53. Zamora-Kapoor, A.; Castañeda, E. *Using Mixed Methods in Comparative Research: A Cross-Regional Analysis of Anti-Immigrant Sentiment in Belgium and Spain*; SAGE: Thousand Oaks, CA, USA, 2021.
54. Castañeda, E.; Morales, C.; Ochoa, O. Transnational Behavior in Comparative Perspective: The Relationship between Immigrant Integration and Transnationalism in New York, El Paso, and Paris. *Comp. Migr. Stud.* **2014**, *2*, 305–334. [CrossRef]
55. Canizales, S.; Diaz-Strong, D. *Undocumented Childhood Arrivals in the U.S.: Widening the Frame for Research and Policy*; Immigration Initiative at Harvard Issue Brief Series; Harvard University: Cambridge, MA, USA, 2021.
56. Kroenke, K.; Spitzer, R.L.; Williams, J.B.W. The PHQ-9. *J. Gen. Intern. Med.* **2001**, *16*, 606–613. [CrossRef]
57. Cuestionario Sobre La Salud Del Paciente-9 2005. Available online: http://www.ocagingservicescollaborative.org/wp-content/uploads/2014/07/PHQ9-Spanish.pdf (accessed on 1 April 2021).
58. Serrano-Ibáñez, E.R.; Ruiz-Párraga, G.T.; Esteve, R. Validation of the Child PTSD Symptom Scale (CPSS) in Spanish Adolescents. *Psicothema* **2018**, 130–135. [CrossRef]
59. Diez-Quevedo, C.; Rangil, T.; Sanchez-Planell, L.; Kroenke, K.; Spitzer, R.L. Validation and Utility of the Patient Health Questionnaire in Diagnosing Mental Disorders in 1003 General Hospital Spanish Inpatients. *Psychosom. Med.* **2001**, *63*, 679–686. [CrossRef] [PubMed]
60. Kroenke, K.; Spitzer, R. The PHQ-9: A New Depression Diagnostic and Severity Measure. *Psychiatr. Ann.* **2002**, *32*, 509–521. [CrossRef]
61. Cognitive Behavioral Intervention for Trauma in Schools CBITS | Forms. Available online: https://cbitsprogram.org/forms (accessed on 30 March 2021).
62. Foa, E.B.; Johnson, K.M.; Feeny, N.C.; Treadwell, K.R.H. The Child PTSD Symptom Scale: A Preliminary Examination of Its Psychometric Properties. *J. Clin. Child. Adolesc. Psychol.* **2001**, *30*, 376–384. [CrossRef] [PubMed]
63. Patler, C.; Hamilton, E.R.; Savinar, R.L. The Limits of Gaining Rights While Remaining Marginalized: The Deferred Action for Childhood Arrivals (DACA) Program and the Psychological Wellbeing of Latina/o Undocumented Youth. *Soc. Forces* **2021**, *100*, 246–272. [CrossRef]
64. Menjívar, C. Liminal Legality: Salvadoran and Guatemalan Immigrants' Lives in the United States. *Am. J. Sociol.* **2006**, *111*, 999–1037. [CrossRef]
65. Mendoza, H.; Masuda, A.; Swartout, K.M. Mental Health Stigma and Self-Concealment as Predictors of Help-Seeking Attitudes among Latina/o College Students in the United States. *Int J. Adv. Couns.* **2015**, *37*, 207–222. [CrossRef]
66. Wainberg, M.L.; Scorza, P.; Shultz, J.M.; Helpman, L.; Mootz, J.J.; Johnson, K.A.; Neria, Y.; Bradford, J.-M.E.; Oquendo, M.A.; Arbuckle, M.R. Challenges and Opportunities in Global Mental Health: A Research-to-Practice Perspective. *Curr. Psychiatry Rep.* **2017**, *19*, 28. [CrossRef] [PubMed]
67. Mikolajczak, M.; Petrides, K.M.; Hurry, J. Adolescents Choosing Self-Harm as an Emotion Regulation Strategy: The Protective Role of Trait Emotional Intelligence. *Br. J. Clin. Psychol.* **2009**, *48*, 181–193. [CrossRef]
68. Zimmermann, P.; Iwanski, A. Emotion Regulation from Early Adolescence to Emerging Adulthood and Middle Adulthood: Age Differences, Gender Differences, and Emotion-Specific Developmental Variations. *Int. J. Behav. Dev.* **2014**, *28*, 182–194. [CrossRef]
69. Abramson, A. Fear of Deportation Has Heartbreaking Mental Health Repercussions. Available online: https://www.brit.co/fear-of-deportation-has-heartbreaking-mental-health-repercussions/ (accessed on 26 March 2021).
70. Abramson, A. US Border Officials Are Creating Lifelong Trauma for Child Migrants by Separating Them from Their Families. Available online: https://www.brit.co/us-border-officials-are-creating-lifelong-trauma-for-child-migrants-by-separating-them-from-their-families/ (accessed on 26 March 2021).
71. Lovato, R. *Unforgetting: A Memoir of Family, Migration, Gangs, and Revolution in the Americas*; HarperCollins: New York, NY, USA, 2020.
72. Haslam, N.; Dakin, B.C.; Fabiano, F.; McGrath, M.J.; Rhee, J.; Vylomova, E.; Weaving, M.; Wheeler, M.A. Harm Inflation: Making Sense of Concept Creep. *Eur. Rev. Soc. Psychol.* **2020**, *31*, 254–286. [CrossRef]
73. Ciftci, A.; Jones, N.; Corrigan, P.W. Mental Health Stigma in the Muslim Community. *Stigma* **2012**, *7*, 17–32. [CrossRef]
74. Bermúdez, J.M.; Kirkpatrick, D.R.; Hecker, L.; Torres-Robles, C. Describing Latinos Families and Their Help-Seeking Attitudes: Challenging the Family Therapy Literature. *Contemp. Fam.* **2010**, *32*, 155–172. [CrossRef]
75. Rastogi, M.; Massey-Hastings, N.; Wieling, E. Barriers to Seeking Mental Health Services in the Latino/a Community: A Qualitative Analysis. *J. Syst. Ther.* **2012**, *31*, 1–17. [CrossRef]
76. Drew, N.; Funk, M.; Tang, S.; Lamichhane, J.; Chávez, E.; Katontoka Dip, S.; Pathare, S.; Lewis, O.; Gostin, L.; Saraceno, B. Human Rights Violations of People with Mental and Psychosocial Disabilities: An Unresolved Global Crisis. *Lancet* **2011**, *378*, 1664–1675. [CrossRef]

77. Marshall, G.N.; Schell, T.L.; Miles, J.N.V. All PTSD Symptoms Are Highly Associated with General Distress: Ramifications for the Dysphoria Symptom Cluster. *J. Abnorm. Psychol.* **2010**, *119*, 126–135. [CrossRef]
78. Millgram, Y.; Joormann, J.; Huppert, J.D.; Lampert, A.; Tamir, M. Motivations to Experience Happiness or Sadness in Depression: Temporal Stability and Implications for Coping With Stress. *Clin. Psychol. Sci.* **2019**, *7*, 143–161. [CrossRef]
79. van Winkel, M.; Nicolson, N.A.; Wichers, M.; Viechtbauer, W.; Myin-Germeys, I.; Peeters, F. Daily Life Stress Reactivity in Remitted Versus Non-Remitted Depressed Individuals. *Eur. Psychiatry* **2015**, *30*, 441–447. [CrossRef]
80. Castañeda, E.; Smith, B.; Vetter, E. Hispanic Health Disparities and Housing: Comparing Measured and Self-Reported Health Metrics among Housed and Homeless Latin Individuals. *J. Migr. Health* **2020**, *1–2*, 100008. [CrossRef]

CHAPTER 2

YOUNG IMMIGRANTS' INTEGRATION INTO A NEW HOME: THE CASE OF CENTRAL AMERICAN CHILDREN AND YOUTH SETTLING IN WASHINGTON, DC

Ernesto Castañeda, Daniel Jenks and Cynthia Cristobal

ABSTRACT

Purpose: *To describe some of the tensions that both unaccompanied and accompanied immigrant children and youth face when reuniting with family members living abroad after years of living apart, separated by borders and anti-immigrant policies are described.*

Methods: *Fifty-eight interviews with immigrant minors from El Salvador, Honduras, and Guatemala and the tensions they reported having after moving in with their biological parents or legal sponsors in the Washington, DC, metropolitan area are drawn upon.*

Findings: *Youth reported that getting used to cohabitation and in-person relationships with their parents or other sponsor was difficult at first, though it improved over time. Despite the biological, emotional, and financial bonds,*

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minors had to learn how to relate to new authority figures and follow their rules. Many reported feeling lonely and missing grandmothers and other family members and friends left behind in the country of birth.

Research implications: *Interviews with counselors and local authorities that interface with these families show that parenting and youth programs in the places of settlement can become effective interventions to improve relations between children and parents recently reunited, which can indeed help with scholastic achievement and socio-economic advancement.*

Value: *The interview extracts bring a window into intrafamily dynamics, often overlooked in discussions of the integration of immigrant children and youth into their new homes and communities.*

Keywords: Family sociology; transnational households; teleparenting; family reunification; unaccompanied children; El Salvador

INTRODUCTION

This chapter focuses on furthering the understanding of the process of refugee and immigrant family reunification abroad. In particular, we describe how dozens of Central American children and youth settling in the Washington, DC metropolitan area position themselves within the new nuclear family as they go through the reunification process, often as they await asylum cases. We specifically look at how parents' rules for the children in the house and the perceptions minors have about their sponsors (parents or legal guardians in the United States) intersect with how they integrate into their new homes and communities.

Many of these families experienced separation for years. Both transnational parenting and family reunification can be difficult. Most of the children interpreted their new position within the family as one of the following:

(1) they felt welcomed and gradually accepted as they are by family members,
(2) they experienced friction at first with one or more members of the household but eventually improved those relationships,
(3) youth felt accepted but maintained a distance between all nuclear family members, including their sponsor, or
(4) the minors did not feel accepted and distanced themself from their sponsor and family in the United States.

Acceptance and understanding were two key aspects we found to affect the relationship between parents and children in the reunification process: if the child felt as though they were heard and seen, even if they acknowledged discomfort, tension, or something else due to years apart, they had happier relationships with their parents.

For many youth respondents, their sponsor is one or both of their parents who migrated years prior. Other times, sponsors are relatives or other close family friends. In cases where parents left before their children, the children were likely being taken care of by other relatives or family friends in their home countries. Often these guardians are the only family or parental figures that these youth ever knew. The time of placement and the resulting adjustment is known as the reunification period. This chapter will discuss how circumstances surrounding sponsor placement, reunification, and in-home contexts shape integration outcomes.

Much of the existing literature on reunification describes the emotional and psychological effects experienced by the youth – how youth find themselves in a new nuclear family, often with family members they view as strangers (Castañeda & Buck, 2011, 2014). This chapter focuses on how the migrants interact and position themselves with a new and often unfamiliar nuclear family, as well as new situations, surroundings, and people in their lives. Our findings show that those from more precarious financial backgrounds tend to struggle more with new surroundings than their better-off counterparts. However, similar dynamics occur for all youth.

First, we describe migration trends of Central American youth. Then, we review the literature on family reunification and Central American youth, report our findings in greater detail, and discuss the implications of those findings. We contribute to the overall literature on family reunification by discussing the integration process of recently arrived children and youth, particularly those from Central America arriving to the DC area during the Trump era, a topic on which we are some of the first to publish on.

MIGRATION TRENDS

Immigration from Mexico to the United States has been declining since the 2008 economic recession (Gonzalez-Barrera & Krogstad, 2019). However, Central American immigration has been increasing, and from the start of the 2010s, unaccompanied Central American immigrant minors have been arriving in the United States in growing numbers.

Since 2015, over 250,000 unaccompanied minors have arrived in the United States and been placed with sponsors nationwide. Most of these youth are from El Salvador, Guatemala, and Honduras, escaping increasing violence and economic and political instability within their home countries. Over 20,000 of them have moved to the Washington, DC region since 2015. This number will continue to grow for the foreseeable future, as there is no easy solution to these complex issues. Central American immigrant children and teens face many structural barriers to integration into their communities. These include experiencing family separation due to migration, inconsistent or interrupted schooling in their home countries, language barriers in their new schools, and the inconsistent application of federal resettlement programming (Fig. 1).

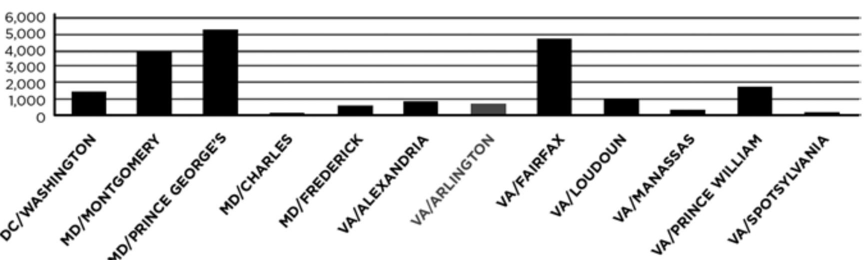

Fig. 1. Total Number of Unaccompanied Minors Placed with Sponsors around the DC Metro Region. *Source*: Department of Homeland Security. Elaborated by the authors.

UNDERSTANDING REUNIFICATION, FAMILY SEPARATION, AND THE IDEA OF "HOME"

When Customs and Border Protection (CBP) apprehends an unaccompanied minor at the border, they must send the youth to the Office of Refugee Resettlement (ORR), a division of Health and Human Services (HHS), within 72 hours (Berger Cardoso et al., 2019; Donato & Sisk, 2015; Roth & Grace, 2015; Zatz & Rodriguez, 2015). Then, the ORR places the minor with an adult sponsor while they await their immigration case. If the ORR cannot locate an adult sponsor, the minor is placed in foster care or a group home (Crea, Lopez, Taylor, & Underwood, 2017; Terrio, 2015; Zatz & Rodriguez, 2015). After they turn 18, they can be placed in "post 18" programs like the ones available at the Latin American Youth Center (LAYC) or Unaccompanied Refugee Minor (URM) program. Between 2013 and 2016, "approximately 90% [of the 123,000 placed UAC's] were released to a parent or other family member" (Berger Cardoso et al., 2019, p. 276). Once youth are with a sponsor, the government is minimally involved in most cases besides in courts and schools. There have been multiple troubling reports of CBP and the ORR during the Trump administration losing track of thousands of youth entirely, unable to check-in or know if they are victims of trafficking (Callahan, 2018).

We view family reunification as a process rather than a one-time event. Several factors can have a massive effect on both parents and children while shaping the family reunification process: the journey northward, time apart (that sometimes can be more than a decade), and difference in life in the new country (Roth & Grace, 2015). The length and the efficacy of the reunification process thus depend on several variables. These can include the amount of time spent separated from the parent(s), whether one or both parents left, the age of the youth at the time of the parents' migration, gender, and parents' financial well-being and security.

Upon reunification, a youth's initial feelings may include excitement to be with their parents or other sponsors and grief for leaving their caregivers in their

country of origin (Berger Cardoso et al., 2019; Lovato-Hermann, 2017). Once these initial feelings fade away, the youth and parents begin to "report that the long-term separation creates a sense of estrangement" (Berger Cardoso et al., 2019). In previous research of Mexican immigrant youth adjusting to the United States, some described resentment because they felt the need to compete for their mother's time and attention from their new siblings or new spouse (Castañeda & Buck, 2011, 2014; Lovato-Hermann, 2017). In that same research, resentment contributed to an overall feeling of invisibility for many migrant children. Moreover, female participants reported that their parents assigned them new responsibilities such as domestic chores or taking care of siblings (McMichael, Gifford, & Correa-Velez, 2011). The work left them feeling physically and emotionally overburdened. While work is one way that youth can find purpose in their new surroundings, it is important to consider the gendered dimensions of work in the home. The male participants felt as if they had a designated role and felt "unburdened" compared to their sisters.

Furthermore, during reunification, many children expressed how the expectations that they had of their parents did not match reality (Berger Cardoso et al., 2019; Dreby, 2007; Roth & Grace, 2015; Rousseau, Rufagari, Bagilishya, & Measham, 2004; Suárez-Orozco, Bang, & Kim, 2011). Artico (2003) interviewed Latin American youth engaged in the process of reunification, and two common themes that appeared were unmet parental expectations and feelings of loss or grief. Other scholars highlight these assessments (Berger Cardoso et al., 2019; Lovato-Hermann, 2017; Rousseau et al., 2004; Suárez-Orozco et al., 2011). Artico stresses that youth may decide not to disclose some of those feelings. He argues that the children are put in a position where they become emotional guardians of their parents, leaning into the "vow" of silence and secrecy around emotions and challenges related to separation and reunification.

Suárez-Orozco et al. (2011) interviewed immigrant youth from Central America, China, the Dominican Republic, Haiti, and Mexico who had been separated from their parents, focusing on how the parent's migration impacted the migrant youth's psychological wellbeing once reunited with their parent. The authors conducted interviews with the migrants shortly after arriving in the United States and once again after five years. They found an association between anxiety and depression levels and the amount of time separated from the parent. The youth who were separated for four years or more from their mothers reported higher levels of anxiety and depression in comparison to children who were separated for less than two years from their fathers or both parents.

Lashley (2000) focused on Caribbean children migrating to Canada to reunite with their families. The researcher describes the child's predicament: they miss their caregiver, adapt to a new household, and acclimate to society through their peers. Moreover, the parents' predicament is getting to know their child anew, helping them adjust to a new country, and managing discipline. Many times, the parents had not seen their children in years.

Transnational families are family units in which one or more parents temporarily leave their children in their country of origin in order to work abroad (Abrego, 2014; Castañeda & Buck, 2011; Dreby, 2007; Lovato-Hermann, 2017),

the family may reunify in another country at a different time (Suárez-Orozco et al., 2011), or the parent(s) may create a home in two countries if they can travel across borders (Boehm, 2012).

Dreby interviewed 141 members who were part of Mexican transnational families and detailed how children felt after one of their parents migrated (Dreby, 2007). Dreby found that the children exerted their agency and feelings over their situation differently based on their age. The younger children reported disappointment and "emotional withholding," as well as a desire for their parents to return. The adolescents would report feelings of distress and resentment, asking for more resources or pressuring their parents to finance their own migration. Mexican transnational families who experienced separation due to constrained choices included migrating for economic prosperity, and involuntary separations included forced separation due to deportation (Dreby, 2015). The children whose transnational family resulted from constrained choices would resent their parents if they believed their parents' migration was not successful and had negative consequences for reunification later on. On the other hand, the children who are part of involuntarily separated transnational families would experience anxiety, often showing destabilized families.

Abrego (2014) interviewed young people in El Salvador whose parents had gone to the United States. When Abrego asked about the possibility of reuniting with their parents in the United States, responses varied based on emotional state and the family's financial circumstances. The youth with financial and emotional struggles felt unsure about their future in the United States. However, those with better finances expressed a desire to stay in El Salvador. Youth with better financial situations also tend to have better-managed emotions. A sense of control over financial or emotional capacity ultimately created a desire among the minors to stay put. If your family is better off, you may be afforded this luxury, and this is as much of a reality in El Salvador as it is in the United States.

Furthermore, family reunification can be complicated by traumas that migrant youth may have experienced before or during the migration trip. Possible post-traumatic stress can make adjusting to their new households and schools harder (Castañeda et al., 2021).

Another struggle faced by transnational families is the varying citizenship status of the family members and how the state legally interprets the family's positionality or situation. In her ethnographic research with Mexican migrants of transnational families, Boehm (2012) discusses US citizens who have undocumented parents or caregivers, and undocumented minors who are de facto members of their community by growing up, attending school, and making friends in the United States. Yet, they are still constructed legally as out of place. This creates uncertainty and a feeling of living in limbo (Castañeda, 2013; Gonzales, 2016). These implications ring true for unaccompanied children who often become citizens, have permanent residency, attend public schools and use public space, but their parents or primary caregivers may not. Children and parents living in different states of being can create additional barriers to reunification.

Experiencing reunification and precarious documentation statuses both trouble the concept of "home," especially when home becomes a non-static place, full of different people and surroundings. Researchers have noted salient themes from reunification and the idea of overcoming challenges and finding strength connected to developing bicultural coping skills, improving communication between parent and child, empathizing with their adolescent children, and finding social support (Perreira, Chapman, & Stein, 2006). Other researchers point to the connection between supportive families and psychosocial health and wellbeing for resettled youth with refugee backgrounds (McMichael et al., 2011). Without psychosocial health and strong communication, families and children can struggle internally and externally, as such can be the case with migration and family reunification. Youth experience various situations during the migration and reunification process, and each possess unique coping skills that equip them to handle them.

These aspects are inextricably tied to the experience of home in the context of migration—researchers argue that home in migration is a culturally oriented experience, tied to the possibility of acquiring a sense of security, familiarity, and control, as an interpersonal process (Boccagni, 2017). This means that youth's migration is an upheaval from home and an arrival in what could be and feel like a new one. There can be challenges and successes, but at the core of feeling at home is a search for a sense of belonging and safety (Castañeda, 2018). Thus, it is important that Central American youth feel at home in their physical homes and the larger regions that they inhabit, be it Washington, DC, New York, Houston, or anywhere else.

METHODS

This chapter derives from the mixed methods project entitled "Household Contexts and School Integration of Resettled Migrant Youth," in which the research team interviewed migrant minors (N=58), some of their parents and sponsors (N=41), and social services practitioners and school officials from the area surrounding Washington, DC (N=23). Eleven of the service providers worked for their respective county public school systems, often specializing in international students, integration, and English for Speakers of Other Languages (ESOL) programs for students and their families. The rest worked for nonprofit organizations that work with immigrants. Verbal informed consent was given, but no written records of identifying information or contact information were kept in order to protect participants. The project was approved by American University's Institutional Review Board. The interviews with youth and sponsors were all conducted in Spanish, and most of the interviews with school officials and community workers were in English. Many interviewers were Central American students or staff, and they were able to establish trust and rapport with the interviewees. This mixed methods study included an instrument with both open- and closed-ended questions, as well as two mental health symptom scales (Castañeda et al., 2021).

The interviews were wide-ranging. Participants responded to questions about their lives in their home countries and the United States, schooling, migration journey, and experience with immigration systems. This work of analytical sociology utilizes data from a hard-to-reach population presenting their understandings in their own words. We share many interview excerpts and aim to contextualize those with other available data about immigrant integration, social services, and public policy.

On average, interviews lasted between one and one and a half hours. Interviews were recorded, transcribed, entered into Qualtrics, coded in NVIVO, and descriptive statistics were produced using SPSS. Thirty-seven respondents were from El Salvador, sixteen were from Honduras, and five were from Guatemala (see Table 1). The average age at the time of interview was 16. Their ages at the time of interview ranged from 10 to 22, and at the time of migration ranged from 8 to 20. We note several other variables – accompaniment and documentation status. At the time of their arrival at the border, 34 were unaccompanied, and 24 were accompanied. We argue that sociologically, and in the discussion of early integration experiences, this distinction is unclear and often unimportant given the similar conditions before migration. For instance, if a child migrated with their

Table 1. Descriptive Statistics Among Immigrant Minors in the DC Metropolitan Area ($N = 58$).

Demographic Characteristics		
	Overall	
	n	
Average age		
At time of arrival	58	14
At time of interview	58	16
Gender	58	
Male	31	53.45%
Female	26	44.83%
Non-binary	1	1.72%
US legal citizenship status at time of arrival	58	
Documented	9	15.52%
Status in process	49	84.48%
Country of origin	58	
El Salvador	37	63.79%
Honduras	16	27.59%
Guatemala	5	8.627%
Jurisdiction within DC metropolitan county	58	
Prince George's county	22	37.93%
Montgomery county	24	41.38%
Fairfax county	12	20.69%
Accompaniment status at border	58	
Accompanied	34	58.62%
Unaccompanied	24	41.38%

mother, but still had to spend two months on foot through Mexico and was then separated from their mother at the border, they are not necessarily any better off than someone who was traveling alone to meet their mother already in the United States.

Another variable that is instrumental in physical, psychological, and economic futures is whether the minors came with legal papers or without – this is a very important distinction sociologically. Nevertheless, they may be placed in the same category as undocumented people by schoolmates and the US-born. Nine respondents arrived with documentation. When interviewed, 22 minors resided in Prince George's County, MD, 24 in Montgomery County, MD, and 12 in Fairfax County, VA. This population also lives in DC, but with increasing gentrification and housing costs, it is harder for new arrivals to find housing in DC's city limits. Thus, these populations are more and more settling, living, and raising their families in the surrounding suburbs. Primarily, these jurisdictions include Fairfax County, VA, Prince George's County, MD, and Montgomery County, MD.

We have organized, translated, and analyzed excerpts from these interviews to shed light on the process and challenges of immigrant integration for youth in the Washington, DC, area. They are used to contextualize theoretical discussions and to provide tangible narratives of the experiences of youth.

FINDINGS

Respondents reported that getting used to a new relationship with their parents or other sponsor was difficult at first, though it improved over time. Parents often go north when children are very young in order to pay for the child's schooling, housing, food, and clothes. This leaves many young children and teenagers to be effectively raised by other relatives or friends. Samantha, age 15, described how she had not seen her mother in years and was very little when she left, making her first year in the United States very challenging. She felt lonely and reported that she missed her grandmother and sister, who had felt like a mother more than anyone else when she was still living in Honduras. Others, including Melissa, age 14, David, age 13, and Sarah, age 18, also reported that one of the more challenging parts of moving to the United States was leaving other relatives like their grandmothers, who acted like their mothers for years raising them.

Fernanda, who migrated at age thirteen and was interviewed at 15, expressed difficulties integrating with her family after initially not even wanting to come to the United States. Even though she came by plane and with papers,

> Yo sentia que … yo no estaba con mi mama porque yo sentia, hasta la vez siento que mi mama es mi abuela porque ella estuvo conmigo desde pequeña, desde que yo estaba pequeña. Me crio. Me dio todo lo que necesitaba, como amor … lo que yo … siempre he querido que mi mama me dijera, que me quiere.

> I felt that I really wasn't with my mother because I've always felt that my real mother was my grandmother because she's been with me since I was little. She raised me since I was very young. She gave me everything I needed, like love. What I've always wanted is that my mother would tell me, that she loved me.

Having spent her early years in El Salvador with her grandmother, Fernanda felt alienated from her family. She felt as though her stepfather was never happy, and everyone in the house got along with everyone but her. Family reunification is not easy and can create or exacerbate old problems: those who feel disconnected from their parents when they move may face even more challenges. Not all respondents felt this way, but many did.

Overall, the benefits of family reunification are worth the struggles. For example, Carlos' father was able to keep a close eye on him and his siblings. Being reunited changed his life in several ways, including a feeling of overall comfort and safety that he did not have in his home community. He did not mind his father keeping a close eye. Similarly, Sarah talked about how being back with her mother and having a better experience in school was an asset.

Sponsors often made drastic sacrifices to find a better life for their families and children. Those goals and actions were often coupled with a fear of failure. Financial, legal, or immigration-related fears were constant, along with the fear for what was going on in their home countries and the possibility of being sent back. One sponsor, Ana, wanted to come to the United States so that her family could escape the crime and poverty in her country of birth and achieve the American dream. However, she struggled economically in the United States due to rent, legal fees, and paying off over $16,000 to the coyotes that brought her five children to the border. She did not particularly fear Immigration and Customs Enforcement (ICE) or other law enforcement.

Conversely, another sponsor, Karla, spoke about how she feared deportation of either her or any of her children. She was fearful due to the political and economic instability in El Salvador and did not want her or her children to have to go back. Even if the children felt integrated and as though they belonged, the parents would fear for their safety and may not personally feel belonging. These fears may affect the way that they parent. One mother kept a close eye on the whereabouts of her children, saying, "this country is not theirs."

Interpreting and Following Rules

The youths' responses to having household rules set by their sponsor and their interpretation of those rules varied widely. This variation was often related to the time spent apart, the presence of new family members, and the family's economic situation.

Some youth clearly identified the home's rules and their importance, while others had rules that were less clear, or may not have understood or agreed with their importance. Isabela, a 17-year-old from El Salvador residing in Montgomery County, said she understood her mother's rules as in her best interest. She stated, "because I should obey." She trusted and respected her mother, which made it easy for her to obey rules. Elizabeth and Monica, on the other hand, found their sponsor's rules to be overly cumbersome. Elizabeth, a 16-year-old from Guatemala residing in Prince George's County, detailed how her mother was bothered by her friends. As a result, she deemed her mother as "worse than a police officer." Likewise, Monica, a 15-year-old from Guatemala

living in Prince George's County, had to ask for permission to go out and stated that her father's response was always no. Most respondents identified how limiting rules felt for them, which indicates struggles in communication, respect, and trust between themselves and their sponsors. Children and adolescents, immigrant or not, may struggle with having these power struggles and differences with their parents. Still, the unique situations that immigrant youth find themselves in have a significant effect on both rules and relationships. Immigrant children must deal with being between two cultures and simultaneously learn the rules and requirements of their new household and their new country. In cases where minors were raised by someone other than the parent they had reunified with, our data show that there may be resentment, distrust, and fear of another separation. These trepidations can get in the way of their relationship with their parents and understanding, respecting, or agreeing with the rules they set.

Some respondents reported no direct rules but instead mentioned instances where their sponsors instated basic limits or warned them about certain situations. Alexander, a 20-year-old from El Salvador (who, importantly in this context, migrated at age 17), residing in Prince George's County, described how his mother did not have any specific rules, per se. Instead, he was given more vague suggestions. For instance, when his mother thought that someone who was in his life was not a good influence, instead of forbidding him from seeing them, she just said: "be careful, this person is not good for you because they are involved in things you shouldn't be." Alexander did not need to be told that he was not allowed to do something – he said: "I respect her opinion because she knows more than us." With his respect for his mother, Alexander seemed to have a strong relationship with her.

Valentina, a 16-year-old from El Salvador residing in Montgomery County, had a similar situation. Her mother did not have any rules, but she asked Valentina to watch out who she hangs out with and make sure they are not bad influences. Valentina even stated that she would be willing to follow the rules if her mother were to put them in place. Whether they understand the rules and guidelines established by their sponsors or parents is important. After a certain age, mutual trust and respect emerge as key to whether people are happy.

Fernanda, a 15-year-old from El Salvador residing in Montgomery County, stated how her mother did not set named or consistent rules. However, she did not allow her to go out with friends or let her friends come over. Fernanda inferred her mother's disapproval came from her stepfather, "My stepfather is very grumpy; he doesn't like anyone coming over." At the time of her interview, she had been living in the United States for two years. This indicates the struggles that come with having new stepparents and stepsiblings, on top of what it is already like to be a 15-year-old, possibly full of rebellion and angst.

Flor, Alexander's sister, also from El Salvador and residing in Prince George's County, disclosed that her mother once had rules that she did not like, but as she is getting close to 18, it seems that the rules have stopped. As a legal adult, her mother may have understood that she had done a good job educating her and that it was time for her to make her own decisions. At the same time, Flor experienced other tensions with her mother that her brother did not describe, which we discuss in the next section.

Moving in with Biological Parents: "I Don't Call Her Mom, I Call Her Vos"

The following section details the dynamics of relationships between children and their mothers, who are also their sponsors. Some appeared to have little trouble reintegrating with their mothers, but others seemed to be dealing with feelings of resentment or abandonment that came from the time they were apart.

Elizabeth, Monica's sister, a 17-year-old from El Salvador living in Montgomery County, described reunification with her mother as "bonito," or "nice." Elizabeth lived with her grandmother before migration and described how:

> con mi abuela y con ella, les tengo el mismo amor porque … yo siempre estuve en contacto con ella. Y [pausa] senti la verdad senti el mismo apoyo

> with my grandma and with her, I have the same love because … I always maintained contact with her. And [pause] in all honesty I felt the same support. – Elizabeth, Guatemala, 17, Montgomery County

Even while her grandmother was raising her in El Salvador, she could still feel connected with and love her mother. Not everyone in her situation could say that.

Alexander, who was also being looked after by his grandmother when he was in El Salvador, described his understanding and feelings toward his biological mother. He mentioned how she has been "attentive to all of us" but "I don't call her mom, I call her *vos*." He explained:

> Yo la trato como a una amiga, porque ella muy bien nos dice a nosotros: "yo se, los entiendo, porque ustedes se han crecido con mi mama y de la noche a la mañana no me van a decir mama, o algo … Ustedes quieren mas a mi mama que a mi," nos dice. Y "yo se que tengo que entender, pero poco a poco se van a ir ambientando conmigo," dice ella. Si, le digo yo, "pero recorda que hemos pasado bastante tiempo con mi abuela, nunca nos olvidamos de vos pero hemos pasado mas tiempo con mi abuela."

> I treat her like a friend because she tells us: "I know, I understand, because you all have grown up with my mother and from one minute to another you won't say mom, or something … you all care more for my mom than me. And I know I have to understand but little by little you will get used to me," she says. "Yes," I say, "but remember we have spent a great amount of time with my grandma, we never forgot you, but we have spent more time with my grandma." – Alexander, El Salvador, 20, Prince George's County

Many Salvadorians would refer to their mothers using the formal *usted* out of respect. For Salvadorians, *vos* is used with an individual you know and are comfortable with; this form is used in the same manner as *tú*. This pattern has been used by Hondurans in the United States as well (Martinez Barahona, 2020). By referring to his mother as *vos*, Alexander acknowledged the sense of comfortability between his mother but that he could not forget his grandmother's role as his primary caregiver. Alexander recognized that he did not refer to his mother as "mom." As he said, he sees her more like an older friend. Furthermore, his mother understood how time would allow him and his siblings to get used to her slowly. He interpreted his mother's statements as understanding and accepting of their situation. This type of relationship shows one reason why Alexander may respect and understand his mother's suggestions to him, even if it was not the same for his sister, Flor.

Flor explained how her Catholic beliefs clashed with her mother's evangelical Christianity. She described how when she first arrived, "we went around the house arguing." Eventually, Flor started learning how to read the Bible. During that time, she was getting used to the new church, which changed her relationship with her mother for the better. However, eventually, she stopped going to church and became interested in reading other materials, which caused her mother to say, "you have drifted away from God."

For Flor, her relationship with her mother largely revolved around their differences in core beliefs such as religion. Flor's experience illuminates that when you leave your home country, you do not just leave the country and its borders; you leave a community you were a part of. Trying to be a part of a different and maybe unfamiliar community can be very lonely and difficult. Furthermore, minors and parents experience these changes in different ways and disjointly. For Flor, immigration did not draw her closer to religion, but it may have for her mother. When her mother saw her struggling, her thought was that she was not close enough to God, but Flor did not view it that way.

Fernanda detailed how her relationship with her mother changed because when she was in El Salvador, she spoke with her mother regularly, and felt close to her, so she thought it would be that way in the United States. However, when she arrived, she felt as though her mother was always angry. Adapting to a new setting and new life can be hard for both the parents and children, and it can be challenging for the children to understand that their parents may be going through the same things they are. Teleparenting is difficult. Even while social media allows for members of a transnational family to stay on top of updates, daily activities, and for getting permission for big decisions, it does not create the tensions and frictions of daily cohabitation that inevitably occur once the families are reunited (Castañeda & Buck, 2011, 2014). Moving in with a new person requires a lot of implicit negotiations and accommodations.

When Isabela listed the individuals who understood her, she mentioned her new friends, friends from her country of origin, and godmother. When asked why she did not include her mother, she stated:

> Porque no me llevo muy bien con ella y hasta hoy en día no se si se ha ganado el cariño mío, porque solo pasa enojada siempre, y nos echa la culpa de todo a mi hermano y a mi, cuando a mi hermano la llama, toda la furia, todo lo que genera en el día, todo se lo desquita con nosotros. Ella prefiere mil veces al señor que esta ahi. El no es mi papa, es mi padrastro. Entonces ella dice que por nuestra culpa el se va a separar de ella. Yo prefiero mil veces que ella me de en adopción o irme de regreso a mi país, pero no que el día de mañana me diga: "mira, por tu culpa me separe de mi esposo," porque ellos dos están casados. Entonces no me llevo con ella.
>
> Because I don't get along well with her, and to this day I don't know if she has won over my affection because she's always mad and blames my brother and me for everything. When my brother calls, all the anger, everything generated from that day, everything is taken out on us. She prefers a million times that man. He is not my dad, he is my stepfather. Sometimes she says it's our fault if they get separated. I would prefer a million times that she gives me up for adoption or return to my country, instead of her saying in the future, "look, because of you I separated from my husband" because they're married. That's why I don't get along with her – Isabela, El Salvador, 17, Montgomery County.

Unlike many of the other minors, Isabela offered concrete reasoning as to why she did not see her mother as someone who understood her and why she felt

hurt and distant from her, even after the physical distance was gone. She even stated that she wishes she could be adopted or have stayed in her home country, away from her mother. While there are often inevitable tensions and struggles, individual relationships between family members often go fine from the start or improve over time. Just as the greater context of the home and the city matters to integration and placemaking, whom one shares a home and a family with has seismic effects.

Valentina described how her relationship with her father, who was not her sponsor but with whom she was allowed to have a relationship, changed over time. She was full of anticipation to see him since she had only ever lived with her mother and sibling. Initially, she admitted to feeling weird about being with and talking to him. She explained how the relationship was with him at first: "distant, I mean like I didn't feel the same as when I was with my mom." Now she is used to him, and all three of them spend time talking close together. Valentina felt an initial distance or unfamiliarity with her father but grew to be more accepting of him.

Similarly, Alexander described the relationship with his stepfather as pleasant. He described how:

> El nos trata bien. El no molesta ni nosotros lo molestamos. El se ha portado demasiado bien con nosotros. Es cercana la relación. El esta atento a todo
>
> He treats us well. He doesn't bother us, nor do we bother him. He has acted extremely well with us. The relationship is close. He is attentive to everything.

Alexander recognized how his stepfather has been helpful as he settled in and felt trust and care between the two of them.

Monica detailed how she had "normal" problems with her father because her mother did not live with them. She mentioned that she felt safe because her mother advised her, "that he is my dad, for me to have trust, all of that" but she disclosed that she would have felt safer if her mom was with her. While she only felt that she had "normal" problems and did not actively feel unsafe, something was still missing from her relationship.

Fernanda, however, had difficulty getting along with multiple family members. She did not get along with her brother, sister, or mother. The only family members she did get along with were her younger sisters. Fernanda recognized herself as the only person having a difficult time since most "are happy and get along well together" except her stepfather, whom she said is "rarely ever happy."

DISCUSSION

One distinct finding from our data was that those who expressed feeling welcome were almost all sponsored by their mothers. This may be because they rejoined their mothers in the United States rather than leaving their biological mothers behind or moving with other relatives who culturally may be expected to be colder than their mothers. Isabela recognized her sponsor's rules as something to obey because those rules would be good for her. This recognition can be interpreted as a sign of the respect that Isabela felt toward her mother. Moreover,

the reunification with her mother appeared to run seamlessly since she expressed receiving the same support from both her mother in the United States and grandmother in El Salvador and in return, having the same loving feelings for them. By describing her mother and grandmother as equals in her life, Isabela detailed how both women were important to her regardless of who they are, or the time spent separated. Because she felt that they were both the same and both as loving to her, this was one less change to adapt to that other teenagers often have issues with.

Similarly, Valentina stated her sponsor did not have rules but would follow them if they existed. Her willingness to follow the rules despite not having them demonstrates how Valentina respects her mother's decision-making and how she felt she was being looked after positively. Valentina also described how the integration of her father in their family was difficult at first, but later she grew to embrace the new family member. Because of this, Valentina found herself in a unique situation. As a new family member herself, she now had to welcome another family member. Lovato-Hermann (2017) describes minors recently reunifing feeling as if they had to compete for attention and time from other family members – exemplary of Valentina's situation, and maybe why she felt it hard to accept her father's reunification at first (Lovato-Hermann, 2017). It could also be inferred from this that she felt comfortable and confident in her relationship with her mother, so she did not feel the need to compete. Both Isabella and Valentina respect their mothers as authority figures who can put rules in place. This respect for and feelings of comfort with their mothers encourages a welcoming nuclear family, allowing minors a more effortless integration experience.

Alexander was the only participant who seemed to be accepted into the family but chose to distance himself from his sponsor. Like Valentina, he stated that his mother did not have any rules but gave him warnings about people and general guidelines within a covenant of trust between them. Alexander clearly started respecting his mother because of her knowledge but still used *vos* to speak with her. The comfortability within his family can be further observed as he described how attentive and well his stepfather has treated him. Although Alexander's mother and stepfather have accepted him into the family, he cannot bring himself to completely immerse into the family. Although he did not state this, Alexander's inability to forget his grandmother may come from feelings of loss and grief (Berger Cardoso et al., 2019; Lovato-Hermann, 2017). The fact that he may not be able to travel back and forth between his hometown and DC makes things worse. Often immigrant youth fear that their grandparents will die while they fix their status in the United States and thus may never see them again, creating an ambiguous loss – an unending grief (Boss, 2002; Castañeda & Buck, 2011).

The third typology is conveyed by the experiences of Elizabeth, Fernanda, Flor, and Monica. Both Elizabeth and Fernanda described how their stepfather had caused problems or created restrictions. Elizabeth highlighted how her mother expressed a preference for her husband over Elizabeth and her brother. Fernanda cannot go on outings with friends nor have them over because of her stepfather's grumpy demeanor. The experiences of Elizabeth and Fernanda illustrate how the position of the father/husband can further complicate their relationship with their mother. Flor also has a complicated relationship with her mother, stemming from

religious differences. The arguments and misunderstandings between Flor and her mother originated from a disagreement over religion, which only ended when Flor gave into her mother's demand to attend the Evangelical church with her, but problems began again when she stopped. Lastly, Monica's estranged relationship with her father drove her further away from him and she instead yearned for her mother. She used her mother as a source of support because she did not trust her father. For all these youth, there was a third person that drove them farther from their sponsor. Elizabeth, Fernanda, and Flor's relationships with their respective mothers were a large source of conflict. On the other hand, Monica's mother was a source of relief from the estrangement between Monica and her father. The role of the mother has been found significant in young immigrants' experiences. Suárez-Orozco et al. (2011) reported how a youth's psychological well-being appears to be more impacted by the separation of their mothers than their fathers.

Ultimately, minors' integration within a new nuclear family during reunification is influenced by the perception of their sponsor and their collective ability to be together again and feel at home, heard, and accepted. At times, the child may feel fully integrated and accepted. Some may be happy and confident yet maintain reservations. Others completely distance themselves from their sponsor, feeling abandoned or that the relationship is not working. These challenges can be met and overcome as minors, and their sponsors find new ways to communicate and understand each other. As discussed, there are significant challenges to the reunification and integration processes, and they are further complicated as politicians scale up attacks and rhetoric about the "dangers" of migrants from Central America.

As youth continue to immigrate and form part of US society, organizations, local and national governments must continue providing resources for sponsors and their children to have an easier transition. Social services organizations that work on immigrant advocacy and help immigrant families connect to the social safety net can serve a key role in the reunification process. After school programming where reunifying migrant families can learn they are not alone in these experiences, and where they can work with each other to learn more about themselves, each other, and understand their relationship better strengthens families and is connected to a larger sense of belonging that can be connected to self-esteem, communication skills, and psychosocial health. These capacities are also connected to the contexts in which children find themselves in the United States – the less danger they find themselves in, the more ready they may be to integrate into a new home. Being in a family and home where one can truly feel at home and cared for is an invaluable necessity for everyone, no matter their background.

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REFERENCES

Abrego, L. J. (2014). *Sacrificing families: Navigating laws, labor, and love across borders*. Palo Alto, CA: Stanford University Press.

Artico, C. I. (2003). Latino families broken by immigration: The adolescent's perceptions. El Paso, TX: LFB Scholarly Publishing LLC. Retrieved from http://ebookcentral.proquest.com/lib/aul/detail.action?docID=3016724

Berger Cardoso, J., Brabeck, K., Stinchcomb, D., Heidbrink, L., Price, O. A., Gil-García, Ó. F., … Zayas, L. H. (2019). Integration of unaccompanied migrant youth in the United States: A call for research. *Journal of Ethnic and Migration Studies*, *45*(2), 273–292. https://doi.org/10.1080/1369183X.2017.1404261

Boccagni, P. (2017). *Migration and the search for home: Mapping domestic space in migrants' everyday lives*. London: Palgrave Macmillan.

Boehm, D. A. (2012). *Intimate migrations: Gender, family, and illegality among transnational Mexicans*. New York, NY: New York University Press. Retrieved from http://ebookcentral.proquest.com/lib/aul/detail.action?docID=866068

Boss, P. (2002). *Family stress management: A contextual approach*. London: SAGE. https://doi.org/10.4135/9781452233895

Callahan, M. (2018). No, the government hasn't lost 1,500 children. What's actually happening might be worse. Retrieved from https://news.northeastern.edu/2018/06/05/no-the-government-hasnt-lost-1500-children-what-is-actually-happening-might-be-worse/

Castañeda, E. (2013). Living in limbo: Transnational households, remittances and development. *International Migration*, *51*(s1), e13–e35. https://doi.org/10.1111/j.1468-2435.2012.00745.x

Castañeda, E. (2018). *A place to call home: Immigrant exclusion and urban belonging in New York, Paris, and Barcelona*. Palo Alto, CA: Stanford University Press.

Castañeda, E., & Buck, L. (2011). Remittances, transnational parenting, and the children left behind: Economic and psychological implications. *Latin Americanist*, *55*(4), 85–110. https://doi.org/10.1111/j.1557-203X.2011.01136.x

Castañeda, E., & Buck, L. (2014). (PDF) A family of strangers: Transnational parenting and the consequences of family separation due to undocumented migration. Retrieved from https://www.researchgate.net/publication/289528977_A_Family_of_Strangers_Transnational_Parenting_and_the_Consequences_of_Family_Separation_due_to_Undocumented_Migration

Castañeda, E., Jenks, D., Chaikof, J., Cione, C., Felton, S., Goris, I., … Hershberg, E. (2021). Symptoms of PTSD and depression among Central American immigrant youth. *Trauma Care*, *1*(2), 99–118. https://doi.org/10.3390/traumacare1020010

Crea, T. M., Lopez, A., Taylor, T., & Underwood, D. (2017). Unaccompanied migrant children in the United States: Predictors of placement stability in long term foster care. *Children and Youth Services Review*, *73*(C), 93–99.

Donato, K. M., & Sisk, B. (2015). Children's migration to the United States from Mexico and Central America: Evidence from the Mexican and Latin American migration projects. *Journal on Migration and Human Security*, *2*(3), 58–79. https://doi.org/10.14240/jmhs.v3i1.43

Dreby, J. (2007). Children and power in Mexican transnational families. *Journal of Marriage and Family*, *69*(4), 1050–1064. https://doi.org/10.1111/j.1741-3737.2007.00430.x

Dreby, J. (2015). U.S. immigration policy and family separation: The consequences for children's well-being. *Social Science & Medicine*, *132*, 245–251. https://doi.org/10.1016/j.socscimed.2014.08.041

Gonzales, R. G. (2016). *Lives in limbo: Undocumented and coming of age in America*. Berkeley, CA: University of California Press.

Gonzalez-Barrera, A., & Krogstad, J. M. (2019). *What we know about illegal immigration from Mexico*. Washington, DC: Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2019/06/28/what-we-know-about-illegal-immigration-from-mexico/

Lashley, M. (2000). The unrecognized social stressors of migration and reunification in Caribbean families: *Transcultural Psychiatry*, *37*(2), 201–215. https://doi.org/10.1177/136346150003700203

Lovato-Hermann, K. (2017). Crossing the border to find home: A gendered perspective on the separation and reunification experiences of Mexican immigrant young adults in the United States. *International Social Work*, *60*(2), 379–393. https://doi.org/10.1177/0020872815611197

Martinez Barahona, S. (2020). The usage of Voseo in social media: Hondurans and Salvadorans in the United States. *Macksey Journal*, *1*(1), 22. Retrieved from https://www.mackseyjournal.org/publications/vol1/iss1/126

McMichael, C., Gifford, S. M., & Correa-Velez, I. (2011). Negotiating family, navigating resettlement: Family connectedness amongst resettled youth with refugee backgrounds living in Melbourne, Australia. *Journal of Youth Studies*, *14*(2), 179–195. https://doi.org/10.1080/13676261.2010.506529

Perreira, K. M., Chapman, M. V., & Stein, G. L. (2006). Becoming an American parent: Overcoming challenges and finding strength in a new immigrant Latino community. *Journal of Family Issues*, *27*(10), 1383–1414. https://doi.org/10.1177/0192513X06290041

Roth, B. J., & Grace, B. L. (2015). Falling through the cracks: The paradox of post-release services for unaccompanied child migrants. *Children and Youth Services Review*, *58*, 244–252. https://doi.org/10.1016/j.childyouth.2015.10.007

Rousseau, C., Rufagari, M.-C., Bagilishya, D., & Measham, T. (2004). Remaking family life: Strategies for re-establishing continuity among Congolese refugees during the family reunification process. *Social Science & Medicine*, *59*(5), 1095–1108. https://doi.org/10.1016/j.socscimed.2003.12.011

Suárez-Orozco, C., Bang, H. J., & Kim, H. Y. (2011). I felt like my heart was staying behind: Psychological implications of family separations and reunifications for immigrant youth. *Journal of Adolescent Research*, *26*(2), 222–257. https://doi.org/10.1177/0743558410376830

Terrio, S. J. (2015). *Whose child am I? Unaccompanied, undocumented children in U.S. immigration custody*. Palo Alto, CA: University of California Press.

Zatz, M. S., & Rodriguez, N. (2015). *Dreams and nightmares: Immigration policy, youth, and families*. Palo Alto, CA: University of California Press. Retrieved from http://ebookcentral.proquest.com/lib/aul/detail.action?docID=1882101

Centroamericanos en su Paso por México hacia los Estados Unidos

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Centroamericanos en su Paso por México hacia los Estados Unidos

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Mientras que la inmigración de México a los Estados Unidos ha estado disminuyendo desde la recesión económica de 2008 (Gonzalez-Barrera and Krogstad 2019), desde - principios de la década de 2010, los inmigrantes Centroamericanos menores de edad no acompañados han llegado a los Estados Unidos en mayor número (Cardoso et al. 2019, HHS 2020, Sacchetti 2019, Stinchcomb and Hershberg 2014, Trull 2014).

Existen trabajos documentando las razones por las que los inmigrantes deciden dejar sus hogares y países de origen (Abrego 2014, Cardoso et al. 2019). También hay varias investigaciones acerca de la violencia de la región, ya sea relacionada a las pandillas, a las instituciones nacionales, o ambas (De Jesus and Hernandes 2019, Menjívar 2011). También se ha discutido el rol que tienen las cuestiones familiares en las decisiones de emigrar, tal como la separación y reunificación familiar (Abrego 2014, Castañeda and Buck 2011, Castañeda 2014, Castañeda and Buck 2014).

Además, hay trabajos relacionados al trauma que los migrantes sufren durante el viaje entre sus países de origen y su destino final (Menjívar 2000). Muchos de ellos están huyendo de las pandillas y por consecuencia temen por su seguridad durante el viaje hacia la frontera de EE UU. También son sometidos al trauma institucional cuando la patrulla fronteriza los arresta (Canizales and De León 2019, Menjívar and Perreira 2019, Teicher 2018). Además de la violencia, hay otras razones por las que alguien emigraría, incluyendo oportunidades de trabajo y las redes sociales de migrantes que existen en los Estados Unidos (Abrego 2014, Menjívar 2000, Menjívar and Perreira 2019).

En este capítulo abordamos el tema de la migración centroamericana, sobre todo la que fue parte de la ola de inmigrantes jóvenes y menores no acompañados (llamados en inglés *Unaccompanied Alien Children*) que inició en 2014 y que en cierto grado sigue hasta la fecha (Stinchcomb and Hershberg 2014). Este capítulo describe esta ola migratoria y presenta casos como ejemplos del viaje de salida, la travesía por México y la llegada a Estados Unidos en particular la zona metropolitana de Washington, DC.

Los resultados provienen de un estudio llevado a cabo por el Center for Latin American and Latino Studies en American University en Washington, DC en el 2017 dirigido por los coinvestigadores Ernesto Castañeda, Noemi Enchautegui de Jesus y Eric Hershberg. El estudio usa entrevistas con menores no acompañados (N=58), así como con algunos de sus padres (N=41) y oficiales de las escuelas en el área alrededor de Washington, DC (N=23). En total se llevaron a cabo más de 122 entrevistas formales que fueron audiograbadas, transcritas y analizadas usando Nvivo, Qualtrics, y SPSS.

Muchos de los inmigrantes jóvenes que dejaron sus países de origen tuvieron que tomar esta decisión de un momento a otro. Aunque algunos de estos menores sabían que sus padres tenían

planeado enviarlos a los Estados Unidos, en general no habían establecido fechas o planes concretos hasta poco antes de comenzar su viaje. Existen varios recuentos de padres entregándoles una maleta a sus hijos y diciéndoles que tenían que empacar porque se iban del país en uno o dos días. Incluso, hay ocasiones en que los papás no les comentaron a sus hijos de sus planes para emigrar y lo mantuvieron en secreto hasta de sus seres queridos, por temor a que maras o policía en sus comunidades de origen quisieran evitarlo.

Muchos de los jóvenes a quienes entrevistamos no formaron su vida alrededor de la idea de emigrar a los Estados Unidos. Al contrario, muchos expresaron una profunda tristeza por tener que dejar sus países.

Mientras algunos dejaron a sus padres en Centroamérica para venir a Estados Unidos, otros vinieron para encontrarse con sus padres, quizá por primera vez. Pero dejando a quiénes los vieron crecer. Lo cual es un aspecto emocional muy difícil así cómo el abandonar sus raíces, sus amigos su cultura y muchos lugares con los que están familiarizados. Esto es particularmente impactante para los jóvenes.

A la vez, cuando llevan varios años viviendo en Estados Unidos, los jóvenes aprecian tener acceso a más oportunidades. No niegan que la inmigración les ha beneficiado más a largo plazo que haberse quedado en su país de nacimiento. Aun así, muchos quisieran regresar eventualmente.

También se puede observar que cualquier deseo de emigrar, y cualquier interacción con los coyotes que resultó de esa decisión, es vista como información que no se debe compartir con amigos, vecinos, y a veces hasta con la familia por cuestiones de seguridad o evitar preocupar a los familiares. Debido a las historias en las cuales la policía local sospecha que alguien planea irse del país y los arresta para prevenir que salgan, compartir los planes migratorios se convierte en un gran riesgo para el migrante y para la familia que dejará atrás.

Estas dos observaciones basadas en las experiencias de varios inmigrantes no apoyan dos de las ideas xenófobas que dominan la discusión acerca de los inmigrantes de Centroamérica en los Estados Unidos. La primera de estas es la idea de que los migrantes desean venir a los Estados Unidos estrictamente por razones económicas, cuando en realidad los jóvenes quienes dejan Centroamérica para llegar a la frontera sur de Estados Unidos básicamente siguen los planes migratorios de los padres que migran con ellos o que ya lo hicieron años o incluso décadas antes. Cuando tienen que dejar su país de origen, esto se vive como un evento muy triste y doloroso para ellos. Quienes se oponen a la inmigración en los Estados Unidos tienden a asumir que los gobiernos de Centroamérica y México no hacen nada para prevenir que migrantes puedan cruzar sus propias fronteras, cuando en realidad hacen tanto que se vuelven una presencia peligrosa y un gran obstáculo para aquellos que deciden emigrar.

Aunque los políticos estadounidenses critican la migración e insisten que los gobiernos Centroamericanos no hacen nada para mantener a sus ciudadanos en su país, los servicios migratorios en Centroamérica y México a veces detienen y molestan a una gran mayoría de los inmigrantes que tratan de cruzar sus fronteras. Recuentos de soborno de oficiales, amenazas con la deportación y abuso sexual son muy comunes entre jóvenes migrantes, aunque debido a que el discurso común es que estos países no hacen nada en términos de migración, estos abusos se quedan sin reportar y no se hace nada al respecto.

Los carteles mexicanos también toman ventaja de la vulnerabilidad en la que se encuentran los migrantes, debido a que no pueden acudir a las autoridades por miedo a la deportación. Esto convierte a los migrantes en candidatos ideales para la extorsión. Tanto que el crimen organizado se ha convertido en la autoridad principal para aquellos que quieren cruzar las fronteras mexicanas. También ha sido reportado que los carteles retienen a migrantes como rehenes hasta que reciben

el pago de la ‘tarifa’ para cruzar. Aunque los migrantes mencionan su preocupación por estos riesgos, varios de ellos insisten en que lo que más temen es a la policía, aún más que a las pandillas o a la violencia del crimen organizado. Debido a que la policía actúa en representación del estado, representan mayor amenaza a los migrantes por su posición en el sistema judicial. La policía puede operar abiertamente, lo que significa que no están restringidos a la clandestinidad como los grupos criminales. Este miedo a las autoridades del estado es un ejemplo del fracaso de los sistemas migratorios a nivel internacional. La política y el discurso imperante dicen que los peligros principales de un viaje migratorio son los pequeños criminales, pero en realidad la amenaza más grande a los migrantes en la actualidad es la policía y otros agentes del estado, así como el crimen organizado.

Otro ejemplo de esta disfunción sistémica son los varios reportes sobre las interacciones entre migrantes y autoridades migratorias en la frontera entre México y Estados Unidos. Algunos migrantes reciben la frase “Bienvenidos a los Estados Unidos” y algunos otros ni siquiera son informados sobre su derecho a pedir asilo en Estados Unidos. Al parecer, uno de los factores más importantes que determina como concluye el viaje de un migrante es la actitud del agente fronterizo con el que interactúan.

La falta de un sistema uniforme de cumplimiento de la ley, junto a los varios reportes de acoso y abuso, por parte de las autoridades, nos enseñan que este sistema no cumple el propósito que se supone debe cumplir. Parece que hay una gran disonancia entre estas historias y el discurso actual sobre la migración. La imagen de un migrante indocumentado que tiene que huir de la violencia de las pandillas y se tiene que subir a un tren de carga (*La Bestia*) para poder cruzar México y llegar a la frontera con los Estados Unidos es solo un ejemplo de cómo se da esta migración. En varios casos los gobiernos han cambiado estos rumbos cancelando trenes o

haciéndolos viajar mucho más rápido con el propósito explícito de disuadir que los migrantes los usen como medio de transporte. Como resultado muchos migrantes pierden manos, brazos, piernas, o la vida.

Las historias que se presentan a continuación demuestran que la migración es el resultado de eventos y conexiones personales interactuando con eventos y fuerzas del entorno. Partes de estas entrevistas nos muestran que en el contexto antinmigrante y con la militarización de la frontera, los *coyotes* son la vía principal para cruzar la frontera.

Datos Demográficos de la Muestra

De los 58 jóvenes entrevistados, la edad promedio al migrar fue de 14.26 años, y la media de 14.5. Al momento de ser entrevistados, la edad promedio fue de 15.98, y la edad media de 16. El más joven en emigrar tenía 8 años, y el más grande tenía 20. Las entrevistas se hicieron cuando estos jóvenes tenían una edad de entre 10 y 21 años. En cuanto al país, 63.8% de los entrevistados nacieron en El Salvador, 27.6% en Honduras, y 8.6% en Guatemala. Al ser entrevistados, 37.9% vivieron en Montgomery County, MD (Maryland), 41.4% en Prince George's County, MD, y 20.7% en Fairfax County, MD. Entre los participantes del estudio, 26 son mujeres, 31 son hombres, y uno se identificó con otro género.

Resumen e Interpretación del Viaje Migratorio

> "De El Salvador me fui a Guatemala, de Guatemala tome un bus, me apeaba, tomaba otro bus, me apeaba (bajarse del bus), en la noche cambiaba los buses... como veinte buses tome de Guatemala para México. De México a EUA viaje en bus y taxi. Me cruce la frontera e iba caminando cuando me agarraron, me llevaron a migración, ahí me entrevistaron, les explique mi caso, por qué venía... Estuve en un centro donde están los menores, casi medio mes. Ahí jugaba, nos daban clases, y de ahí me vine para donde mi papá. El viaje duró como tres meses" -Carlos, 15, El Salvador

Los jóvenes relataron las diferentes formas en las que cada uno llegó a los Estados Unidos. La gran mayoría de los participantes de este estudio eran indocumentados y por lo tanto no llegaron al país con documentos oficiales. Algunos sí, pero sus experiencias no serán discutidas a fondo en este capítulo por motivos de espacio. En cuanto a la mayoría en situación de indocumentados, algunos tuvieron viajes muy cortos, de una o dos semanas, y otros tuvieron viajes de hasta tres meses antes de llegar al área metropolitana de Washington, D.C.

Entrar y Pasar por México

Para muchos de los jóvenes entrevistados, el viaje a través de México fue una parte larga y llena de dificultades antes de llegar a la frontera con Estados Unidos y ser detenidos por el sistema de inmigración de los Estados Unidos para eventualmente llegar con sus familiares. En varios casos, también fue difícil poder entrar a México. Jose, de 17 años y de El Salvador, dijo que se sentía seguro en Guatemala, pero no en México.

> "Por Guatemala sí, porque obviamente es fácil, son hermanos con El Salvador, pero México si ya no" -Jose, 17, El Salvador

Existen actitudes antiinmigrantes en México y se han materializado en varias formas, tal como las demostraciones en Tijuana en 2018 en las que cientos de personas protestaron en contra de las caravanas inmigrantes. Por medio de normas sociales y leyes nacionales, los inmigrantes centroamericanos han sido discriminados y asociados con la criminalidad y una mala economía (Vogt 2013). Estos sentimientos están profundamente arraigados en el racismo e ideas antiindígenas y se han infiltrado a la vida cotidiana, creando un ambiente peligroso para los inmigrantes centroamericanos en su viaje hacia el norte (Figueroa 2010).

Algunos de los entrevistados de El Salvador también dijeron que Guatemala se les hizo menos desconocido que México. Los salvadoreños en Guatemala no sentían que su vida estaba en riesgo, pero eso cambiaba cuando estaban en México. Luis, salvadoreño de 19 años, explica como no se sentía seguro mientras viajaba por México:

> "[Entrevistadora] *¿Pasaste por Guatemala?* Si, allí me tuvieron, como dos días, porque para pasar a México estaba—no se podía había mucha migración allí. El coyote tenía una casa en Guatemala y ahí esperamos para pasar." -Luis, 19, El Salvador

Además de estar preocupados por la posibilidad de ser arrestados por las autoridades migratorias mexicanas, los jóvenes también temían ser secuestrados y extorsionados, en México y en el área alrededor de la frontera mexicana con Guatemala. Las pandillas y el miedo a las mismas, también alentaban estos viajes que ya eran bastante largos y traumáticos. Un joven de El Salvador que tenía 14 años explica como estas preocupaciones afectaron su viaje a través de Guatemala y México:

> "los coyotes tienen que pedirles permiso a ellos para pasar y ellos les daban dinero, les pagaban para poder pasar. Sino los secuestraban o algo así, pedían dinero"-Dominic, 12 años al migrar, El Salvador

Este miedo que comparten muchos migrantes se volvió una realidad para Samantha, una joven hondureña de 15 años. Ella explica como su grupo fue detenido en el área de la frontera entre Guatemala y México por un grupo de pandilleros armados que los amenazaban con prender fuego al camión en el que venían viajando con todos ellos a bordo, a menos que el grupo les pagara. Ella tuvo que dormir en un terreno por cuatro noches mientras los coyotes se arreglaban con las pandillas para que estos los dejaran pasar.

"Y ellos andaban en carros, también, armados y todos eso. Y se pusieron enfrente de los carros, y no los dejaban pasar. Porque supuestamente en ese puesto allí ellos mandaban y todo. (*¿Y eso era en que país?*) En Guatemala, creo que en la frontera entre México y Guatemala. Y si no le pagaban una cantidad de dinero, no nos iban a dejar. Y supuestamente, le iban a encender fuego a los camiones porque veníamos cerrados por fuera. O sea, nadie podía abrir por dentro, ni nada. Los otros no podían abrir, ni nada. No se cómo lo resolvieron. Ellos, creo que se regresaron de dónde venían... Bueno, a nosotros nos fueron a dejar en esa cancha, que le digo. Y dormimos, creo que estuvimos como 4 días allí. *(¿En la cancha?*) Aja, durmiendo con frio y todo. Esas personas decían que tienen que pagar o que si no... los matan a todos. Entonces el conductor del camión hizo un trato con ellos. Y que les daban, creo que una semana ... Aja, y creo que lo consiguieron y después nos dejaron libres. Y nos venimos" -Samantha, 15, Honduras

Cuando Samantha continuo su relato, dijo que solo los alimentaban una vez al día y aparte de eso solo tomaba agua. Para muchos de los jóvenes, el viaje a través de México fue una experiencia no solo incomoda e inhumana, si no también físicamente peligrosa. Un joven salvadoreño, Alberto, que tenía 16 años cuando lo entrevistamos cuenta algunas de sus experiencias:

"Por México el transito al principio no fue muy movido, como ya llegando a la frontera, porque en la frontera ya hay migración mexicana y también hay federales. Pasar por México no fue muy difícil, pero si teníamos que andar con cuidado porque la gente rápido se daba cuenta que éramos inmigrantes… y bueno, uno nunca se siente seguro viajando por México porque puede ser que lo deporten de vuelta..." -Alberto, 14 años al migrar, El Salvador

Todos los participantes de este estudio habían emigrado antes de las caravanas y antes de que la administración de Trump creara el programa para mantener a migrantes y refugiados en México. Aun así, muchos de los jóvenes no confiaban en las autoridades mexicanas debido al riesgo de que fueran deportados de México, lo cual haría su viaje más largo y caro ya que tendrían

que intentar de nuevo y volver a empezar su viaje. Ana Cristina, una joven hondureña de 17 años comparte la experiencia que tuvieron ella y su hermano durante su tiempo en México:

> "En México teníamos un celular, y podíamos llamar a mi mamá. Traíamos un poco de dinero, pero después se nos terminó el dinero y aguantamos hambre por dos días. Estábamos asustados, mi hermano lloraba y quería regresar, pero yo dije que siguiéramos" -Ana Cristina, 14 años al migrar, Honduras

Arrestos

La mayoría de los jóvenes entrevistados que contrataron a coyotes para cruzar la frontera sur de Estados Unidos planeaban entregarse a la patrulla fronteriza (CBP) para ser detenidos y empezar el proceso legal que posiblemente les permitiría quedarse en el país. Después de llegar a la frontera, los jóvenes tuvieron experiencias muy diferentes en cuanto al cruzar el río en la frontera y llegar cara a cara con los agentes de la patrulla fronteriza y agentes de aduanas (CBP):

> "Nosotros, umm, nos agarró la migración estadounidense. Pasamos por el centro de detención y contactaron a mi papá, él es mi patrocinador oficial. (Dennis: Y eso fue a propósito, tu sabías que ellos iban a pasarte a vivir con tu papá?) Si. (Dennis: Entonces.. intentabas evitar las autoridades de migración Americanas?) Bueno, no teníamos más recursos, porque los coyotes solo nos dejaron pasar el rio y nos dijeron: ""caminen derecho"" y no encontramos la carretera. (Dennis: Pero no era como a propósito, tu no querías que ellos los detuvieran?) Lo mejor era que la migración nos agarrara porque sería más fácil todo."
>
> Alberto, 14, El Salvador

Diana, una salvadoreña de 16 años, comparte su experiencia cruzando la frontera y el tiempo qué pasó bajo la custodia del CBP:

> "Estamos en una casa y luego un señor dijo que nos iba a llevar a dejar en un bosque. Había como un bosque, pero estaba/ Se escuchaba el río. Y estábamos en una piedra allí con otros señores, que eran de la misma persona que nos traía. Y se escuchaba un ruido cómo de un animal, muy feo. Y

> teníamos miedo. Eran como las 5 de la mañana. Entonces, ya estuvimos allí como 2 horas, y nunca llegaba él que nos iba a pasar al río, y luego llegó, y pasamos el río una vez, pero eso era lo que íbamos a caminar para el desierto. Luego lo volvimos a pasar otra vuelta porque el señor se equivocó, y dijo 'No, vamos a pasarlo pa' acá para México.' Luego volvimos a pasarlo para los Estados Unidos, y el señor se volvió a equivocar. Y luego lo volvimos para México, y a la otra vez que lo pasamos, allí habían sembrado algodón, y caminamos mucho, mucho para llegar a un portón grande, negro, y allí estaba un carro de Inmigración, y nos agarró. Nos pregunto que como nos llamábamos, y nos subieron allí, y nos llevaron a una casita, donde había mucha gente. No mucha, había como más 15 niñas allí. Y me dieron una cobija, y luego como a las… como ya que estaba haciendo noche, nos llevaron a bañar, porque teníamos toda la ropa, y nos dieron ropa, y luego el otro día nos llevaron para el centro de detención" -Diana, 16, El Salvador

Valentina, una salvadoreña de 16 años, describe una experiencia similar y también el lugar de detención que es conocido por los migrantes como la Hielera.

> "Pues cuando nosotros cruzamos, ya estaba migración ahí. Prácticamente, casi que nos estaban esperando, prácticamente. Pues de ahí de eso, nos dijeron que nos quitáramos todo lo trajéramos, como punzantes, como anillos, pulseras, aritos, y nos llevaron para la hielera, prácticamente. (¿Que es la hielera?) Es un tipo de cuarto, así, pero súper helado. (¿Y ahí estaban con tu mamá y tu hermano?) No, solo con mi mamá. A mi hermano lo separaron, porque como tenía diez años, y en ese cuartito solo había mujeres con niños pequeños porque los baños estaban así enfrente. Por eso a él lo quitaron y lo mandaron para donde estaban otros niños"
>
> -Valentina, 16, El Salvador

Allison, de 14 años y también de El Salvador, comparte como se enfermó mientras estaba detenida en la hielera. Explica también que en la instalación solo había un baño que compartían todos los que estaban detenidos, y éste no estaba cubierto, así que no existía la privacidad al usar el baño.

“En grupo cruzamos- *Cruzaron el rio o cruzaron-* El rio, en balsa. Y después caminamos como tres horas en la noche. Y yo andaba mojada porque como en el rio se moja uno, ya no aguantaba caminar, y me senté un ratito y se hizo más tiempo, como a las cuatro horas fue que me agarraron. *¿Cuatro horas de haber estado sentada o cuatro horas después de que entraste, que cruzaron el rio?* De que entre. *Entonces estuvieron caminado como por tres horas y te quedaste sentada como por-* Una hora. *¿Y alguien más se quedó sentado con voz, esperando?* Si, una señora que venía. *¿Y allí lo agarro inmigración?* [Si]. *¿Y allí que paso cuando las agarró inmigración?* Nos llevaron a un lugar donde es frio, y allí no dan cobijas – *¿Como una celda más o menos?* [Si]. Y uno no aguanta frio y como yo andaba mojada más frio. *¿Te enfermaste después de eso?* [Si]. *Entonces los agarra inmigración. ¿Cuándo te detienen, que pasó? O sea, te encontraron, estabas sentada en-* No iba caminando. *Ah, ibas caminando. ¿Y qué pasó cuando los agarro inmigración? ¿Me puedes contar un poco de eso?* Solo nos dijo que [inaudible] nos quitáramos los zapatos y nos llevaron a la celda. *¿Sin zapatos estabas en ese cuarto bien helado?* Si, con zapatos. *Con zapatos. ¿Y cuánto tiempo estuviste en ese lugar frio?* Como 24 horas. *¿Y qué paso en esas 24 horas? Solo estabas allí esperando o-* Solo me entrevistaron que por que venía, y llamaron a mi mami que ya estaba allí *Y después de eso, ¿qué paso?* Me llevaron al albergue y allí solo estuve 13 días. *¿Y el albergue que tal es?* Está bien. *¿Qué te dieron allá en el albergue?* Cuando llegue, llegue de madrugada. Me dieron comida allí, ropa y zapatos. *¿Y en ese momento tenías gripe o no?* No, después. *¿Después fue?* [Si] *En esas 24 horas que estuviste en ese lugar frio, ¿te dieron algo de comida, agua, tenías acceso a un baño?* Baño, pero era el que todos ocupaban como allí había bastante gente, todos miraban cuando me iba al baño. *Los tenían separados por hombres-mujeres o-* Hombres y mujeres. *¿Les dieron algo de comida, agua, o algo así?* Solo un sandwich. Solo eso. *¿Agua no?* No. *Entonces en el albergue, después de que le avisan a tu mamá que estas acá, ¿sabes si le pidieron algo a tu mamá, si le pidieron que ella pagara un boleto aéreo o algo así?* En el albergue. *¿Era en el albergue?* Si. *¿Y tú mamá pagó el boleto aéreo?* Si. *¿Y en eso 13 días que estuviste en el albergue, que hacías?* Allí iba a la escuela, porque hacen allí escuela y solo eso.

Hacían juegos. *Y estaban, ¿había otras personas de tu edad?* Si, todas eran niñas y niños de mi edad. *¿Come te sentías en el albergue?* Bien, estaba divertido" -Allison, 14, El Salvador

El albergue parecía ser un lugar mucho mejor para los jóvenes, donde podían dejar atrás todas las cosas que les habían pasado durante las semana o meses previos. Aún después de su experiencia en la hielera, Allison describió el tiempo qué pasó en el albergue como "divertido." Los jóvenes podían participar en cursos, jugar con otros jóvenes, y también tenían acceso a diferentes servicios y materiales. Con una experiencia similar, Ana Cristina entonces de 14 años explico su experiencia en el albergue para jóvenes casi como un campamento.

Los jóvenes estuvieron en el albergue por períodos de varias semanas mientras se arreglaban los detalles de su patrocinio y reubicación. A veces, los jóvenes que viajaban con sus padres se volvían a ver después de estar en el albergue y podían comenzar sus vidas en los Estados Unidos. En otras ocasiones, después de estar en el albergue, estos jóvenes se reunirán con unos de sus papás que no habían visto en años.

Discusión

El análisis de las entrevistas de manera global arroja los siguientes hallazgos:

- Los jóvenes migrantes reportan menos incidentes de violencia durante su tránsito por México que las que son frecuentemente reportadas:

Aunque tal vez esperábamos más incidencias de violencia de las que fueron reportadas, los jóvenes entrevistados relataron varios incidentes de violencia durante el viaje por Guatemala y México: un solo caso incluyó el secuestro de un joven. Otro incluyó fuerza excesiva por parte de agentes mexicanos de inmigración y amenazas a punto de pistola por un criminal. Así como otros incidentes que afectaron a todo el grupo de migrantes viajando solos. En el último caso, de la niña migrante, fue protegida de daño por su guía y por otros migrantes centroamericanos.

Puede ser que los jóvenes migrantes reciben protecciones adiciónales por parte de los coyotes, una hipótesis que se apoyada en el hecho de que los caminos y modos de transporte utilizados para mover a jóvenes migrantes hacia el norte son más seguros que los utilizados por adultos. Por ejemplo, el uso de camiones y automóviles en lugar de la Bestia (tren). Pero, eso no evita las difíciles experiencias de nuestros entrevistados. Sí los coyotes de hecho están haciendo un esfuerzo concertado para proteger a los jóvenes migrantes de probables daños, estas acciones no fueron del todo altruistas y más bien provocadas por un modelo de negocio con base en resultados, como lo es el negocio del transporte de personas a través de las fronteras. Muertes repetidas de jóvenes migrantes son dañinas para las perspectivas de negocio de esos coyotes en el futuro. En un caso extremo de protección por parte del coyote, una entrevistada reportó que voló a los Estados Unidos usando los papeles de la hija del coyote después de que la esposa del coyote desarrollo gran empatía con ella.

- <u>El impacto mixto en la intensificación de acciones antinmigrantes hechas por las autoridades mexicanas</u>:

Bajo la creciente presión de los Estados Unidos tras el crecimiento en el flujo de la migración adolescente y familiar a Estados Unidos en 2014, México anunció medidas más estrictas de seguridad con sus fronteras del sur con Guatemala y Belice, y dentro el país entero. En consecuencia, las detenciones de jóvenes migrantes subieron más de 315%, de 9,630 en 2013 a 40,114 en 2016. Las deportaciones de los jóvenes migrantes de México siguen una trayectoria similar subiendo de 8,477 en 2013 a 38,555 en 2016. Un descubrimiento algo sorprendente en este contexto fue que a pesar de estas restricciones solo dos de los más de 40 jóvenes migrantes entrevistados para nuestro estudio fueron detenidos formalmente por agentes de inmigración en

México. El incremento de las actividades migratorias en México sin duda impactó el negocio del tráfico de humanos en conjunto porque las rutas de contrabando fueron rediseñadas y los coyotes forzados a prepararse para la posibilidad de hacer hasta tres viajes, algo que fue reflejado en el aumento de honorarios.

- <u>La migración repetida puede ser un factor detrás el numero inflado de las detenciones y deportaciones en México:</u>

En 2016, a pesar del incremento del esfuerzo inmigratorio en México, esos esfuerzos han probado ser cada vez menos efectivos en los años recientes para prevenir que los jóvenes migrantes lleguen a la frontera de México y los Estados Unidos y de presentarse ante agentes estadounidenses de inmigración. Paradójicamente, el aumento en las detenciones en México coincidió con el aumento en los arrestos en la frontera en 2016. Mientras no es improbable que un mayor número de jóvenes pueda estar saliendo de Centro América y causar el aumento en la contabilización de arrestos en los dos lados de la frontera. Otra explicación posible surge de la experiencia de dos jóvenes migrantes que participaron en este estudio que fueron detenidas en México. Una adolescente salvadoreña fue detenida y deportada por las autoridades mexicanas dos veces antes de llegar a los Estados Unidos en su tercer intento. En la primera ocasión, ella fue detenida y deportada con su hermana menor. Al final, estas dos niñas representaron cinco arrestos de las autoridades estadounidenses y mexicanas. Este es un hecho que no solo frustra a los investigadores que usan las estadísticas oficiales de detenciones y arrestos como un "proxy" para medir la migración saliendo de México, pero que también enfatiza la relativa futilidad del esfuerzo de las actividades migratorias en México cuando la intención de migrar es clara.

- La separación de familias ha demostrado ser un factor único y el más importante afectando el intento para reintentar migrar después de una detención y retorno/deportación entre otras poblaciones de migrantes (ver Cardoso et al. 2014). El relato de una madre de las deportaciones de México de sus hijas parece indicar ese descubrimiento a por lo menos un subconjunto de jóvenes migrantes. Cuando a ella se le preguntó si le ofrecieron asilo en México a su hija, la madre respondió afirmativamente, pero aclaró que el asilo en México nunca fue su intención, la cual siempre fue reunirse con la madre en Maryland. A diferencia de los Estados Unidos, México está aún por imponer sanciones severas en múltiples entradas ilegales, y por ello existe una 'puerta giratoria' que probablemente continuará siendo la norma entre migrantes centroamericanos que están huyendo de las condiciones adversas en sus países de origen y que están determinados a reunirse con sus familias en los Estados Unidos.
- El incremento en la sofisticación de las redes del tráfico de personas: Más que estar con un solo coyote durante el viaje, los jóvenes migrantes reportaron consistentemente que fueron transferidos a diferentes coyotes durante varios tramos de sus viajes. Un descubrimiento que revela un incremento en la sofisticación de las redes de contrabando. Mientras los migrantes son transferidos de un sector contralado por ciertos carteles a otro, también son transferidos a un coyote diferente quien también autorizado a participar en el contrabando (incluyendo de personas) en el territorio de ese cartel. Presumiblemente, esto ha dejado a coyotes, quienes están ahora limitados a ciertos tramos del camino, a ser más efectivos para huir o para comprar a agentes judiciales locales entre sus limitados territorios.

Conclusión

La inmigración y la integración son procesos interconectados – entre más fácil sea el viaje migratorio, más fácil tiende a ser la integración, o por lo menos las dificultades no serán tantas si el viaje no fue tan traumático. Los jóvenes que pudieron llegar a estados unidos con una tarjeta de residencia a bordo de un avión sufrieron mucho menos que aquellos quienes viajaron a través de México con coyotes o a bordo de La Bestia. Esto es cierto para jóvenes y adultos que viajan hacia el norte. Al considerar la cantidad de jóvenes viajando solos hacia los Estados Unidos, podemos informarnos mejor y entender la inmigración por medio de México y sus consecuencias. La inmigración de Centroamérica es sustentada por necesidad, y muchas veces es una decisión de último minuto o es un plan que se mantiene en secreto. Los patrones migratorios que hemos estudiado siguen redes migratorias que ya han sido establecidas, ya que la reunificación familiar sigue siendo una razón principal por la que inmigran los jóvenes. Las oportunidades, factores económicos y educacionales siguen estando dentro de las cinco razones más comunes por las que una familia manda a un hijo solo hacia Estados Unidos. Después de haber viajado por México y haber navegado el sistema de inmigración en Estados Unidos, los jóvenes tienen que reasumir sus vidas en Washington D.C., posiblemente con un padre o madre que no han visto en años, con un padrastro o madrastra que no conocían, o con hermanos y hermanas nuevos. Esta etapa de la migración trae sus propios desafíos: como integrarse a una nueva familia, comunidad, escuela y cultura. Pero esto es posible y las familias migrantes centroamericanas no demuestran un riesgo real a México ni a los Estados Unidos.

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Referencias

Abrego, Leisy .J. 2014. *Sacrificing Families: Navigating Laws, Labor, and Love across Borders*. Stanford, CA: Stanford University Press.

Canizales, Stephanie and Samuel De León. 2019, "The Uncontained Violence against Unaccompanied Central American Minor Migrants in the U.S.", Los Angeles, CA: University of Southern California. (https://dornsife.usc.edu/csii/blog-violence-against-central-am-migrant-minors/).

Cardoso, Jodi A. Berger , Kalina Brabeck, Dennis Stinchcomb, Lauren Heidbrink, Olga Acosta Price, Óscar F. Gil-García, Thomas M. Crea and Luis H. Zayas. 2019. "Integration of Unaccompanied Migrant Youth in the United States: A Call for Research." *Journal of Ethnic and Migration Studies* 45(2):273-92. doi: 10.1080/1369183X.2017.1404261.

Castañeda, Ernesto and Lesley Buck. 2011. "Remittances, Transnational Parenting, and the Children Left Behind: Economic and Psychological Implications." *The Latin Americanist* 55(4):85-110. doi: 10.1111/j.1557-203X.2011.01136.x.

Castañeda, Ernesto. 2014, "There Is No Immigration Security Threat That Reform with an Earned Path to Citizenship Cannot Address", Cambridge, MA: Scholar Strategy Network. Retrieved Septembre 1, 2020 (https://scholars.org/there-no-immigration-security-threat-reform-earned-path-citizenship-cannot-address).

Castañeda, Ernesto and Lesley Buck. 2014. "A Family of Strangers: Transnational Parenting and the Consequences of Family Separation Due to Undocumented Migration." in *Hidden Lives and Human Rights in America: Understanding the Controversies and Tragedies of Undocumented Immigration*, edited by L. A. Lorentzen. Santa Barbara, CA: Praeger.

De Jesus, Maria and Carissa Hernandes. 2019. "Generalized Violence as a Threat to Health and Well-Being: A Qualitative Study of Youth Living in Urban Settings in Central America's "Northern Triangle"." *International Journal of Environmental Research and Public Health* 16(18):3465.

Figueroa, Mónica G. Moreno. 2010. "Distributed Intensities: Whiteness, Mestizaje and the Logics of Mexican Racism." *Ethnicities* 10(3):387-401.

Gonzalez-Barrera, Ana and Jens Manuel Krogstad. 2019, "What We Know About Illegal Immigration from Mexico", Washington, DC: Pew Research Center. Retrieved August 30, 2020 (https://www.pewresearch.org/fact-tank/2019/06/28/what-we-know-about-illegal-immigration-from-mexico/).

HHS. 2020, "Unaccompanied Children Released to Sponsors by State - December 2019", Washington, DC: Department of Health and Human Services (https://www.hhs.gov/programs/social-services/unaccompanied-children-released-to-sponsors-by-state-december-2019.html).

Menjívar, Cecilia. 2000. *Fragmented Ties: Salvadoran Immigrant Networks in America*. Berkeley, CA: University of California Press.

Menjívar, Cecilia. 2011. *Enduring Violence: Ladina Women's Lives in Guatemala*. Berkeley, CA: University of California Press.

Menjívar, Cecilia and Krista M. Perreira. 2019. "Undocumented and Unaccompanied: Children of Migration in the European Union and the United States." *Journal of Ethnic and Migration Studies* 45(2):197-217. doi: 10.1080/1369183X.2017.1404255.

Sacchetti, Maria. 2019, "'You Want a Cookie?': As Families Arrive En Masse, Border Agents Offer Snacks and Medical Checks", Washington, DC: Washington Post. Retrieved September 1, 2020 (https://www.washingtonpost.com/local/immigration/you-want-a-cookie-as-families-arrive-en-masse-border-agents-offer-snacks-and-medical-checks/2019/02/19/1b334d5c-1dd7-11e9-9145-3f74070bbdb9_story.html).

Stinchcomb, Dennis and Eric Hershberg. 2014. "Unaccompanied Migrant Children from Central America: Context, Causes, and Responses." Vol. *Center for Latin American and Latino Studies Working Paper Series.* Washington, DC: American University.

Teicher, Martin H. 2018. "Childhood Trauma and the Enduring Consequences of Forcibly Separating Children from Parents at the United States Border." *BMC Medicine* 16(1):146. doi: 10.1186/s12916-018-1147-y.

Trull, Armando. 2014, "Dc Struggles with Surge of Underage Immigrants", Washington, DC: NPR. Retrieved September 1, 2020 (https://wamu.org/story/14/06/19/dc_area_struggles_with_surge_of_underage_immigrants).

Vogt, Wendy A. 2013. "Crossing Mexico: Structural Violence and the Commodification of Undocumented Central American Migrants." *American Ethnologist* 40(4):764-80. doi: 10.1111/amet.12053.

SSN BASIC FACTS

HOW TO HELP UNACCOMPANIED CHILDREN FROM CENTRAL AMERICA—IDEAS FROM THE WASHINGTON, DC AREA

JUNE 11, 2021 CIVIC ENGAGEMENT ■ DEMOCRACY & GOVERNANCE ■ PUBLIC HEALTH ■ RACE & ETHNICITY

By Ernesto Castañeda and Daniel Jenks

Since 2015, nearly 250,000 unaccompanied minors have arrived in the United States and been placed across the country with sponsors, who may be their parents, other family members, or friends. Many of these young people—from El Salvador, Guatemala, and Honduras—are motivated to travel by increasing violence and economic and political instability in their home countries, as well as a desire for reunification with their parents.

Of these children, over 20,000 have moved to the Washington, D.C. region, where many face barriers to integration in their communities. Their difficulties include dealing with traumatic experiences, family separation, inconsistent or interrupted schooling, and language barriers in their new schools. As scholars and policymakers, we must rapidly respond to the needs of migrant children and find the best ways to support these young newcomers who now call our region home.

Our research with the Center on Latino and Latin American Studies at American University includes interviews with fifty-eight recently resettled youth, thirty-six sponsors, and seventeen social service providers and school staff in the District of Columbia, Fairfax County in Virginia, and Prince George's County and Montgomery County in Maryland. The stories from these youths, sponsors, and practitioners illuminate a cross-section of the experiences of resettled Central American minors—experiences that, we hope, can inform policy interventions at the county level that can help the unaccompanied minors thrive.

Violence, Family Separation, and Trauma

The traumas these young people have been through in their sending communities, during the journey north, and in Customs and Border Protection detention are hardly imaginable to those of us that have not experienced them. Although migrants from Central America are commonly believed to pose a violent threat to native-born Americans, we found that the youth we interviewed were often fleeing gang or state-sponsored violence. The United States was a place of freedom and safety for many of them. Carlos, age 13, mentioned he felt much safer and could perform better in school in the states. Gang activity in his country of birth made it hard for him to study, go to school or visit family around town, or take advantage of opportunities that many in America take for granted, like playing soccer with his friends. In DC, he was reunited with his father and could visualize both short- and long-term goals. In the short term, he wanted to join a soccer team; in the

long term, he wanted to become a lawyer. These things had not been conceivable to him while living with the backdrop of gang violence, thousands of miles away from his father.

Parents often go north and leave behind very young children in order to pay for their schooling, housing, food, and clothes in their places of birth. This leaves many children to be raised by other relatives or friends. Young people in our study reported that after reuniting in the United States, getting used to the relationship with their parents or other sponsors was hard at first, but the situation sometimes improved. Samantha, age 15, described how she was very young when her mom left for the United States and had not seen her in years. Because of that, the first year in the states was challenging. She felt lonely and missed her grandmother and sister, who had felt more like mothers than anyone else while still living in Honduras. Other youth, including Melissa, age 14, David, age 13, and Sarah, age 18, also reported that one of the more challenging parts of coming to the states was leaving other relatives like their grandmothers.

Schools and Friendships

Immigrant minors are often enrolled in programming for students with interrupted formal education and in English classes for speakers of other languages. Our interviewees reported that being in school was hard at first, but their sense of belonging improved after some time, to the point that they were even excited to attend. Schools often have difficulty welcoming and accommodating these young adults due to language barriers, and the young migrants in our study reported that contending with English-language instruction hampered their performance and happiness in school. At the same time, by making friends and speaking in Spanish with other Latino students in the United States, they could feel more at home and part of their community. We conclude that opportunities to communicate with others in Spanish can be an essential determinant of school enjoyment.

Students also benefited from support services they could find through schools and in the companionship of their peers—a network comprising friends, bilingual counselors in schools, and social service organizations in the community that could also include their families. Melissa, age 14, reported that she felt welcome in her school and had a sound support system composed of free public school, language and integration support programs, and many students in situations like her own.

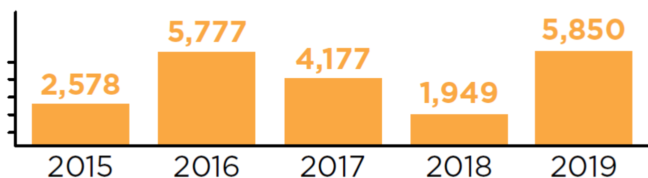
Addressing Trauma and Supporting Immigrant Communities through Our Institutions

Over time, schools can become welcoming and supportive institutions for minors and their families, but there are challenges. Schools need more language support, staff who speak Spanish, and more social workers. School systems should ensure that explicit training is provided to all school officials to work with Central American immigrants and those with a history of traumatic experiences.

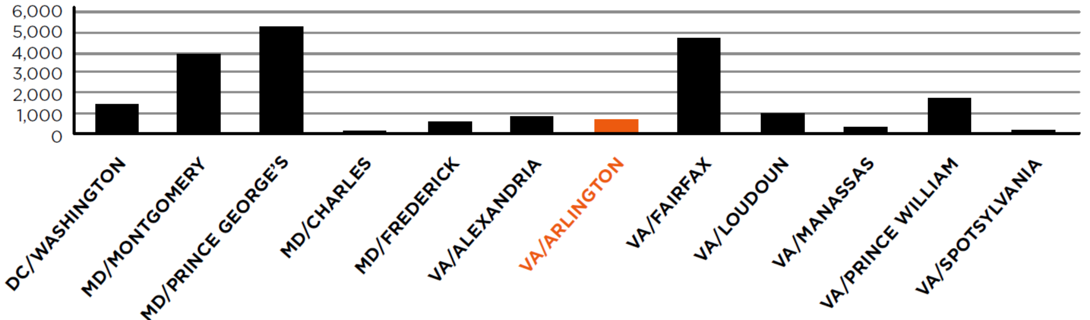
Overall, the benefits of family reunification are worth the struggles. Our interviewees repeatedly reported that, while the experience could be incredibly challenging, they are now more comfortable in their day-to-day lives, like living in this country, and feel that they are working towards a better

future. Family services for refugees, asylees, and immigrants can make considerable differences in the lives of immigrant families. For example, Arlington County could consider establishing its own family support programming or providing grants for community organizations to do so. This would give youths and their families more opportunities to process their pasts and consistently achieve health and happiness. Arlington County's unaccompanied youth population is relatively small, so a few targeted programs could have an enormous impact at a modest cost. This is likely to be the case for many counties around the country as the youth who entered the border recently get resettled with their family members.

NUMBER OF UACS RELEASED TO SPONSORS IN THE DC METROPOLITAN AREA BY YEAR



TOTAL UACS PLACED WITH SPONSORS, 2015-2019



"Here . . . I'll be going to university. I want to study. And where I used to live was very dangerous, and there are no opportunities to pursue higher education."

—DIANA, 16, EL SALVADOR

"[The gang] wanted to force me to join the Maras. And that is why you can't study, because I was scared to leave the house, to go to school, and then to come back home."

—CARLOS, 15, EL SALVADOR

scholars.org

Research and data for this brief are drawn from Ernesto Castañeda and Daniel Jenks' ongoing project with American University's Immigration Lab & forthcoming book "Reuniting Families." Originally published here: https://scholars.org/contribution/how-help-unaccompanied-children-central

Supporting Unaccompanied Children from Central America in Arlington County Schools

Ernesto Castañeda & **Daniel Jenks,** American University

Over 20,000 unaccompanied minors (UAC) – many from El Salvador, Guatemala, and Honduras – have moved to the Washington, D.C. region. The Arlington County School Board can support the migrant youth who call our region home by increasing language support, hiring more Spanish-speaking staff and social workers, expanding programs that address economic anxiety and food insecurity for all students, and provide trauma-informed training to all staff.

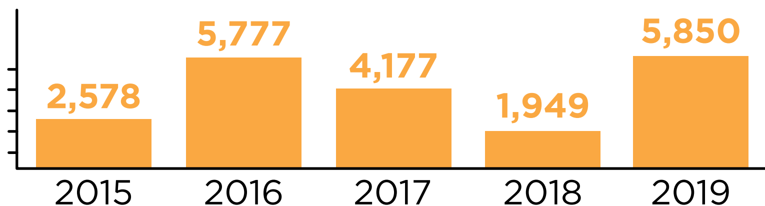
WHAT SETS THESE STUDENTS APART FROM OTHER ENGLISH LANGUAGE LEARNERS?

Every interviewee brought their own sets of stories. Many bring trauma from experiencing or witnessing violence, from the notoriously dangerous journey north, or detention by Customs and Border Protection. Others are leaving family members and entering unfamiliar households with family members they have not seen in years. They also bring dreams and ambition, a desire to learn English, make friends, and follow a career they are interested in.

WHAT INTERVENTIONS EFFICIENTLY ADDRESS MIGRANT STUDENTS' BARRIERS TO INTEGRATION?

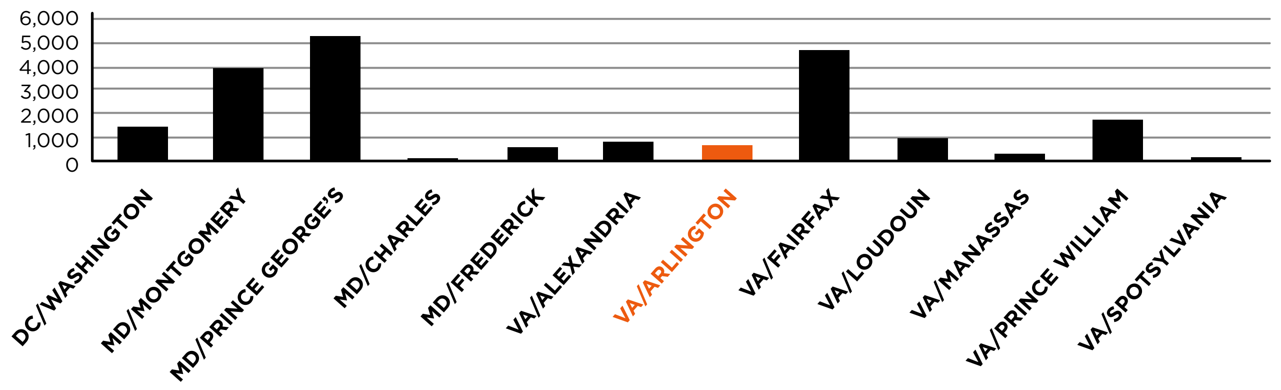
Our study participants reported that struggling with English-language instruction hampered their performance and happiness in school. Simultaneously, by making friends and speaking in Spanish with other Latinx students, they could feel more at home and part of their community. Arlington Public Schools can hire more bilingual staff and provide more and more extensive bilingual/immersion programs, expand the Students with Interrupted Formal Education (SIFE) and English as a Second Language (ESL) offerings, and emulate counties in the region that have programs designed explicitly for immigrant youth and parents reuniting after years apart.

NUMBER OF UACS RELEASED TO SPONSORS IN THE DC METROPOLITAN AREA BY YEAR



Economic anxiety and **food insecurity** – exacerbated by the pandemic – have meant that food pantries, school-based meal programs, and school-based counseling and family services have been lifesaving. There needs to be more contact with parents to ensure that they know what federal services are available to them. **Public youth programming** can make an effort to enroll more immigrant youth whose parents do not speak English well, to better engage families in community activities.

Arlington County should ensure that explicit training is provided to all school officials to work with Central American immigrants and those with a history of traumatic experiences. The County could consider funding its own programming or create grant programs for community organizations to scale up their school and family support programs so that youths and their families can process their pasts and futures together, and so that these populations can more consistently achieve health and happiness. Arlington County's unaccompanied youth population is smaller than in other parts of the DMV, **so a few targeted programs could have an enormous impact** and not be prohibitive in terms of resources required.



WHAT INSIGHTS DO WE HAVE INTO THE PERSONAL EXPERIENCES OF MIGRANT YOUTH WHO ATTEND ARLINGTON COUNTY SCHOOLS?

Our research with the Center for Latin American and Latino Studies at American University includes interviews with 58 recently resettled youth; 41 sponsors; and 23 social service providers and school staff in the DC metropolitan area.

"Here . . . I'll be going to university. I want to study. And where I used to live was very dangerous, and there are no opportunities to pursue higher education."

—DIANA, 16, EL SALVADOR

"[The gang] wanted to force me to join the Maras. And that is why you can't study, because I was scared to leave the house, to go to school, and then to come back home."

—CARLOS, 15, EL SALVADOR

Defunding the Police is an Immigrants' Rights Issue, Too

Black and Brown Lives are Under Attack by Law Enforcement

Daniel Jenks and Ernesto Castañeda

July 6, 2020

Immigrant girls sleep in a cell in an immigrant detention facility in Nogales, Arizona, Jun. 18, 2014.
AP Photo/Ross D. Franklin

In 2016, the Center for Latin American and Latino Studies at American University launched a study into the lives of unaccompanied Central American youth residing with sponsors in the Washington, D.C. metropolitan area. Many youth reported that they wished to eventually return to their home countries but that it often was not safe for them to do so because of threats from organized crime or government authorities. In our survey, youth expressed that police in their home countries had targeted them and their families. There, if it was not the police, it was local gangs or MS-13. In the United States, the major threats to them have also been gangs and the police. Sometimes youth reported pressure to join local gangs in their home countries, which many

of them resisted successfully. Nonetheless, some police officers and members of the community assume that these young men are gang members. Youth often feel terrorized by gangs and police in both their home and host countries while their parents are very busy working multiple low-paying jobs to ensure their safety, health, and education.

There have long been efforts to abolish ICE, and recently a group of Undocumented, DACAmented, and formerly undocumented leaders published an open letter to the Immigrant Rights Movement. They make a clear case as to why the Immigrant Rights movement is in line with, and in clear support of, the Black Lives Matter movement. Youth integration outcomes in Washington, D.C., as shown by our study, illustrate yet another reason why.

Integration refers to the process of immigrants feeling as though they belong or feel at home in their neighborhoods, communities, cities, and country overall. Unlike assimilation, integration, or incorporation, allows immigrants to maintain their cultures, customs, and mores while still being included as part of the general public. Immigrants have different immigration outcomes depending on local contexts: in France, for instance, immigrants from North Africa find themselves in a highly xenophobic environment where they may never feel truly "French" (Castañeda 2018). So the question emerges: how do we aid integration?

Contexts where institutions and society accept immigrants more readily are those where integration occurs more effectively (Castañeda 2018). Effective integration prevents extremism and creates more close-knit and compassionate communities. Furthermore, it safeguards an overall democratic structure. Unfortunately, the political discourse around immigration does not often include how to effectively create environments conducive to integration. Rather, politicians scapegoat groups of people, such as immigrants, for the economic anxieties created by neoliberal economic policies (Castañeda 2019, Castañeda 2020). Due to this, we get caught in conversations

about building walls and deportations rather than acknowledging and recognizing the humanity of others and seeing the entire situation for what it is.

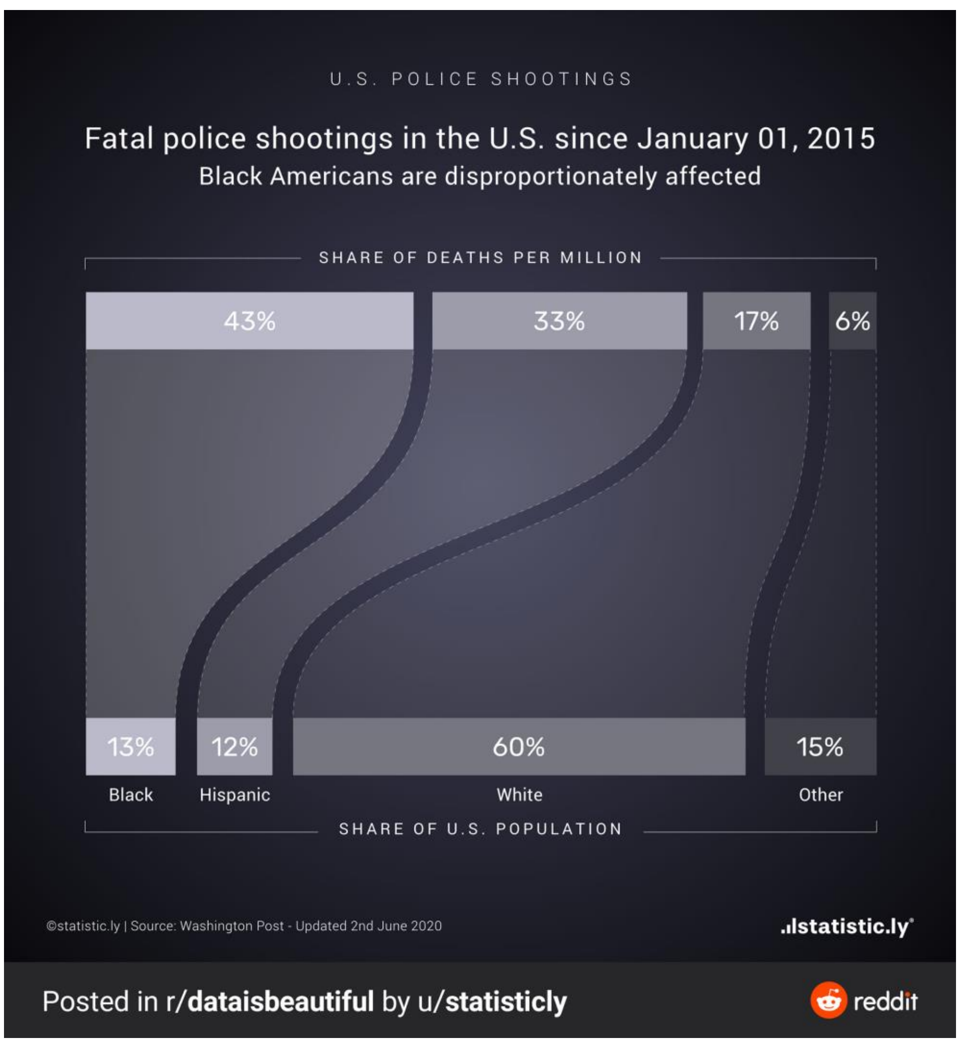
The integration needs of immigrant youth referenced in the study are many but there are things that can be done to address them. Our findings showed that some schools are more prepared than others to receive these youth and provide services to them and their families that make them feel more at home, and thus integrated. For instance, many of these young people still need to learn English. Many of them have also often experienced significant traumas at home and during the journey to the United States. Traumatic experiences can, in turn, affect their attention span and behavior in school. Because of this, immigrant youth need English for Speakers of Other Languages (ESOL) courses, more social workers in schools, and the ability to be connected with other social services, both for them and their families.

Our research also found that youth did not worry much over their own legal status per se, but many did worry about the deportation of their parents or other family members, some of whom they had been reconnected with for the first time in many, many years. The last thing that we should be doing as a country is targeting and tearing apart families. Because our immigration system has decided to let these youth come and stay, we owe them a life of dignity that is free from fear and terror. Separating their families is not a way to ensure even the most basic human rights. Instead, by decreasing some of the 8 billion that is spent on Immigration and Customs Enforcement (ICE) for programs that more effectively handle immigration as a nuanced and multifaceted topic. It could be redistributed it into the Office of Refugee Resettlement, school districts with high numbers of unaccompanied youth, and the expansion of educational and work opportunities for immigrant youth and their families, would allow them to more quickly prosper in the United States.

The results of this survey illuminate why we must still address the demands of the Immigrant's Rights movement. These demands include overhauling the immigration and asylum system, aiding the integration of youth and adult migrants in their communities, and investing in community development at home and abroad. Furthermore, the results reveal the effects of the massive funding of law enforcement agencies, including local police and ICE, alongside the defunding of education, social work, and mental health services. This disproportionate funding structure has left minorities and oppressed people in far worse conditions than non-minorities. Education funding, affordable housing, and a wide range of other necessities experience funding cuts that disproportionately affect black and brown and low-income communities.

Many of the people calling for the defunding of the police feel that not only do police unfairly target black and minority communities throughout the country, but that city budgets and politicians have been willing to defund education, healthcare, and social services while simultaneously expanding the budgets of the police. Immigrant and Latinx communities also suffer at the hands of police and would benefit from the defunding and subsequent re-investment of public resources into social programs and education in their communities. Furthermore, abolishing ICE, dismantling DHS into smaller units, re-imagining the Border Patrol's work, and updating the Office of Refugee Resettlement's procedures could result in more efficient use of funds that solve problems rather than create new ones.

After Black Americans, Hispanic Americans are the second-most disproportionately affected racial group by fatal police violence in the U.S., as shown in the chart below.



While Black Americans are disproportionately affected by policing and community disinvestment, the fight for racial and economic justice, and against racialized police brutality, ultimately concerns everyone. Racial justice is also concerned with how the federal government handles the southern border, visa allocation, asylum and refugee status, family separations, deportations, immigration detention centers, and even foreign policy.

Further attacks on DACA by the Trump administration and a failure to pass the DREAM Act could bear significant consequences toward immigrant integration, pushing immigrants further into the shadows and minimizing their ability to interact with public institutions such as higher

education (Castañeda, 2020). This is why the police and ICE should be defunded or abolished: they do not serve the general public, but profile U.S. Citizens and tear families apart.

During the past year, there have been widespread calls to abolish Immigration and Customs Enforcement (ICE). These calls came in response to the egregious living conditions in detention centers, countless family separations, and overall gain of traction from the growing Immigrant Rights movement. Calls to abolish ICE follow the same logic of calls to defund municipal police forces: a government agency does more harm than good, especially to a single categorical group, and the funds allocated to them would be better used on things like community development, social services, and education. Progressives in Congress are pushing for a meager reduction of the Department of Defense budget a 10% reduction would provide $74 billion that could be reinvested into cities and towns that are disproportionately affected by incarceration and poverty.

As previously referenced, ICE has an annual budget of approximately $8 billion. The Office of Refugee Resettlement (ORR), to compare, only receives $1.9 billion annually. While this is indeed a substantial amount of money, the ORR could nearly double the scope of its operation with only a quarter of ICE's funding. We propose that ICE's funding be used to fund nationwide social integration programs for unaccompanied youth residing in cities across the United States, and USAID/State Department aid for communities ravaged by poverty and lack of economic opportunity in Central America. We believe that this defunding of ICE and subsequent funding of other immigration policy programs could create an all-around better world where youth can both safely return to their country of birth if they choose to do so, and simultaneously feel at home when they are in the United States.

Integration does not just happen — it is dependent on local context, public policy, and the sociocultural environment someone hails from. The ever-increasing funds given to police forces

and ICE could be used to actually craft these local environments and enact pro-integration policy. Youth in D.C. who have experienced abuse and profiling at the hands of police in the U.S. and Central America illustrate how policing as we currently understand it is rife with issues, but also that the funding we put into policing may be less efficient in creating "safe" communities than if we put them toward resources in schools, affordable housing, and labor protections. Abolishing ICE and defunding the police would allow for better deliberate integration of youth and families, stronger feelings of "safety" for immigrant communities, and the promotion of stability in other parts of the world.

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Daniel Jenks *is an incoming student in the M.A. in Sociology Research and Practice program at American University, and a recent graduate of American's B.A. program in Sociology.*

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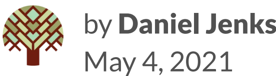
https://medium.com/@ernestoetc/defunding-the-police-is-an-immigrants-rights-issue-too-1c2d1bcb824e?sk=4d7fff5040e878c96b09de7ba3e5bbd0

LETTERS TO THE EDITOR

Consider budget priorities for policing



by **Daniel Jenks**
May 4, 2021

> *The other thing about prisons and police is how they make people — the vast majority of people — feel secure. I don't mean safe, I mean secure. Secure means that the scary, awful, monster people are kept at bay by those institutions. That is the story that gets told and reinforced by media, by our parents, by our culture, that is our story. That's our narrative.*
>
> **Mariame Kaba**, *Activist, organizer*

Many Oak Parkers **balked when they saw the nonbinding referendum** on our ballots: "Should Oak Park defund its police department?" It did not pass, of course. I doubt that the outcome would have been substantively different had the question been: "Should the village of Oak Park re-analyze its crime prevention strategy and budget priorities, aiming to decrease investment in policing and raise investment in education, social services, and other such programming?"

Why? Because Oak Parkers like to be comfortable — many of them probably think that issues in policing are only issues in Chicago, over there but not here. We acknowledge systemic issues but refuse to confront them when they are in our own community. We should do better.

The data tells us about how systemic issues related to policing indeed exist in Oak Park. For starters, Wednesday Journal published an opinion piece over the summer

exposing data that 97% of minors stopped by Oak Park police are black. Police in schools are well-documented as disproportionately creating criminal records for children of color for incidents whereas their white classmates would just receive a suspension, a call home, or a stern talking-to.

Systems we are born into feel natural and correct. They create the world around us, and we want that world to make sense. It's human instinct. We need to look at ourselves, our systems, and institutions and think about if these systems are right or if they just feel right. I will not pretend I have all of the answers, but I know there is a problem. I think redistributing some of the money into more comprehensive social services, mental health care, and education could be an excellent place to start. Traffic policing — if you have a taillight out, for example — should that be an invitation for an armed police officer to pull you over? Could an unarmed village services worker do that instead?

If we want to put our money where our mouths are, we need to collectively consider our values and priorities and then put those in line with our actions.

Daniel Jenks, *Oak Park*

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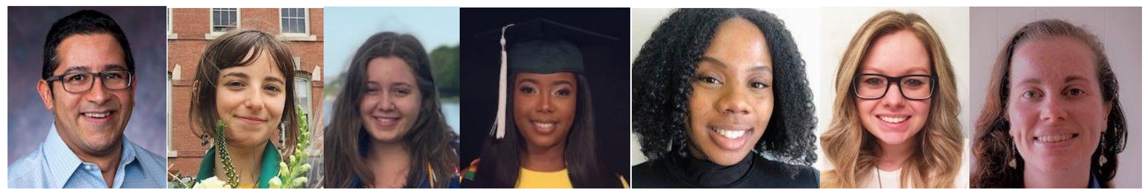
Corona Times

Understanding the world through the Covid-19 pandemic

Why are Black and Latin people in the US more affected by Covid-19?



Ernesto Castañeda, **Carina Cione**, **Abby Ferdinando**, **Jhamiel Prince**, **Deziree Jackson**, **Emma Vetter**, **Sarah McCarthy**

June 11, 2020 • 7 min read

In the United States, the coronavirus pandemic has been racialized since its emergence. Leading political figures, including the President, have referred to Covid-19 as the "Chinese virus". With the growth of positive cases, media attention has focused on emergent health disparities in rates of infection and mortality among different racial groups.

Discussing health disparities is crucial. However, this still runs the risk of further racializing and sensationalizing the impacts of the current public health crisis, rather than addressing the root causes of these inequalities. Experts continue to vigorously debate how these issues can be best measured and appraised. Accurate data on racial and ethnic disparities in the pandemic are vital, but there is also a need to contextualize information from public health authorities about which populations are the most vulnerable and why.

We must be cautious because race is often used as a justification for unequal outcomes, thus potentially feeding into the perception that there are essential differences between humans when that is clearly not the case. Uncontextualized claims about racial health disparities can be misinterpreted as evidence of genetic differences among groups and can lead to the unfair blaming of minorities. In a recent piece in *The Atlantic*, historian Ibram X. Kendi poses the question: why are Black Americans blamed for their increased exposure to the virus and for their higher death rates, when inequalities such as racism, exploitation, and lack of resources all contribute to these health disparities? We need to account for all of the factors that lead to health disparities instead of blaming vulnerable and excluded groups.

A dire picture: Black Americans and Covid-19

The first academic peer-reviewed article that addresses racial and ethnic health disparities related to the coronavirus outbreak in the United States was published in April this year. Using data from the Connecticut State Department of Public Health, scholars Cato T. Laurencin and Aneesah McClinton address the implications of higher infection and death rates for Black Americans in Connecticut.

They highlight that, of the 3,141 cases recorded in that state at the time of their research, 50% had missing racial and ethnic data. The available data as of 1 April 2020 shows that Black Americans constituted 17.2% of Covid-19 cases, and 14.4% of Covid-19 deaths, but only 12% of the Connecticut general population.

Black Americans in Washington, D.C. are also overrepresented among deaths from complications due to Covid-19. As of 10 June, the District of Columbia government reports that the Black

American community constitutes 46% of positive cases and approximately 74% of deaths in the region, while they constitute 46.4% of the district's population.

When we look at the entire US, a recent report by the Centers for Disease Control and Prevention (CDC) states that 33% of hospitalized cases were Black Americans, while this group is only 18% of the national population.

As of 10 June, the New York City Health Department reports that 222 deaths of every 100,000 people are Black Americans. In comparison, the white and Asian/Pacific Islander death rates are 111 and 102 per 100,000 people, respectively.

For hundreds of years, institutions have maintained racial hierarchies that are responsible for the vast majority of health disparities in the US. Therefore, it is possible that Black Americans are exposed to the virus more often as a result of institutionalized racism that places less value on minority lives. Perhaps they contracted the virus before other racial groups, and experienced its impacts in its early spread.

Not everyone has been exposed to the virus yet, so it is too early in the pandemic to know the final extent of racial health disparities, and the differences in the burden of diseases from Covid-19. Nevertheless, the early numbers in New York City mentioned earlier show a very troubling trend.

Early on, some believed that Black Americans were immune to the coronavirus. Some of the advocates for an early reopening of the economy seemed to believe that white and "patriotic" Americans were also immune.

Clearly, neither of these ideas are true – individuals across racial and class lines can and will be affected by the pandemic. So, why are Black Americans contracting the virus, and dying from it, more often than their white counterparts?

Native Americans and communities of color face many structural inequalities, including everyday racism, poverty, residential segregation, and limited access to quality health care, that affect their propensity to infection. The US also has a history of inadequately addressing the needs of underserved communities during times of crisis. For all of these reasons, we can expect that communities of color will have an especially difficult time recovering from this pandemic.

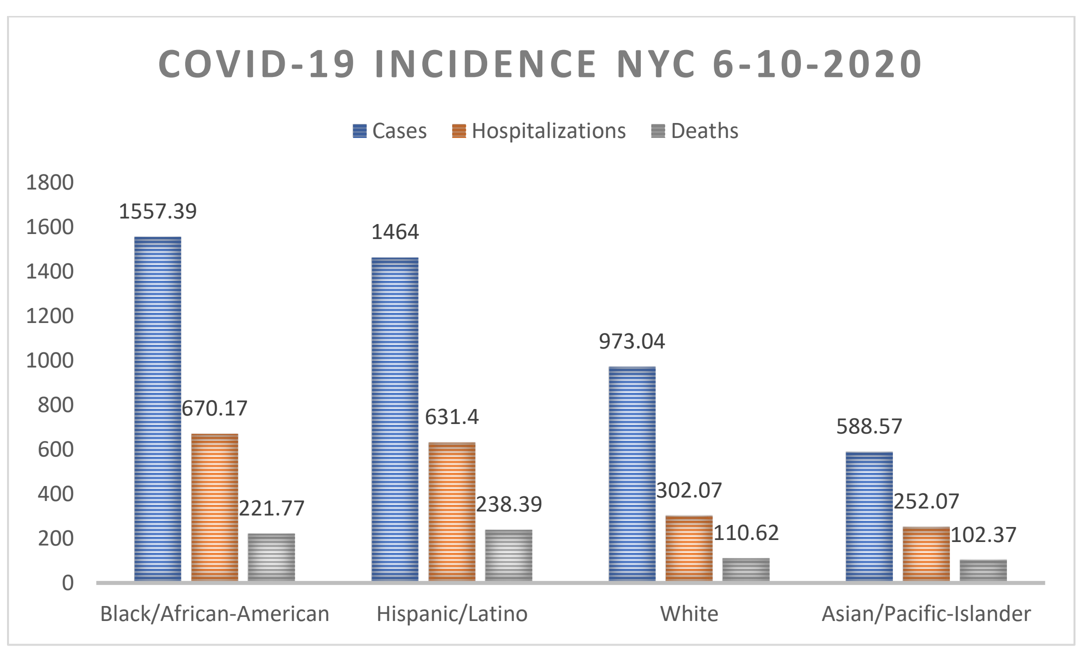
Latinos and Black Americans compared

The public conversation on racial inequalities thus far has centered primarily on Black Americans. In contrast, the impact of Covid-19 on Latin people has received less attention. An important question then is if the emerging picture for Black American communities applies to Latin communities – who also face high levels of structural racism and everyday discrimination. A recent analysis by historian José Moya suggests that "Latinos have both the highest infection rates and the lowest mortality rates". Moya's numbers are compiled from data updated to 15 May from the Covid Racial Data Tracker.

It is too early to provide a substantial analysis of why the mortality rates are lower so far – given the high proportion of undocumented immigrants in this population and the often incomplete death statistics that experience constant lags. If consolidated statistics in the future were to confirm this trend, it could have to do with what is known in the epidemiological literature as the "Hispanic

Health Paradox", which refers to the fact that, despite the discrimination and disadvantage they face, Latinos tend to have better health outcomes and behaviors than their white counterparts.

It should also be noted that there are also significant differences in terms of demographics of Latino communities across the US, such as whether they are immigrants, and if so, which country they come from. This means that the Covid-19 outcomes, as the data compiled by Moya also shows, can be highly uneven. For instance, the same dataset from New York City we mentioned before shows that Latinos have a higher death rate than Black Americans: 237 deaths per 100,000 people are among Latin communities, while the Black American rate is 222 per 100,000 people.



While an analysis of mortality rates will need more data and time, it is worth focusing on the convergent trend that sees both Black Americans and Latinos experiencing higher infection rates than the rest of the population. One prominent explanation that might account for the increased exposure to coronavirus of both groups is the higher presence of members of these communities

in essential jobs. At this stage, this is a hypothesis that will need to be further developed as more data becomes available.

The Latin and Black American communities are an integral part of the labor force. According to data from the Current Population Survey, in 2018 17% of the national labor force was comprised of Latin workers, and 13% of Black workers. The CDC reports that, in 2020, around a quarter of the Latin and Black American workers in the US is employed within the service industry, including hospitality, transportation and travel, delivery, food, healthcare, and education services. By comparison, only 16% of white workers are in the service industry.

Latin workers are significantly overrepresented in agricultural labor (53% of the total agricultural workforce), and Black workers are overrepresented among nursing, psychiatric, and home health aides (36%) and nurses (30%). Another dataset also shows the key role played by immigrants (many of whom are Latinos) in the food supply chain: they constitute 35% of crop production workers and 37% of meat processing industry workers.

This means that workers from these communities are far more likely to be in essential jobs that require continued work throughout the public health crisis, and put workers at increased risk of exposure to the coronavirus. Are working class folks, specifically women and men of color, being sacrificed, so others may continue to receive deliveries and go to grocery stores?

Essential workers have also been more exposed to the virus since the beginning of the epidemic. Those who got sick earlier faced a higher risk of dying because of the novelty of the disease, and because health systems in certain cities were overwhelmed by the number of new cases. As time

passes, scientists learn more about how to treat the disease more effectively and might get closer to developing a vaccine or a cure.

What can be done?

It is challenging to draw definite conclusions because the pandemic is still ongoing, and because of the limited data that is currently available on race and ethnicity. We will not know the true extent of disparities in mortality rates among racial, ethnic, and religious lines until a greater proportion of the overall population is exposed and tested for the virus, and all of the new data has been gathered, checked, and analyzed. If health disparities persist, we must ensure that racial minorities' behaviors or genomes are not blamed for this extra burden.

Rather, explanations should focus on structural inequalities. What is clear is that cities and towns with higher numbers of working-class Black Americans and Latin people should be prepared to conduct extensive community-based health education and outreach, as well as provide referrals to critical medical care for these populations at higher risk. We also have to be honest about who is put most at risk by the partial reopening of the economy: it is low-income workers, often Black American or Latin workers.

Universal policies can work to reduce health disparities during the current pandemic, but also in anticipation of future ones. These could include increasing the minimum wage, a universal basic income, expanding coverage under Medicare, placing the elderly with family members, releasing those with immigration and non-violent offences from prison and detention centers, and reopening the borders to nurses and healthcare workers, professionals, and agricultural workers.

Providing amnesty to DACA (Deferred Action for Childhood Arrivals) recipients and all undocumented workers doing frontline work during the pandemic, would go a long way to support the individuals that we have finally come to recognize as essential for our society to function.

By increasing labor protections, recognizing the undocumented as people, and reducing the costs of healthcare, we can help the working and middle classes increase their incomes. That would not only improve their individual health and reduce health disparities, but also increase the health of the whole population, making us all more resilient to Covid-19 and other health threats.

Ernesto Castañeda is a professor at the Department of Sociology at the American University in Washington, DC, where he is a faculty fellow with the Center for Health, Risk, and Society, and affiliated with the Center for Latin American and Latino Studies, and the Metropolitan Policy Center.

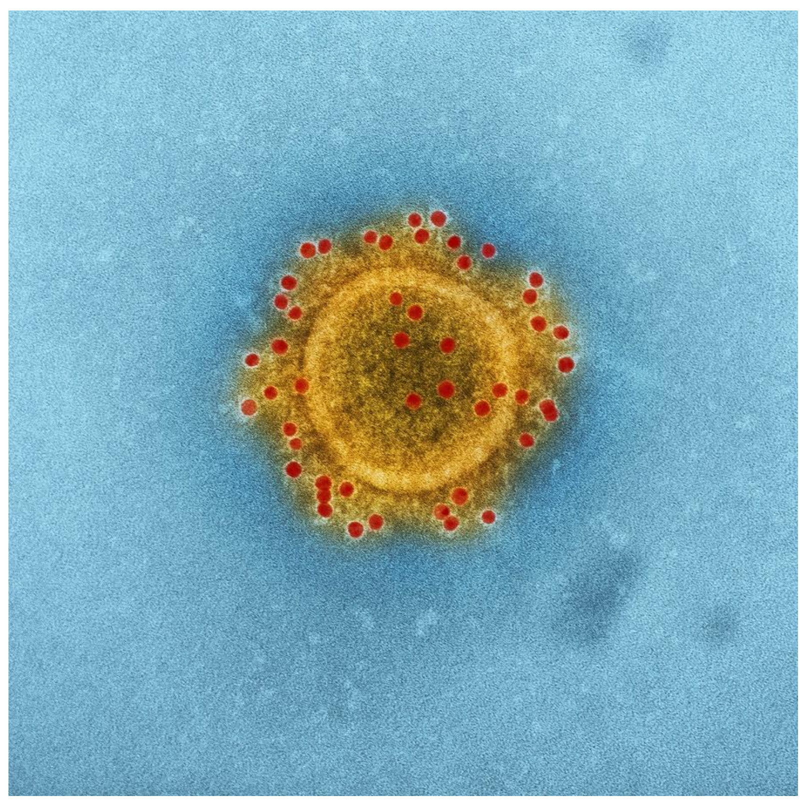
Carina Cione, Abby Ferdinando, Jhamiel Prince, Deziree Jackson, Emma Vetter, and Sarah McCarthy are students in the Sociology Research and Practice Master's Program at the American University.

The views expressed in this article are those of the authors and do not necessarily reflect Corona Times' editorial stance, or the position of any institution or association.

Original posted here

Latinos, Health Disparities, and COVID-19

Ernesto Castañeda, Abby Ferdinando, Carina Cione, Jhamiel Prince, Deziree Jackson, Emma Vetter, and Sarah McCarthy

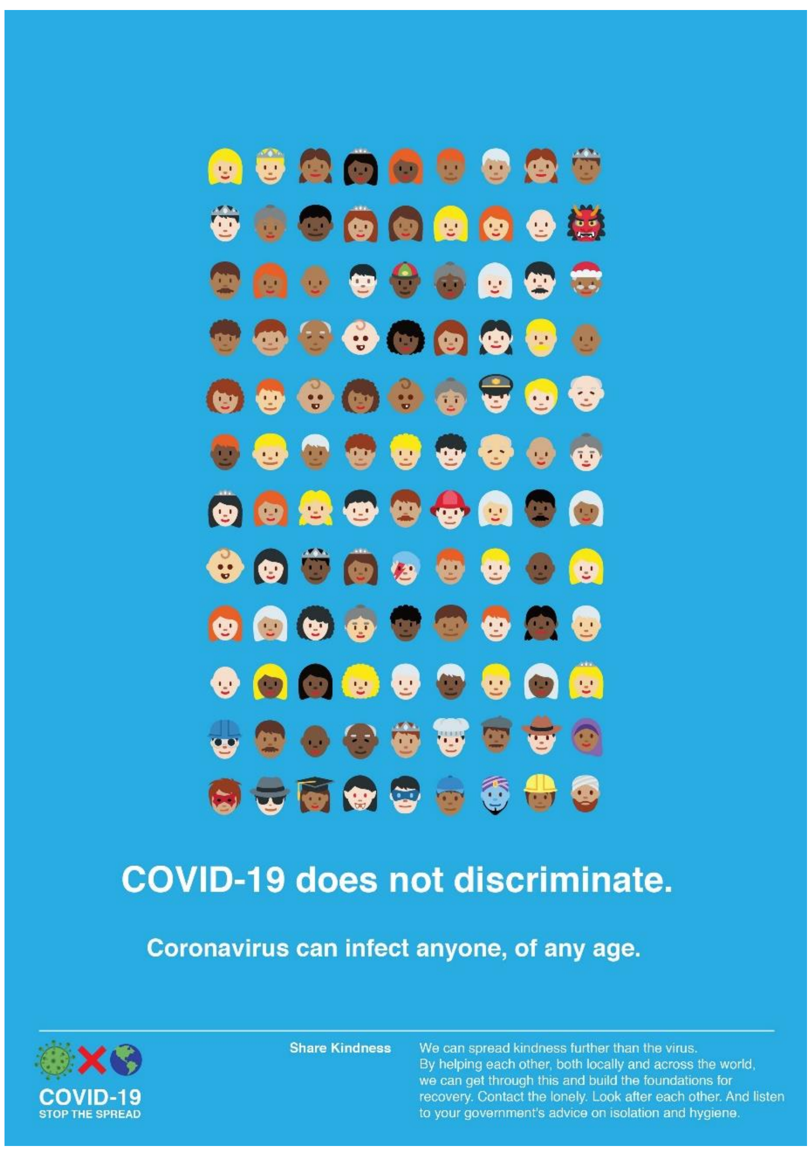


The coronavirus pandemic has been racialized since its emergence in the United States with some leading political figures and the news media referring to it as the "Chinese virus." With the growth of infections in the U.S., media attention has primarily focused on emergent health disparities in both rates of infection and mortality. The conversation on racial inequities thus far has centered primarily on African-Americans. In contrast, the impact of COVID-19 on Latin people has received less attention.

We hypothesize that the disproportionate rate of minorities working in essential positions and with preexisting medical conditions are two prominent explanations that account for the increased exposure of minorities and the racial disparities regarding COVID-19 mortality rates.

Discussion about health disparities is important. However, this still runs the risk of further racializing and sensationalizing the impacts of the current public health crisis. How to measure and discuss racial disparities in public health has been debated for some time. Accurate data on racial and ethnic disparities in COVID-19 are vital, but there is also a need to contextualize cautionary information from public health authorities about which populations are the most vulnerable.

We must be cautious because race is often used as a justification for unequal outcomes. Uncontextualized claims about racial health disparities can be misinterpreted as evidence of genetic differences among categorical groups. As Dr. Ibram X. Kendi, Director of the Antiracist Research and Policy Center at American University, explains people hearing of these differences can unfairly blame minorities. Dr. Kendi poses the question: why are black Americans to blame for their increased exposure to the virus and their higher death rates when inequalities such as racism, exploitation, and lack of resources all contribute to their health disparities? We need to account for all the factors that lead to health disparities instead of assigning blame to vulnerable and excluded groups.



UN poster. The coronaviruses do not discriminate but structural inequalities can make historically discriminated groups more susceptible.

The first peer-reviewed article that addresses health disparities related to the coronavirus outbreak in the United States was published on April 3, 2020, in the *Journal of Racial and Ethnic Health Disparities*. Using data from the Connecticut State Department of Public Health, Laurencin and McClinton address implications of higher infection and death rates for African Americans in Connecticut. They highlight that of the 3,141 cases at the time of their research (April 1, 2020),

50% had missing racial and ethnic data. Notably, 18% of the U.S. community is Black, yet 33% of hospitalized cases were among Black people (CDC 2020).

In New York, the Bureau of Communicable Disease Surveillance System reported that as of April 16, 92.3 of every 100,000 deaths occur among Blacks, and 74.3 of every 100,000 deaths are among Latinos. In comparison, the White and Asian death rates are 45.2 and 34.5 per 100,000 people, respectively. These numbers are understood to be low estimates since this data only covers an estimated 88% of lab-confirmed cases, effectively leaving out asymptomatic and non-lab confirmed cases.

Coronavirus Deaths per 100,000 People by Race/Ethnicity in New York City

Black	Hispanic	White	Asian	Total Deaths
92.3	74.3	45.2	34.5	24.63

Source: Bureau of Communicable Disease Surveillance System, 2020

For hundreds of years, institutions have maintained racial hierarchies that are responsible for the vast majority of health disparities in the United States. Therefore, it is possible that Black and Latin communities are exposed to the virus more often as a result of institutionalized racism that places less value on minority lives. Perhaps they contracted the virus before other racial groups and experienced its impacts in its incipient stage. Everyone has not yet been exposed to the virus, so it is too early in the pandemic to know what the final extent of racial health disparities and the differences in the burden of diseases from COVID-19 will be. However, the early numbers in New York City, as shown above, show a very troubling trend.

Early on, some believed that African Americans were immune to the coronavirus, as shown in articles published in the New York Times, and the Los Angeles Sentinel. Some of the reopen proponents seem to believe that white and “patriotic” Americans are also immune to COVID-19. Clearly, neither of these ideas ring true – individuals across racial and class lines can and will be

affected by the pandemic. So why are African Americans and Hispanics contracting the virus more often and dying from the virus more often than their white counterparts? Communities of color face many structural inequalities, racism, poverty, residential segregation, and access to quality health care that affect the propensity to infection. This, alongside the United States' history of inadequately addressing the needs of underserved communities during times of crisis, we can expect that communities of color will have an especially difficult time recovering from this pandemic.

As of May 1, Illinois reported that Latinos made up the racial group with the highest number of confirmed cases within the state. In Arlington, Virginia, while only 15% of the population is of Latin origin, 51% of COVID-19 cases are among Latin individuals. The disproportionate impact of COVID-19 on Latin communities across the U.S. represents a significant issue that has so far been excluded from the larger conversation. Notably, the Latin community is an integral part of the labor force. In 2018, 17% of the national labor force was comprised of documented Latin workers. This number does not account for another estimated 5.1% of the labor force that is made up of Latin American undocumented workers. Furthermore, the CDC reports that in 2020, at least 25% of the Latin population in the U.S. is employed within the service industry, including hospitality, transportation/travel, delivery, food, healthcare, and education services. Many of these sectors require continued work throughout the public health crisis and put workers at increased risk of exposure to the coronavirus.

After carefully analyzing health disparities among Hispanics in El Paso, Texas, our data suggest that Latin people in El Paso, about 83% of the population, have comorbidities that may make them more vulnerable to complications from COVID-19 (as described in a recent report).

Additionally, there are high poverty levels and low levels of healthcare coverage for Latin people in El Paso.

Disease Prevalence among Hispanics in El Paso, TX in 2010-11

Cancer	High Blood Pressure	High Chole sterol	Asthma	Diabetes	Severe Obesity	Heart Attack / Stroke	Kidney Disease	Hepatitis or Cirrhosis	Emphys ema	Tuber culosis	HIV
16.8%	16.1%	13%	7.4%	7.3%	3.4%	2.6%	2.3%	2.2%	1.3%	0.2%	<0.1%

Source: Original data

Structural factors, underlying medical conditions, and increased exposure to COVID-19 disproportionately put Black and Latin people in more vulnerable positions during times of "normalcy" and more so during the pandemic. We should consider structural and historical inequalities when assessing public health measures that aim at both prevention and recovery. We should be cautious in our reporting of racial and ethnic inequities to ensure that data is contextualized with an understanding of structural factors that cause disproportionate rates among minority groups. African Americans and Latinos may show higher rates of infection as compared to other groups because they are more likely to work in essential jobs. These essential jobs may have not been considered "essential" before the pandemic, yet they are now clearly seen as essential, and they expose the workers to COVID-19. Are working-class folks, specifically women and men of color, being forced to sacrifice so that all continue to receive packages and go to the grocery stores? Those who got sick first had a higher risk of dying because of the novelty of the disease and because medical systems in certain cities were overwhelmed by the number of new cases. As time passes, scientists learn more about how to treat the disease and get closer to developing a vaccine.

PSA campaign in New York City's metro subway system.

It is challenging to draw definite conclusions because the pandemic is still ongoing, and because data that is currently available on race and ethnicity may be limited. We will not know the disparities in mortality rates among racial, ethnic, and religious lines until a greater proportion of the overall population is exposed and tested for the virus, and all of the new data has been gathered, checked, and analyzed. If health disparities persist, we must ensure that racial minorities' behaviors or genomes are not blamed for this extra burden, but rather structural inequities. What is clear is that cities and towns with higher numbers of working-class African Americans and Latin people should be prepared to conduct extensive community-based health education and outreach as well as provide referrals to critical medical care for these populations at higher risk. We also

have to be honest about who is put at risk by the partial reopening of the economy – low-income workers often Black or Latin workers.

Universal policies can work to reduce health disparities during the next pandemic. These could include increasing the minimum wage, a universal basic income, expanding Medicare and health coverage, releasing those with immigration and non-violent offenses from prison and detention centers, reopening the borders to nurses and healthcare workers, professionals, and agricultural workers. Providing amnesty to undocumented workers doing essential work during the pandemic would go a long way to support the individuals that we have finally come to recognize as essential for society to work. By increasing labor protections, recognizing the undocumented as people, and reducing the costs of healthcare, we can help the working, and middle class increase their income. That would not only improve their health and reduce health disparities but also increase community health, making us all more resilient. For these reasons, we must build more equitable and sustainable economic and health systems while acknowledging our interconnectedness.

Ernesto Castañeda in Professor at the Department of Sociology at American University in Washington, DC, where he is a faculty fellow with the Center for Health, Risk, and Society, and affiliated with the Center for Latin American and Latino Studies, and the Metropolitan Policy Center. Carina Cione, Abby Ferdinando, Jhamiel Prince, Deziree Jackson, Emma Vetter, and Sarah McCarthy are students in the Sociology Research and Practice Master's Program at American University. Thanks to Daniel Jenks and Deanna Kerrigan for their feedback.

The data was gathered as part of the project "Social Determinants of Physical and Mental Health of Migrant and Transient Populations: Health Disparities amongst Hispanics in El Paso" which was supported by Award Number P20MD00287 from the National Institute on Minority Health and Health Disparities to UTEP's Hispanic Health Disparities Research Center. The content is solely the responsibility of the authors and does not necessarily represent official views of the National Institute on Minority Health and Health Disparities or the National Institutes of Health.

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Voices from the Border

Latinos in El Paso at Risk from COVID-19

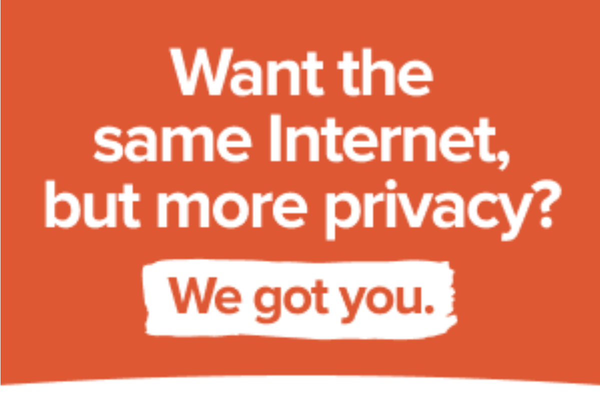
According to data (https://www.dshs.state.tx.us/coronavirus/additionaldata/) from the Department of State Health Services, as of May 28, the state of Texas has 59,776 confirmed positive cases and 1,601 deaths due to COVID-19. Texas has the eighth highest number of cases in the country. El Paso has 2,569 positive confirmed cases and 72 deaths; El Paso ranks number five in the state for the highest number of confirmed cases.

In El Paso, although 83% of the population is of Latin origin, **89% (http://www.epstrong.org/results.php)** of COVID-19 cases are among Latin individuals, compared to the white population that is comprised of 9%, but only **7% (http://www.epstrong.org/results.php)** of COVID-19 cases. Similarly, African Americans make up 4% of El Paso and **2% (http://www.epstrong.org/results.php)** of confirmed cases. The disproportionate impact of COVID-19 on Latin communities in El Paso, is similar to that in other parts of Texas, and especially border cities. In Dallas, although

41.7% (https://www.census.gov/quickfacts/fact/table/dallascitytexas,US/PST045219) of the population is of Latin origin, **34% (https://www.dallascounty.org/Assets/uploads/docs/covid-19/hhs-summary/PCCI-C19-EthnicityDistribution-20200526.pdf)** or 3,141 of COVID-19 cases are among Latin individuals. However, notably, in Dallas, **46% (https://www.dallascounty.org/Assets/uploads/docs/covid-19/hhs-summary/PCCI-C19-EthnicityDistribution-20200526.pdf)** of confirmed positive cases do not have race or ethnicity reported. We question how many of those unreported cases are Latin individuals.

Similarly, across the country in Arlington, Virginia, **51% (https://www.arlnow.com/2020/05/19/data-shows-demographic-disparities-in-arlingtons-coronavirus-cases/)** of COVID-19 cases are among Latin individuals, while only 15% of the population is of Latin origin. This disproportionate impact of COVID-19 on Latin communities has been excluded from the larger conversation. Latinos have received little attention during this pandemic despite their vulnerability to COVID-19. Furthermore, it is important to acknowledge and discuss these disparities in El Paso and other majority Latino populations to suppress the spread of the virus.

We hypothesize that the disproportionate rate of minorities working in essential positions and with preexisting medical conditions are **two explanations (https://medium.com/@ernestoetc/latinos-health-disparities-and-covid-19-bdd07a01872b)** that account for the increased exposure of minorities and racial disparities regarding COVID-19. Notably, the Latin community is an integral part of the labor force. In 2018, 17% of the national labor force was comprised of documented Latin workers. This number does not account for another estimated 5.1% of the labor force that is made up of undocumented Latin American workers. Furthermore, the CDC reports that in 2020, at least 25% of the Latin population in the U.S. is employed within the service industry, including hospitality, transportation/travel, delivery, food, healthcare, and education services. Many of these sectors require continued work throughout the public health crisis and put workers at increased risk of exposure to the coronavirus.



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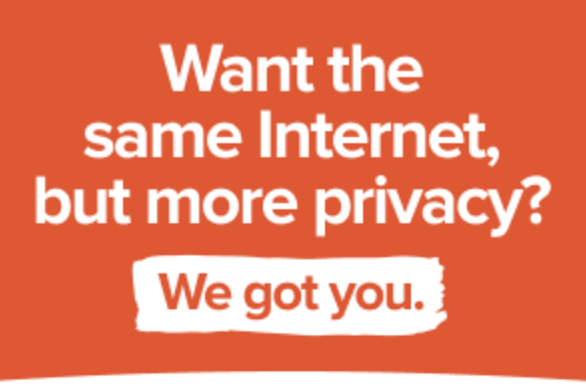

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There are **reports (https://kfoxtv.com/news/local/el-paso-not-testing-essential-workers-says-it-could-give-false-sense-of-security)** of essential workers in El Paso only being tested when specific criteria is met. Marisa Saenz **reports (https://kfoxtv.com/news/local/el-paso-not-testing-essential-workers-says-it-could-give-false-sense-of-security)** that Dr. Ocaranza with El Paso Health Authority believes that each city is different and the health authorities are tailoring the tests specifically to what they see in El Paso. According to the U.S. Bureau of Labor Statistics, in May 2019, El Paso Metropolitan Statistical Area comprised of the following **essential occupations (https://www.bls.gov/regions/southwest/news-release/occupationalemploymentandwages_elpaso.htm)**:

Healthcare	Food Preparation	Education	Constru
12.4%	10.5%	7.5%	3.7%

Source: U.S. Bureau of Labor Statistics, May 2019

The CDC reported many pre-existing conditions that increase the risk of severe illnesses and hospitalization related to COVID-19: high blood pressure, high cholesterol, asthma, serious heart conditions, cancer, diabetes, as well as people 65 years and older. In El Paso, hypertension and diabetes are the leading pre-existing conditions reported among deaths due to COVID-19. At the time of death, **50.8% (http://www.epstrong.org/results.php)** of patients had diabetes and 64.9% of patients had hypertension; **15% (http://www.epstrong.org/results.php)** of confirmed cases of COVID-19 were 65 and older, although those 65 and older only make up 12% of El Paso's population. According to the data from the Department of State of Health Services, high blood pressure, high cholesterol, and diabetes are common morbidities that may place El Pasoans at a higher risk of experiencing serious complications from COVID-19.

Disease Prevalence among El Pasoans in 2018

High Blood Pressure	High Cholesterol	Diabetes	Cancer	As
31.5%	26.9%	15.4%	5.2%	4.3

Source: **Texas Department of State Health Services (Behavioral Risk Factor Surveillance System) 2018 (http://healthdata.dshs.texas.gov/dashboard/surveys-and-profiles/behavioral-risk-factor-surveillance-system)**

The Texas Department of State Health Services provided limited data on health conditions relating to COVID-19 and especially limited data on Hispanic health conditions, specifically in El Paso. However, a **recent (https://papers.ssrn.com /sol3/papers.cfm?abstract_id=3608396)** **report (https://www.academia.edu/43139124/REPORT_COVID-19_Susceptibility_among_Latin_People_in_El_Paso_TX)** analyzed health disparities among Hispanics in El Paso that suggested that Latin people in El Paso have comorbidities that may make them more vulnerable to complications from COVID-19. We find that a significant percentage of the Hispanic population in El Paso in 2011 had at least one underlying condition that deemed them at higher risk of suffering from serve illness or death by COVID-19. Currently, among positive confirmed cases in El Paso, **32% (http://www.epstrong.org/results.php)** of patients had one or more comorbidities; **49.15% (http://www.epstrong.org**

/results.php) had at least one; **29.1% (http://www.epstrong.org/results.php)** had two; and **21.75% (http://www.epstrong.org/results.php)** had three or more. Additionally, there are high poverty levels and low levels of healthcare coverage for Latin people in El Paso. During the pandemic, **24% of El Pasoans (http://www.epstrong.org/results.php)** do not have health insurance and 33% of positive confirmed cases of COVID-19 did not have health insurance. This is concerning due to a high prevalence of comorbidities among El Pasoans.

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The first step to ensure El Paso recovers from this difficult time is expanding Medicaid. Due to COVID-19 related layoffs, 382,000 are expected to be uninsured and not qualified for Medicare in the state. If Texas makes the right decision of expanding Medicaid, not only will **1.1 million low income (https://www.texastribune.org/2019/02/12/texas-legislators-filed-bills-put-medicaid-expansion-decision-ballot/)** Texans, including El Pasoans, be eligible for health coverage, but the state could receive an estimated **100 billion (https://www.themonitor.com/2020/04/16/commentary-protect-texans-well/)** in federal funding. Thus, it is important to acknowledge communities of color, such as El Paso, may face structural inequalities, racism, residential segregation, poverty, and access to quality health care that increases their risk of infection. This, alongside the United States' history of inadequately addressing the needs of underserved communities, we can expect that communities of color may have a difficult time recovering from this pandemic. We will not know the disparities in morality and incidences until all data is reviewed and analyzed. However, it is clear that with high numbers of essential workers, people without health insurance and people with underlying conditions, alongside Gov. Greg Abbott continuing to reopen the state, El Paso should be prepared to provide financial support and conduct extensive community-based health education and outreach to minimize the spread of COVID-19 and prevent more deaths.

Deziree Jackson, Abby Ferdinando, Carina Cione, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, and Emma Vetter are

affiliated with the Department of Sociology at American University in Washington, DC. This is part of a series of press releases connected to our report on COVID-19 in El Paso regarding an ongoing data analyses of detailed health data gathered in 2011.

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MAY 30, 2020 **BORDERTWINCITIES** **THE LATINO LIFE**

Voices from the Border

Health Disparities and the Coronavirus and Why This Matters for El Pasoans

by Carina Cione, Deziree Jackson, Abby Ferdinando, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, and Emma Vetter

Image from **Salud America (https://salud-america.org/coronavirus-latino-health-equity/)IHPR (http://ihpr.uthscsa.edu)** at UTSA.

The coronavirus pandemic has been racialized since its emergence in the United States with some leading political figures, including the President, referring to it as the **"Chinese virus." (https://www.politico.com/news/2020/05/03/trump-supporters-china-226309)** The conversation thus far has primarily focused on African Americans, and Hispanics in the U.S. have received relatively little attention despite their vulnerability to COVID-19. Based on our risk assessment of the possible impact of COVID-19 in El Paso and analysis of literature on health disparities, we found that the Hispanic community is significantly at risk of

severe illness or death. The disproportionate number of Latinos working in "essential" positions and being diagnosed with pre-existing health conditions account for racial health disparities regarding COVID-19. With rising rates of infection and the recent resignation of the city's Public Health Director, El Paso must take proactive precautions to suppress the spread of the virus and counteract disparities that threaten the lives of Latinos.**[i]**

In New York City, the death toll and infection rates in the Latin community are among the highest in the world.**[ii]** On May 27, **NYC Health (https://www1.nyc.gov/site/doh/covid/covid-19-data-deaths.page)** reported that at least 5,026 Latinos in New York alone have died of COVID-19 since the outbreak began on March 11, exceeding the number of White deaths by over 800 lives. Even so, these numbers are understood to be low estimates since the data include only lab-confirmed COVID-19 cases, effectively leaving out asymptomatic and other cases not confirmed in a laboratory.

Coronavirus Deaths by Race/Ethnicity in New York City

Hispanic	Black	White	Asian/Pacific Islander	C Un
5,026	4,623	4,188	1,295	[illegible]

Source: **NYC Health (https://www1.nyc.gov/site/doh/covid/covid-19-data-deaths.page)**

The reasons behind why the Latin population in the U.S. is disproportionately suffering from COVID-19 remain unclear, but the horrific numbers in New York City reveal a troubling trend that is mirrored in states and cities across the United States.

Texas is one of the **21 U.S. states (http://ilas.columbia.edu/covid-19-and-latino-immigrants/)** that report infection rates that exceed their total Hispanic population. The Latin community has suffered **46% (http://ilas.columbia.edu/covid-19-and-latino-immigrants/)** of the state's total confirmed COVID-19 cases, although they constitute 40% of the state population. Texas is one of the **top ten (https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html)** most infected states with 59,039 positive cases, and an estimated 1,595 people have died as a result of complications related to COVID-19. El Paso, which is predominantly Latino, is one of the counties that have been most affected and reports **4.3%**

(https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html) of the state's documented deaths. The region is experiencing mounting pressure as time passes, and more people are admitted to hospitals because of COVID-19. Sixty-five people were hospitalized in the first week of May, 17 of which were dependent on ventilators for survival.**[iii]** Local public health officials worry that El Paso will suffer from limited resources, as the county only has 285 licensed beds in their Intensive Care Unit.**[iv]** On top of these concerns, Robert Resendes, the City Director of Public Health, resigned on May 4. His replacement still has not been selected, but the city insists that his resignation will not negatively impact preventative action since the Office of Emergency Management is handling the public health crisis. Ciudad Juarez, which sits parallel to El Paso across the southern border, is also grappling with an upward trajectory of COVID-19 cases and reported a new total of **1,087 confirmed infections (https://kfoxtv.com/news/local/more-than-70-new-cases-of-covid-19-9-deaths-reported-in-ciudad-juarez)** on May 28.

According to the Centers for Disease Control and Prevention (2020), adults over the age of 64, racial and ethnic minorities, the homeless, incarcerated individuals, and people with underlying medical conditions are at heightened risk of severe illness or death caused by COVID-19.**[v]** Our data that was gathered with the support of the NIH revealed that an overwhelming amount of Hispanics living in El Paso in 2011 met one or multiple criteria of being at higher risk of COVID-19 in addition to other risk factors, such as being an "essential" worker, undocumented or low-income.**[vi]** A significant number of Latinos in El Paso that year had at least one underlying health condition that would now categorize them as especially vulnerable to severe illness or death by COVID-19. Some of those health conditions include obesity, diabetes, asthma, kidney disease, cancer, emphysema, HIV/AIDS, heart attack, and stroke, nearly all of which have been documented as prevalent causes of hospitalization for people with COVID-19.**[vii]** However, many Hispanics with underlying health conditions were found to be vulnerable in more ways than one. For example, more than half (51.7%) of Hispanics with asthma did not have medical insurance, as well as nearly half (42.2%) of those with chronic kidney disease. The Affordable Care Act in 2013 created medical benefits for naturalized citizens, but legal visa holders, DACA recipients, and undocumented immigrants received limited to no help from it.**[viii]** Citizenship status affected a

person's overall likelihood to have medical coverage in 2011, and 89.3% of undocumented Hispanics in El Paso lacked coverage. Since the Affordable Care Act barely recognizes them, it is likely that this percentage of uninsured undocumented people has not drastically changed in the region.

Health disparities are not the only cause for increased exposure to COVID-19 for the Latin community in the U.S. We also analyzed "essential" employment and incarceration as causes of a disproportionately high Hispanic death toll across the country. The CDC (2020) reports that one-quarter of the U.S. Hispanic population works in the healthcare, service, hospitality, transportation, delivery, maintenance, education, and food industries, all of which are considered "essential" or "emergency" under shelter-in-place orders issued across the U.S.**[ix]** Frontline workers are required by law to report to work under COVID-19 regulations, including those who are considered high-risk, and do not qualify for unemployment insurance unless they are laid off.**[x]**,**[xi]** Given that more Hispanic workers are in this position than Whites or Asians, they are more likely to come into contact with COVID-19. Incarcerated communities, who are predominantly racial and ethnic minorities, are also contracting the virus at alarmingly high rates. The close quarters, shared spaces, lack of comprehensive medical care and culture of punishment in correctional institutions foster an environment where the virus is easily contracted and spread. On May 20, 2020, 29,251 cases of COVID-19 were documented in federal and state U.S. prisons.**[xii]** The Marshall Project defines these numbers as "almost certainly an undercount" because there is no testing protocol for individual states.**[xiii]** Given the mass incarceration of communities of color, this puts racial and ethnic minorities at further risk of severe illness or death from COVID-19. Texas has the fifth-highest amount of cases, but the Latin community will be impacted more harshly because the ratio of Hispanic prisoners compared to Whites is 2:1.**[xiv]**

We conclude that Hispanics in the U.S. are particularly vulnerable to COVID-19 as a result of multiple structural inequalities that increase their exposure to the virus and obstruct their access to resources. Also, our data revealed that the Latin community in El Paso suffers from extremely high rates of disease that puts people in danger of severe illness or death from COVID-19. We will not know the disparities in mortality rates among racial and ethnic

groups until a higher proportion of the overall population is tested for COVID-19, and all data is reviewed. Right now, it remains unclear whether more Hispanics living in the U.S. will die from COVID-19 since the pandemic is projected to make a return in early autumn. Even so, it is clear now that cities and towns with higher numbers of working-class Latin people, including El Paso, should be prepared to properly allocate health resources, provide financial support for high-risk individuals, and conduct extensive community-based health education and outreach in the effort to minimize the spread of COVID-19 and prevent more deaths.

Carina Cione, Deziree Jackson, Abby Ferdinando, Jhamiel Prince, Sarah McCarthy, Ernesto Castañeda, and Emma Vetter are affiliated with the Department of Sociology at American University in Washington, DC.

[i] Willard, Keenan. May 4, 2020. "Public Health Director in El Paso Resigns as City Response to COVID-19 Continues." *KFOX14,* **https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues (https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues)**.

[ii] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. **https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf (https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf)**.

[iii] "El Paso COVID-19 Cases Surpass 1,000 Mark." May 4, 2020. KTSM.com, **https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html (https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html)**.

[iv] "El Paso COVID-19 Cases Surpass 1,000 Mark." May 4, 2020. KTSM.com, **https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html (https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html)**.

[v] Centers for Disease Control and Prevention 2020. "People Who Are at Higher Risk for Severe Illness."

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html).

[vi] Report COVID-19 Susceptibility among Latin People in El Paso, TX **https://www.academia.edu/43139124/REPORT_COVID-19_Susceptibility_among_Latin_People_in_El_Paso_TX (https://www.academia.edu/43139124/REPORT_COVID-19_Susceptibility_among_Latin_People_in_El_Paso_TX)**

[vii] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." **https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w (https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w)**.

[viii] National Immigration Law Center 2014. "Immigrants and the Affordable Care Act (ACA)." **https://www.nilc.org/issues/health-care/immigrantshcr/ (https://www.nilc.org/issues/health-care/immigrantshcr/)**.

[ix] Centers for Disease Control and Prevention 2020. "COVID-19 in Racial and Ethnic Minority Groups." **https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html)**.

[x] District of Columbia Department of Human Resources 2013. "E-DPM Instruction No. 12-51." *Government of the District of Columbia*, **https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf (https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf)**.

[xi] Stewart, Emily. 2020. "The Essential Worker Trap." *Vox*,

https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state- (https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state-).

[xii] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. **https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf (https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf)**.

[xiii] Park, Katie, Tom Meagher, and Weihua Li. 2020. "Tracking the Spread of Coronavirus in Prisons." *The Marshall Project*, **https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons (https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons)**.

[xiv] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. **https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf (https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf)**.

MAY 29, 2020MAY 29, 2020 **BORDERTWINCITIES** **THE LATINO LIFE**

Understanding How El Paso, Texas Voted in the 2020 Presidential Election

Ernesto Castañeda on Medium

Nov 25·7 min read

By *Emma Vetter, Sarah McCarthy, Ernesto Castañeda, and Carina Cione*

President Obama speaking about immigration policy on May 10, 2011. Photo by Castañeda.

Texas is a well-known Republican stronghold and has been for decades. The state of Texas has voted Republican in every presidential election since 1976 (Wilson 2020). Republicans have controlled the Statehouse for the past 18 years, and it has not elected a Democrat for 26 years (Rayasam 2020; Wilson 2020). However, with a growing minority population who tend to vote Democrat rather than Republican and Texas Democrats fundraising at historic highs, pollsters predicted that Texas could be a closer race in the 2020 presidential election than in years past (Gramlich 2020; Rayasam 2020; Wilson 2020). With 38 electoral votes, second-most after California, pollsters believed a blue victory in Texas would sway the election firmly in Joe Biden's favor (Wilson 2020).

In hindsight, this was not the case as Donald Trump won the state with 52.2% of the vote (The Associated Press 2020). To many Democrats' surprise, while Joe Biden won by 17 percentage points in counties near the Texas-Mexico border, this was only half of Hillary Clinton's 33-point lead in the same counties (Samuels et al. 2020). This indicates that more people voted for Donald Trump in 2020 than in 2016 in these traditionally Democrat counties. One of these counties, El Paso, boasted that more El Pasoans voted in the 2020 presidential election than in any other election in the past 20 years (Villagran 2020). According to the El Paso Times, "more than 256,000, or 53% of registered voters cast a ballot in the 2020 election," and a majority of these votes, 222,149, were cast via early voting (Villagran 2020). More specifically, in El Paso County, 66.4% of voters cast a ballot for Joe Biden while 32.0% voted for Donald Trump (El Paso Times 2020). For comparison, in 2016, 72.7% of El Pasoans voted for Hillary Clinton, and 27.3% voted for Donald Trump (The New York Times 2016).

According to data we collected surveying 1,152 Latinos in 2011 and 2012, 50.9% of Hispanic citizens living in El Paso voted in the 2008 presidential election. While this is slightly less than the 53% of those who voted in the 2020 election, sociologists note that people who participate in surveys, such as ours, are also more likely to vote and engage in civic activities (Keeter et al. 2017). Thus, surveys consistently overestimate political activity. Keeter et al. (2017) additionally suggest that no one political party is more likely to respond to surveys. This indicates that while our respondents may be more likely to vote than the general population, their political affiliations are still largely representative of El Paso County.

While our survey did not specify political affiliation, several demographic questions that may help to determine political leanings, such as educational attainment, immigration generation, and religion, were included. According to Pew Research, 41% of voters who identify as Democrats or with Democratic leanings are more likely to have a college degree versus 30% of Republican voters (Gramlich 2020). In our data, 33.6% of participants had a college degree or higher. After examining the relationship between voting and educational attainment, 53.4% of participants with a college degree or more said they voted in the last presidential election ($p<0.001$). This percentage decreases with the level of educational attainment: only 34.8% of those with a high school education voted in the last election, in addition to 31.8% of those with less than a high school education ($p<0.001$). Therefore, our data supports the notion that people with higher educational attainment are more likely to vote (Abraham, Helms, and Presser 2009). These voters are also more likely to vote Democrat than Republican, supporting the idea that a majority of El Pasoans voted for Joe Biden.

Border Patrol and El Paso Police officers on bikes. El Paso employs thousands of Latino federal workers for local, state, and federal law enforcement agencies. Many vote Republican. Photo by Castañeda 2011.

Immigrant generation, or the number of generations one is removed from the family member who immigrated to the U.S., is another demographic variable that may influence political leanings. Immigrant generation, particularly for Latinos and Asian Americans, plays a role in the likeness of supporting the Democratic Party, with first, second, and third generations more likely to vote for the Democratic presidential candidate than native-born voters whose family was born in the U.S. (Hawley 2019). Though this effect does lessen with each subsequent generation, Latinos are still more likely to support Democratic candidates across generations (Hawley 2019).

When looking at immigrant generation and voting patterns, Latinos of higher immigrant generations were more likely to vote. For example, 51.8% of third-generation and higher immigrants reported voting in the last election, but voting rates steadily decreased down to only 32.5% of first-generation Latino immigrants ($p<0.001$). It is possible that the longer one lives in the U.S., the more likely they are to become citizens and participate in civic activities.

Furthermore, Hispanic Catholics are more likely to identify with the Democratic party rather than the Republican party (Gramlich 2020). According to our survey, 72.3% of Hispanics in El Paso were Catholic, 4.9% were Protestant, and 10.1% did not practice a religion. Pew Research Center also identified that Hispanic voters are more likely to vote for Democratic than Republican candidates (Gramlich 2020). Given that our database is entirely Hispanic, this would indicate that our participants were more likely to vote Democrat than Republican. Looking at the relationships between religion and voting patterns in our dataset, only 44.1% of Hispanic Catholics voted in the last presidential election ($p<0.001$), meaning that Democrats in the region were likely underrepresented in the voting booths.

Given the combination of a Hispanic population that is well-educated, predominantly Catholic, and with immigrant roots, it makes sociological sense that 66.4% of El Paso County residents voted Democrat rather than Republican in the 2020 election. Knowing that mail-in ballots largely favored Joe Biden (Pew Research 2020) and that approximately 86.7% of El Pasoans voted via mail-in ballots further strengthens this conclusion. Additionally, because of the deep conservative roots in the state of Texas, this may help explain why the percentage of votes for Joe Biden was not as high as in previous years. While people are more likely to vote a certain way because of demographic markers, this does not entirely determine political leanings, especially in

a historically red state. While Texas may have more Democratic leanings than at first glance, in 2020, it voted red enough for a Republican victory.

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References

Abraham, Katharine G., Sara Helms, and Stanley Presser. 2009. "How Social Processes Distort Measurement: The Impact of Survey Nonresponse on Estimates of Volunteer Work in the United States." *American Journal of Sociology* 114(4):1129–65.

AP. 2020. "Understanding the Election: AP." *The Associated Press*. Retrieved November 12, 2020 (https://www.ap.org/media-center/understanding-the-election).

Bedoya, Aaron A. 2020. "El Paso Election: 5 Key Takeaways from the Results." *El Paso Times*. Retrieved November 12, 2020 (https://www.elpasotimes.com/story/news/politics/elections/2020/11/04/el-paso-election-updates-takeaways-mayor-runoff-voter-turnout/6165294002/).

Cai, Mandi, Anna Novak, Alex Samuels, and Patrick Svitek. 2020. "Joe Biden's Struggles along the Texas Border Raise Questions about Democrats' Outreach There." *The Texas Tribune*. Retrieved November 12, 2020 (https://www.texastribune.org/2020/11/04/joe-biden-texas-border-democrats/).

El Paso Times. 2020. "2020 Texas Election Results." *El Paso Times*. Retrieved November 12, 2020 (https://www.elpasotimes.com/elections/results/2020-11-03/state/texas/).

Gramlich, John. 2020. "What the 2020 Electorate Looks like by Party, Race and Ethnicity, Age, Education and Religion." *Pew Research Center*. Retrieved November 12, 2020 (https://www.pewresearch.org/fact-tank/2020/10/26/what-the-2020-electorate-looks-like-by-party-race-and-ethnicity-age-education-and-religion/).

Gutierrez, Angela, Angela X. Ocampo, Matt A. Barreto, and Gary Segura. 2019. "Somos Mas: How Racial Threat and Anger Mobilized Latino Voters in the Trump Era." *Political Research Quarterly* 72(4): 960–975.

Hawle, George. 2019. "Immigrant Family Ties, and Support for the Democratic Party." *Social Science Quarterly* 100(4):1171–1181. doi: 10.1111/ssqu.1221

Keeter, Scott, Nick Hatley, Courtney Kennedy, and Arnold Lau. 2019. "What Low Response Rates Mean for Telephone Surveys." Pew Research Center Methods. Retrieved January 28, 2020 (https://www.pewresearch.org/methods/2017/05/15/what-low-response-rates-mean-for-telephone-surveys/).

New York Times. 2017. "Texas Election Results 2016." *The New York Times*. Retrieved November 22, 2020 (https://www.nytimes.com/elections/2016/results/texas).

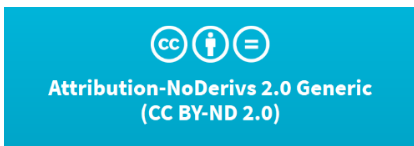
Pew. 2020. "Mail-in Voting, Absentee Ballots and Voter Engagement." *Pew Research Center — U.S. Politics & Policy*. Retrieved November 12, 2020 (https://www.pewresearch.org/politics/2020/10/09/voter-engagement-and-interest-voting-by-mail-and-in-person/).

Potochnick, Stephanie and Mary Stegmaier. 2020. "Latino Political Participation by Citizenship Status and Immigrant Generation." *Social Science Quarterly* 101(2):527–544. https://doi.org/10.1111/ssqu.12747

Rayasam, Renuka. 2020. "Where Texas Could Actually Turn Blue in 2020." *POLITICO*. Retrieved November 12, 2020 (https://www.politico.com/news/magazine/2020/10/20/texas-house-race-blue-democrat-2020-429826).

Villagran, Lauren. 2020. "Election Day: El Paso Voters Withstand Pandemic Threat as Thousands Forge Record Turnout." *El Paso Times*. Retrieved November 12, 2020 (https://www.elpasotimes.com/story/news/politics/elections/2020/11/03/election-day-2020-el-paso-covid-economy-tops-voters-minds/6125266002/).

Wilson, Chris. 2020. "Yes, Texas Could Go Blue This Year." *Time*. Retrieved November 12, 2020 (https://time.com/5904873/texas-blue-biden-trump/).



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Latinos in the U.S. have received relatively little attention during the current pandemic despite their vulnerability to COVID-19. In New York City, the death tolls in Black and Hispanic communities are among the highest in the world and exceed those of Whites and Asians.[1] With rising rates of infection in El Paso and the recent resignation of the city's Public Health Director, the region must take proactive precautions to suppress the spread of the virus.[2] To assess the possible impact of COVID-19 in El Paso, we analyzed risk factors associated with the virus, respectively, and in combination with each other. To do this, we utilized detailed survey data on health indicators from a sample of 1,152 Hispanics living in the city that was gathered with the support of NIH in 2011. We also reference existing research on health disparities that illustrate how Hispanic communities are being infected at disproportionate rates in the U.S.

According to the Centers for Disease Control and Prevention (2020), adults 64+, racial and ethnic minorities, the homeless, incarcerated individuals, and people with underlying medical conditions are at heightened risk of complications or death caused by COVID-19.[3] Our data revealed that an overwhelming amount of Hispanics living in El Paso in 2011 met one or multiple criteria of being at higher risk of COVID-19 in addition to other risk factors, such as being an "essential" worker, undocumented or low-income.[4] We found that a large proportion of the Hispanic population in El Paso in 2011 had at least one underlying health condition that categorized them as disproportionately vulnerable to complications or death by COVID-19. Some of the health conditions analyzed in our report include obesity, diabetes, asthma, kidney disease, cancer, emphysema, HIV/AIDS, and heart attack/stroke, nearly all of which are currently cited by the CDC as causes of hospitalization among individuals with COVID-19.[5] However, many Hispanics with underlying health conditions are vulnerable in more ways than one. For instance, more than half (51.7%) of Hispanics with asthma did not have medical insurance, as well as nearly half (42.2%) of those with chronic kidney disease. The institution of the Affordable Care Act in 2013 created medical benefits for naturalized citizens, but legal visa holders, DACA recipients, and undocumented Hispanic immigrants received limited to no help.[6] Citizenship status affected an individual's likelihood to be insured in 2011, as 89.3% of undocumented Hispanics in El Paso lacked medical coverage. Medicaid expansion into Texas makes sense given the pandemic as COVID-19 related layoffs are expected to leave another 382,000 uninsured without qualifying for

Medicare in the state.[7] Medicaid expansion would benefit 1.1 million low-income Texans, and Texas could gain an estimated 100 billion dollars in federal funding.[8,9]

Furthermore, we assess how "essential" employment and incarceration might be causes of a disproportionately high death toll among Hispanics across the country. The CDC (2020) reports that one-quarter of the U.S. Hispanic population works in the healthcare, service, hospitality, transportation, delivery, maintenance, education, and food industries, all of which are currently considered "essential" or "emergency".[10] Frontline workers are required by law to report to work under COVID-19 regulations, including those who are considered high-risk, and do not qualify for unemployment insurance unless they are laid off.[11,12] Given that more Hispanic workers are in this position than Whites or Asians, they are more likely to come into contact with COVID-19. Incarcerated communities, which primarily consist of racial and ethnic minorities, contract the virus at alarmingly high rates. On May 20, 2020, 29,251 cases of COVID-19 were documented in federal and state U.S. prisons.[13] Notably, Texas has the fifth-highest number of cases. This is concerning because the ratio of Hispanic prisoners compared to Whites is 2:1.[14]

After reviewing our data generated in El Paso in 2011 in conjunction with existing research on health disparities, we concluded that Hispanics are particularly vulnerable to COVID-19 as a result of multiple structural inequalities that increase their exposure to the virus and obstruct their access to resources. Furthermore, our data revealed that the Hispanics in El Paso also suffer from extremely high rates of disease that put individuals in danger of severe illness or death from COVID-19. We will not know the disparities in mortality rates among racial and ethnic groups until a higher proportion of the overall population is tested for COVID-19, and all data is reviewed and analyzed. Presently, it remains unclear whether more Hispanics living in the U.S. will die from COVID-19, as the pandemic is projected to return in early autumn. Nonetheless, it is clear now that cities and towns with higher numbers of working-class Latin people should be prepared to properly allocate health resources, provide financial support for high-risk individuals, and conduct extensive community-based health education and outreach in the effort to minimize the spread of COVID-19 and prevent more deaths.

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[1] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

[2] Willard, Keenan. May 4, 2020. "Public Health Director in El Paso Resigns as City Response to COVID-19 Continues." *KFOX14,* https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues.

[3] Centers for Disease Control and Prevention 2020. "People Who Are at Higher Risk for Severe Illness." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

[4]REPORT COVID-19 Susceptibility among Latin People in El Paso, TX https://www.academia.edu/43139124/REPORT_COVID-19_Susceptibility_among_Latin_People_in_El_Paso_TX

[5] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[6] National Immigration Law Center 2014. "Immigrants and the Affordable Care Act (ACA)." https://www.nilc.org/issues/health-care/immigrantshcr/.

[7] Najmabadi, Shannon and Walters, Edgar. 2020. "They Lost Their Jobs and Insurance in the Pandemic. Now They're Slipping Through Texas' Health Care Safety Net." *The Texas Tribune.* https://www.healthinsurance.org/texas-medicaid/

[8] The Monitor Board of Contributors. 2020. "COMMENTARY: Protect Texans' Well-being." *The Monitor.* https://www.themonitor.com/2020/04/16/commentary-protect-texans-well/

[9] Evans, Marissa. 2019. "Voters in four states have approved Medicaid expansion by ballot. Will Texas do the same?" *The Texas Tribune.* https://www.texastribune.org/2019/02/12/texas-legislators-filed-bills-put-medicaid-expansion-decision-ballot/

[10] Centers for Disease Control and Prevention 2020. "COVID-19 in Racial and Ethnic Minority Groups." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[11] District of Columbia Department of Human Resources 2013. "E-DPM Instruction No. 12-51." *Government of the District of Columbia*, https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf.

[12] Stewart, Emily. 2020. "The Essential Worker Trap." *Vox*, https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state-.

[13] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

[14] Bureau of Communicable Disease Surveillance System 2020. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

REPORT

COVID-19 Susceptibility among Latin People in El Paso, TX

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The Latin population in the United States has received relatively little attention in relation to the current pandemic despite their vulnerability to COVID-19. This is especially true in the City of El Paso, Texas, where Hispanics constitute about 81% of the population.[1] On May 28, 2020, the City recorded 1,029 cases and 22 deaths.[2] Since then, both the total number of infections and mortalities across the county have skyrocketed to a staggering 3,069 cases and 89 deaths, respectively.[3] With rising rates of infection and the resignation of the city's Public Health Director, El Paso and the surrounding region must take proactive precautions to suppress the spread of the virus and provide

assistance to vulnerable individuals. To assess the possible impact of COVID-19 in El Paso, we constructed a risk assessment about the populations that could be at higher risk. To do this, we used detailed survey data on health from a sample of 1,152 Hispanic individuals that was gathered with the support of NIH in 2011.[4,5] To understand how COVID-19 may impact the Latin residents of El Paso, we analyzed risk factors associated with the virus on their own as well as interacting with each other.

The Centers for Disease Control and Prevention (CDC) state that "older adults and people of any age who have serious underlying medical conditions" are at highest risk of severe illness or death from COVID-19.[6] This umbrella term refers to people with chronic lung diseases, severe asthma, heart conditions, severe obesity, diabetes, immunocompromising illnesses (including, but not limited to chemotherapy/radiation or organ/bone marrow transplantation, HIV/AIDS, or prolonged use of corticosteroids), liver disease, and those undergoing dialysis for chronic kidney disease.[7] The CDC Morbidity and Mortality Weekly Report released on April 17, 2020 disclosed that 89.3% of people hospitalized due to COVID-19 by March 30 had at least one of the following underlying health conditions: hypertension (49.7%), obesity (48.3%), chronic lung disease (34.6%), diabetes mellitus (28.3%), or cardiovascular disease (27.8%).[8]

Racial and Ethnic Minorities

Risk is identified not only in physiological terms but also on socioeconomic, racial, and ethnic planes. The CDC expands upon their definition of "high-risk" citizens by distinguishing racial and ethnic minorities, as well as people who are currently homeless, pregnant, and breastfeeding.[9] Latin communities across the U.S. suffer from the virus in several ways at disproportionately high rates compared to other subpopulations. According to the City of New York and the CDC, Black and Hispanic/Latino communities bear the brunt of virus-related deaths.[10,11] In a weekly report,

the CDC revealed that although 18% of the U.S. population is Black, 33% of hospitalized COVID-19 cases were among Black people.[12]

In New York, the Bureau of Communicable Disease Surveillance System reported that as of April 16, 2020, the death rates for Blacks were 92.3 per 100,000 people, and 74.3 per 100,000 for Latinos.[13] In comparison, the White and Asian death rates were 45.2 and 34.5 per 100,000 people, respectively.[14] Just two months later, the mortality and infection rates have skyrocketed. At least 5,322 Latinos have died from COVID-19, the majority of whom were ages 65 and above.[15] This is the highest amount of lab-confirmed deaths of a racial group in the region, exceeding that of the White population by almost 1,000.[16] Even so, these numbers are understood to be low estimates since the data cover only lab-confirmed cases, effectively leaving out asymptomatic and non-lab confirmed cases.

Non-Fatal Hospitalizations per 100,000 by Race/Ethnicity in New York City on **April 16**, 2020

Black	Hispanic	White	Asian/Pacific Islander
271.7	198.6	114.5	82.2

Source: Bureau of Communicable Disease Surveillance System, 2020

Deaths per 100,000 by Race/Ethnicity in New York City on **April 16**, 2020

Black	Hispanic	White	Asian/Pacific Islander
92.3	74.3	45.2	34.5

Source: Bureau of Communicable Disease Surveillance System, 2020

Deaths per 100,000 by Race/Ethnicity in New York City on **June 11**, 2020

Black	Hispanic	White	Asian/Pacific Islander
222.4	238.7	110.8	102.8

Source: NYCHealth, 2020

Health Disparities

As discussed lately by mainstream media, existing health disparities that act as obstacles to healing for minority communities have been exacerbated by COVID-19.[17,18] Long before the pandemic, race and ethnicity were proven to be associated with life expectancy, mortality, and burden of illness in the U.S.[19] Communities of color consistently lack the access to care, proper treatment, available resources, and provider diversity that exist in high-income and white-populated areas of the country.[20] These disparities cause and prolong poor health in minority communities and result in higher-risk individuals with multiple risk factors beyond that of old age.[21] This is echoed by some public health professionals who believe that Black and Hispanic individuals die at higher rates because of an increased likelihood of suffering from underlying health conditions and structural barriers to healthcare.[22] While gaps in care increase the vulnerability of a group of people, their existence springs from an insidious culture of inequality that has not been properly addressed in discussion of COVID-19 disparities.

Black and Hispanic communities are exposed to COVID-19 more often as a result of structural racism. State institutions that place lesser value on the lives of Black and Brown people not only turn a blind eye to healthcare disparities, but restrict minorities to riskier jobs and force them to work in dangerous conditions. Research based in Canada, Europe, and the U.S. shows that immigrants and minority communities bear higher rates of work-related accidents, illnesses, and deaths because of their over-representation in high-risk occupations.[23] Because of this, they are coming into contact with COVID-19 before other racial groups and experiencing its impacts earlier in the pandemic.

Although discussion of racial disparities is critical, it is just the tip of the iceberg. Health disparities explain *how* communities of color disproportionately suffer from poor health, but not

why state and federal institutions do not properly allocate health resources. The heart of the problem lies in systemic racism, discrimination, and state-sanctioned violence against minorities that is manifested in multiple ways. Later on in the article, we discuss other covert forms of violence against communities of color, particularly Latinos, that have arisen during the spread of COVID-19.

Altogether, despite the alarming statistics, it is too early in the pandemic to conclude that COVID-19 will disproportionately infect and kill communities of color in the long-term. Nevertheless, the available data makes it clear that minorities and the poor are among the first populations to experience significant death tolls and high rates of positive COVID-19 diagnoses. Given that communities of color face many structural inequalities, such as poverty, residential segregation, racism, and access to healthcare, they are not to blame for pre-existing or virus-related health disparities.[24]

Essential and Frontline Workers

The Hispanic community is an integral part of the U.S. labor force. In 2018, 17% of the national labor force was comprised of documented Hispanic citizens, and more than half (61%) of whom were Mexican.[25] However, this percentage does not include undocumented workers, who constitute upwards of an estimated 5.1% of the U.S. workforce.[26] This is supported by our data gathered in El Paso, which shows that 53.5% of undocumented Hispanics in 2011 were employed.

Employment by Citizenship Status among Hispanics in El Paso, TX in 2010-11

	Citizen	**Resident**	**Undocumented**	**Legal Visa**	**Total**
Unemployed	33.6%	46.5%	46.5%	19.2%	35.6%
Employed	66.4%	53.5%	53.5%	80.8%	64.4%

Source: Original data

Furthermore, the CDC (2020) reports that at least 25% of the Hispanic population in the U.S. is employed by the service industry, including hospitality, transportation/travel, delivery, food, healthcare, and education services.[27] Unfortunately, these are some of the industries that suffer the most under COVID-19 restrictions and regulations, and nonessential businesses have laid off millions of workers across the country as a result of forced closures.[28] This is particularly worrisome for undocumented immigrants because they cannot file for unemployment insurance and do not qualify for Pandemic Unemployment Assistance (PUA) that was passed in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[29] Then, some people are considered "essential" employees, including those who work in grocery stores, mail services, agriculture, city maintenance, and construction, in addition to the industries mentioned earlier, who are legally required to work despite the pandemic. Laws surrounding "essential and emergency employees" require that such employees continue working through national emergencies, including those who are immunocompromised or have pre-existing health conditions.[30] This makes it difficult for frontline workers to receive unemployment benefits if they prefer not to work because one must be fired or laid off in order to collect unemployment insurance.[31] Employees who quit during the pandemic are disqualified from unemployment claims, jeopardizing their financial stability for the sake of their health. Therefore, they are forced to engage with customers and coworkers in close quarters, as before COVID-19 regulations, and thus run a higher risk of contracting and spreading the virus.

Prison, Jail, and Juvenile Delinquent Centers

Incarcerated populations in prisons, jails, and juvenile delinquent centers are also at higher risk of severe illness related to COVID-19. The close quarters, shared spaces, and lack of comprehensive

medical care in correctional institutions create a breeding ground for the virus. The Marshall Project reports that there were at least 9,437 cases of positive COVID-19 diagnoses in state and federal prisons across the U.S. as of April 25, 2020.[32] One hundred forty people, 131 of whom were incarcerated, and seven of whom were prison employees, died as a result.[33] The deaths of prisoners rapidly increased throughout the spring months, eventually amounting to 496 dead inmates by June 4, 2020.[34] There is no testing protocol for individual states, and many have refused to release information regarding the number of prisoners who were tested. For example, the Federal Bureau of Prisons reports lower numbers compared to state correctional facilities.[35] On April 26, the Federal Bureau released information which indicated that 799 federal U.S. inmates tested positive for the virus, along with 319 staff members. Although no staff member was among the deceased, 27 inmates died from virus-related complications.[36] Furthermore, three inmates died at Fort Worth Federal Medical Center alone, and all federal prisons in Texas currently have at least one positive diagnosis within the facility.[37] The Marshall Project defines these numbers as “almost certainly an undercount.”[38]

This puts racial and ethnic minorities at further risk, given the mass incarceration of communities of color. In the U.S., Hispanics are imprisoned 1.4 times higher than Whites.[39] In 2016, approximately 61% of state prisoners of New Mexico were Hispanic, although 49.1% of people living in New Mexico were Hispanic in 2018.[40] The ratio of Black and Hispanic prisoners exceeds that of incarcerated Whites across the country, but the disparities are widest in Texas and other southern states. For example, ranking second only to the Black community, 541 per 100,000 prisoners in Texas are Hispanic.[41] The state’s ratio of Hispanic to White prisoners is 2:1, although Arizona has the highest total number of Hispanic prisoners in the U.S.[42] Juvenile delinquent centers that incarcerate children ages 10 to 17 share similar demographic trends with adult

correctional institutions. The Department of Justice revealed that Latino youth in the U.S. have a 65% higher chance of being detained and incarcerated than their white counterparts.[43] This deep disparity also exists in the state of Texas, where juvenile prisoners are 1.47 times more likely to be Latino than white.[44] Black, Hispanic, and other minority communities in the U.S. are currently contracting, spreading, and dying from COVID-19 at higher rates than White Americans because they are disproportionately imprisoned.

Citizenship

Citizenship status impacts peoples' access to proper healthcare and medical treatment. Our data revealed that the likelihood of being medically insured increased with the stability of U.S. citizenship status. In 2011, before the Affordable Care Act, 89.3% of undocumented Hispanics living in El Paso lacked medical insurance followed by 66% of residents. However, the Affordable Care Act does not provide coverage for all immigrants and excludes the undocumented community from nonemergency services.[45] Recipients of Deferred Action for Childhood Arrivals (DACA) have been denied both Medicaid and ACA benefits since 2012, and children of undocumented parents must be lawful residents or citizens in order to qualify for Medicaid or Children's Health Insurance Program (CHIP) services.[46] Despite the implementation of the Affordable Care Act, undocumented individuals have not experienced any major improvement in access to healthcare.

Medical Insurance by Citizenship among Hispanics in El Paso, TX in 2010-11

	Citizen	Resident	Undocumented	Legal Visa	Total
Does not have medical insurance	43.1%	66%	89.3%	40.2%	48%
Has medical insurance	56.9%	34%	10.7%	59.8%	52%

Source: Original data

Homelessness

The United States struggles to properly address homelessness. In 2019, over 500,000 people were estimated to have been homeless on any given night.[47] People experiencing homelessness are at high risk of severe illness related to COVID-19 for multiple reasons. In shelters, encampments, and other congregate housing settings that homeless individuals occupy, there are almost no isolated or private spaces.[48] People are in close proximity to one another, which makes it difficult to maintain six feet of distance that medical professionals recommend to inhibit the spread of COVID-19. The homeless are less likely to have access to masks, gloves, and other materials that prevent the spread of the virus. This also includes basic hygienic facilities and necessities, like soap, which obstructs them from practicing consistent hand washing and showering.[49] Furthermore, the Council of Economic Advisers found that just under 200,000 people sleep in unsheltered places, like cars, parks, sidewalks, and abandoned buildings.[50] Many homeless individuals also rely on public transportation and facilities, like bathrooms and water fountains. Living and interacting within public spaces increases the possibility of exposure to COVID-19, as the potential to come into contact with infected surfaces and individuals is higher.

According to our data taken in El Paso, being homeless lessens the likelihood of having medical insurance. In 2011, only approximately one-quarter (24.7%) of homeless Hispanics in El Paso were medically insured, which was not even half of the percentage of housed people with medical coverage. Homeless individuals who lack medical insurance have a decreased likelihood of being tested for COVID-19 and being properly treated for potentially fatal symptoms.

Altogether, experiencing homelessness can almost guarantee poorer health outcomes. Compared to housed individuals, people who have ever experienced homelessness are more likely to face health issues, unmet health care needs, and be subject to accelerated health erosion.[51,52] Their obstructed access to basic hygienic amenities, isolated spaces, and medical care make it immensely difficult for homeless individuals in the U.S. to protect themselves and their peers from COVID-19.

Socioeconomic Status

Of the total population of Hispanics living in El Paso, we classified 52.1% as low-income and only 7.1% as high-income. People who are both low-income and Hispanic are at heightened risk of severe illness related to COVID-19, and it is vital to analyze the risks associated with socioeconomic status, race, and pre-existing conditions. Furthermore, all homeless people, who are commonly low-income, are at a higher risk of contracting, spreading, and dying from COVID-19.[53]

Pre-Existing Conditions that Increase Risk of Severe Illness Related to COVID-19

In the analyses below, we ran health conditions with medical insurance status, socioeconomic status, taking medication, age, and homelessness using the SPSS 26 statistical package. We included data on medical insurance, socioeconomic status, and age for all conditions, but only

included medication and homelessness information when the findings were at least statistically significant at $p<0.05$ or significantly exceeding the average percentage of the sample population. The table below reflects the prevalence of health conditions and diseases in the Hispanic community of El Paso in 2011.

Disease Prevalence among Hispanics in El Paso, TX in 2010-11

Obesity	High Blood Pressure	High Cholesterol	Asthma	Diabetes	Heart Attack/Stroke	Kidney Disease	Cancer	Hepatitis or Cirrhosis	Emphysema	Tuberculosis	HIV / AIDS
26.2%	16.1%	13%	7.4%	7.3%	2.6%	2.3%	16.8%	2.2%	1.3%	0.2%	<0.1%

Source: Original data

High Blood Pressure

Of the Hispanic population surveyed in El Paso, TX, 16.1% reported high blood pressure, 59.9% of whom were low-income. High blood pressure (hypertension) has been coined the "silent killer" given the absence of symptoms that accompany it. Many people go unaware of their high blood pressure, which can lead to the development of kidney disease, cardiovascular diseases, or fatal cardiac events, such as heart attack or stroke.[54] According to our data, 23.2% of adult Hispanics living in El Paso in 2011 never had their blood pressure checked. These numbers are concerning because the contraction of COVID-19 is especially dangerous for people with hypertension. The CDC reported that, as of March 30, 49.7% of people hospitalized due to virus-related complications had hypertension.[55] Given the high number of those who had never checked their blood pressure, this analysis only accounted for Latin individuals who were aware of their blood pressure status in addition to a large subsample whose blood pressure was measured as part of the study, as we discuss elsewhere.[56]

Although high blood pressure is a cause of serious health conditions, medical coverage varied greatly among those with diagnoses. Our analysis revealed that 33.7% of Hispanics were aware of their high blood pressure, but not medically insured. Even though they were aware of their health condition, just under half of those with hypertension either chose not to enroll in medical insurance or *could* not because of cost or citizenship status. Clearly, there were, and still may be, significant obstacles to healthcare for the Latin community in El Paso.

High Cholesterol

Thirteen percent of Latin people living in El Paso, TX reported high cholesterol. Similar to high blood pressure, people are often unaware of their cholesterol levels until a serious or fatal event occurs. This analysis showed that 28.8% of those who had been diagnosed with high cholesterol did not have medical insurance at the time. More than half (52.8%) of those who had been diagnosed were low-income whereas 10.2% were high-income. Approximately one-quarter (25.1%) of cases of high cholesterol occurred in Hispanics above the age of 60. The majority of cases occurred among people between the ages of 46 and 65.

High cholesterol is a predicting factor of heart disease, hypertension, and type 2 diabetes.[57] Low-lipid cholesterols increase the growth of plaque in the arteries that flow to the brain and heart, eventually accumulating to the point where blood struggles to pass.[58] Heart attack (myocardial infarction) and stroke occur when plaque buildup has completely obstructed the blood from flowing through the arteries.[59] Both are extremely dangerous health conditions that exhibit little to no symptoms, and the lack of knowledge regarding residents' blood pressures and cholesterol statuses might render them especially susceptible to health complications or death caused by COVID-19.

Asthma

In 2011, 7.4% of Hispanics across El Paso reported asthma diagnoses. Out of this portion of the population, approximately half (51.7%) did not have medical insurance prior to the Affordable Care Act. Around 56.3% of Hispanic residents with asthma were of low socioeconomic status, and 42.1% were middle-class, and a small number of residents with asthma had a high income.[60] Only 9.6% of asthma cases occurred in Hispanics over the age of 60. The majority (53.2%) were among people ages 18-25.

When treated and closely monitored, asthma is not life-threatening. However, if someone with asthma has an asthma attack and lacks access to an inhaler or ventilator, then it can be fatal. An attack is caused by severe inflammation that constricts and narrows the air passages that lead to the lungs.[61] Communicable diseases, like the flu or an upper respiratory infection, can trigger an asthma attack.[62] It is dangerous to be unaware of the condition because those with asthma are at higher risk of complications or death after contracting a communicable illness. Although it is unknown whether COVID-19 induces asthma attacks, shortness of breath and dry cough are common symptoms of the virus that alter the flow of breath through the airways.[63] Severe symptoms and difficulty breathing might trigger an asthma attack, so medical professionals warn individuals with asthma to take caution. Nonetheless, there has been no information that distinguishes asthma attacks from common symptoms of COVID-19. Because of this, virus-related symptoms may be mistaken as a routine asthma attack and deter individuals with asthma from seeking medical attention.

Heart Attack/Stroke

Only 2.6% of Latin individuals in El Paso reported a previous heart attack or stroke in 2011, 27.4% of whom were not medically insured. An overhwelming percentage (72.8%) of those who

experienced a heart attack and/or stroke were of low socioeconomic status. Socioeconomic status was also associated with medication use. About half (50.2%) of low-income Latin individuals who experienced a heart attack and/or stroke reported being on medication at the time compared to 83.2% of middle-class Hispanics.

When examining the age groups that were most affected by these conditions in 2011, our data showed that 27.2% of heart attacks and strokes were reported by people between the ages of 60 and 80. Deaths caused by COVID-19 are highest among those over the age of 64, so Latin individuals in this age group who have suffered a heart attack or stroke have compounded risk factors that render them disproportionately vulnerable to virus-related complications.[64]

Heart attack and stroke are often caused by high cholesterol, as the low-lipid cholesterols create buildups of plaque that block proper blood flow to the heart and brain.[65] A heart attack is defined as a form of cardiovascular disease by itself, but also serves as a signifier of heart diseases like arteriosclerosis, diabetes, or coronary artery disease. [66] Further, the CDC reported that 27.8% of COVID-related hospitalizations were among people with cardiovascular disease.[67] Heart attack and stroke are both potentially fatal health events that affect an individual for the rest of their life. For example, Cione's father experienced three heart attacks before receiving a diagnosis of arteriosclerosis. He was prescribed multiple pharmaceuticals that altered his metabolism, sleep quality, mood, energy levels, and ability to eat. His diet changed drastically, and he must regulate his consumption of cholesterol-rich foods for the remainder of his life.

The physiological processes leading to stroke are similar to those that result in heart attacks, although the life-long impacts may differ greatly. Depending on the part of the brain that was depleted of blood, stroke can cause paralysis, memory loss, changes in behavior, speech issues, and/or vision impairment.[68] In extreme cases, individuals lose entirely the ability to speak or move

their body.[69] Those who are medically uninsured and have experienced one or both of these health events are at higher risk of other health complications, such as an additional heart attack or stroke, if they do not receive proper follow-up care.

Emphysema

A minority (1.3%) of the Hispanic population in El Paso had emphysema in 2011. Our data revealed that 27.4% of those who were diagnosed with emphysema were not medically insured. Furthermore, emphysema was associated with low socioeconomic status, as 54.5% of those with emphysema were low-income whereas none were high-income. 18.2% of emphysema cases occurred in people ages 60-75 and 81-85, both of which are age groups that have been classified as especially susceptible to severe illness or death related to COVID-19.[70]

Emphysema is a chronic lung disease and heightens one's susceptibility to virus-related complications.[71] Smoking tobacco is the most common cause of emphysema, but air pollution and respiratory infections can also cause or aggravate it. It is defined as a chronic obstructive pulmonary disease (COPD), and people can live with emphysema for years before symptoms develop.[72] Western medicine typically involves medications, surgery, and oxygen therapy, but it is typical for those with emphysema to forgo these costly treatments.[73,74]

Hepatitis or Cirrhosis

A total of 2.2% of the Hispanic population of El Paso either has hepatitis, cirrhosis, or both. Of those who received a diagnosis, 33.6% are not medically insured. A small percentage (11.1%) of middle-class Hispanic residents have hepatitis or cirrhosis, also 11.1% of high-income Hispanics in the survey. Then, the remaining 77.8% are considered low socioeconomic status, the highest

percentage across the illnesses in this analysis. The majority of hepatitis or cirrhosis cases were reported by people between the ages of 18 and 30, although 5.5% of cases occurred in people ages 61-65.

All hepatitis infections (A, B, C, D, and E) are inflammatory and occur in the liver, as well as cirrhosis, as cirrhosis is technically the progression of any liver disease.[75] Hepatitis B and C are the most common causes of cirrhosis, and those who are most at risk of contracting B, C, and D are injection drug users and those who practice unsafe sex.[76] While Hepatitis A is curable, B, C, D, and E are not.[77] Injection drug use and unsafe sex are risk factors also associated with the contraction of HIV, and any HIV-positive person who contracts hepatitis is at severe risk of death.[78]

Kidney Disease

Around 2.3% of the Hispanic population in El Paso, TX reported kidney disease, and 42.2% of those do not have medical insurance. Of the Hispanics diagnosed with kidney disease, 41.3% are low socioeconomic status, whereas 52.8% are of middle status. Kidney disease is an illness that does not exhibit symptoms until the occurrence of a potentially fatal event, like kidney failure. It is intimately linked with heart disease, diabetes, high blood pressure, and certain forms of cardiovascular disease that are known to cause or evolve into kidney disease.[79] Further, it is a chronic disease, meaning that the kidneys are permanently damaged and cannot properly filter blood.[80] Unless the patient immediately changes their diet and/or seeks medical treatment, their condition will worsen with time.[81] 36.4% of Hispanics in El Paso with kidney disease are above the age of 60, which adds another layer of risk in the case of a positive COVID-19 diagnosis.

Cancer

In 2012, around 16.8% of Hispanic residents of El Paso, TX, who had cancer were uninsured, one of the lowest percentages across this report. 2.3% of the population received cancer diagnoses, which is approximately equal to that of kidney disease, heart attack, or stroke. This could be that the culture surrounding cancer in the United States is serious and fearful, which encourages people to remain insured after a diagnosis. People who are nearing remission, are in remission or may have been diagnosed as a child are also among those who are likely to be insured. Approximately half of Hispanic residents diagnosed with cancer at some point in the past are of low socioeconomic status (50.1%) whereas the other half is middle-class (40.9%). The ages of people who reported cancer diagnoses at one point in their lives varied greatly. Of those with diagnoses, 8.3% were ages 18-25, 16.6% for those ages 31-35, and 8.3% for ages 46-50. Ultimately, the highest rates were reported by people between the ages of 51 and 65, who constitute 58.2% of the diagnosed population, which ebbs off to 8.3% in the 71-75 years old age group. This is significant because people ages 65 and older are considered "high risk" by the CDC for COVID-19. Hispanics at that age, or older, who also have cancer are more likely to be negatively impacted by a positive COVID-19 diagnosis.

HIV/AIDS

The percentage of those with HIV/AIDS in our data constitute about 0.00002% of all Hispanics living in El Paso, which is significantly lower than the 2019 national percentage of .34%.[82,83] However, the stigma surrounding HIV/AIDS makes people wary of getting tested and learning about prevention methods. It is estimated that 1 in 7 people living with HIV/AIDS in the United

States are unaware of their positive status.[84] Therefore, it is likely that there are other HIV/AIDS-positive Latin people living in the region.

All of the HIV/AIDS-positive Hispanic residents in the sample were not medically insured. Although the amount of HIV/AIDS-positive people in the data is small, it is nonetheless worrisome considering that HIV/AIDS killed over 37,000 people in the U.S. in 2018.[85] The year before, 53% of new known HIV cases were diagnosed in the South, 21% of which were among Hispanics/Latinos. Although numbers have gradually decreased over the past few years, the rate of new cases in Texas was 15.4 per 100,000 in 2019.[86,87] Just five years ago, the South reported the lowest number of HIV-positive people who received medical care and had a suppressed viral load from being treated with antiretroviral therapy.[88] Similarly, according to our data, half of Hispanic residents with HIV/AIDS were on medication in 2011. Whether the medication being taken was antiretroviral therapy is unknown, so it is possible that even less were being treated for HIV/AIDS. Our data taken in El Paso showed that half of HIV/AIDS-positive diagnoses were reported by people ages 18-25, whereas the other half were ages 41-45.

Because of the incredibly small number of HIV/AIDS-positive survey participants, the analysis with socioeconomic status was not statistically significant. Nonetheless, the total number of HIV/AIDS-positive Hispanic residents in El Paso was split between low and middle socioeconomic statuses. In fact, 100% of those with HIV/AIDS were homeless at the time of the survey. Given the high-risk status associated with being homeless and having a positive HIV/AIDS diagnosis, respectively, this portion of the Latin population is extremely vulnerable to health complications or death related to COVID-19.

Tuberculosis

Only 0.2% of the Hispanic community of El Paso reported having tuberculosis at one point in their life. Of this portion of the population, approximately half (49.6%) have medical insurance. 100% of the tuberculosis diagnoses were among Hispanic people of low socioeconomic status, almost all of which were on medication at the time (99.6%). Half of the tuberculosis diagnoses (49.6%) were people ages 18-25, the remainder by people ages 41-45.

The rates of tuberculosis are falling 2% each year, but it is still one of the top 10 leading causes of death worldwide.[89] 25% of the global population has the tuberculosis bacteria lying dormant in their system, so others in the Hispanic community in El Paso may have contracted the bacteria as well. Only 5-15% of these people are estimated to fall ill with tuberculosis, but those with compromised immune systems and pre-existing conditions are at high risk of developing the illness. For instance, HIV/AIDS-positive people are 19 times more likely to die from tuberculosis, which causes further concern that many HIV/AIDS-positive people lack medical insurance.[90]

Diabetes

In our 2011 survey data, about 7.3% of Hispanics in El Paso reported a diabetes diagnosis, 60.1% of those with diabetes were of low socioeconomic status, whereas only 3.3% had high incomes. More than half (65.5%) had medical insurance, but 34.5% were not insured. According to the CDC, diabetes puts one at a higher risk of severe health complications related to COVID-19. About half (49.7%) of people hospitalized with severe virus-related illness as of March 30 had a previous diabetes diagnosis.[91]

Furthermore, only 31.2% of Hispanics in El Paso with diabetes took insulin at least once in 2011. Diabetes diagnoses varied considerably according to age, and Hispanics over the age of 60 constituted 29.3% of total cases. These are significant findings that reveal the disproportionately

poor health experienced by Hispanic individuals living with chronic diseases and inform us of who might be especially vulnerable to COVID-19.

Obesity

A bit over a quarter (26.2%) of Latin people living in El Paso were considered obese, of whom 3.4% were considered severely obese with a Body Mass Index (BMI) of 40 or higher.[92] 56.8% of obese individuals were medically insured, leaving almost half of obese Hispanics without medical coverage. 58.2% of those diagnosed as obese were low-income, and over one-third (38.3%) were between the ages of 18 and 30. However, our data shows that 10.8% of obese Hispanics were ages 61 and older.

Obesity, characterized by a body mass index of (BMI) of 30 or higher, increases a person's vulnerability to severe illness related to COVID-19.[93] As of March 30, 2020, the CDC reported that 48.3% of individuals hospitalized for virus-related health complications were obese.[94]

Before COVID-19, obesity was regarded as a public health issue for the U.S. Hispanic population. In 2019, an estimated 80.4% of Hispanics living in the United States were overweight or obese.[95] According to the CDC, Hispanics are more likely to be obese than White adults.[96] These trends are concerning because obesity is associated with many health conditions, including type 2 diabetes, hypertension, stroke, coronary heart disease, sleep apnea, certain cancers, and gallbladder disease.[97] Some of these conditions, as previously discussed, increase the risk of complications from COVID-19.

Statistics on COVID-19 Deaths in El Paso

Reuters estimated a COVID-19 death count of at least 69,457 in the United States on May 5, 2020.[98] This number continues to rise and reached 92,038 on May 20, marking the United States

as the country with the highest COVID-19 death toll in the world.[99] The number of lives lost to COVID-19 exceeded that of the United Kingdom, then the country with the second highest mortality rate, by over 57,000.[100] According to available official figures, the death count on mainland China reached 4,633, which is 6.7% of COVID-19 deaths in the U.S. [101] The total estimated number of cases in the U.S. is also the highest across the globe at 1,189,198, outnumbering China by more than 1 million cases despite China's population being approximately four times larger.[102] However, the data on COVID-19 cases, hospitalizations, and deaths are far from complete because of 1-2 week lags and an increase in spread of the virus.[103] The "fourth" wave is characterized by its infiltration of mid-sized cities and towns that are less densely populated than regions like New York, New Jersey, and Los Angeles.[104] With each wave, infection and death rates are estimated to rise in smaller and loosely populated areas of the country.[105]

Texas is one of the top ten most infected states with over 32,954 cases, and an estimated 912 people have died from virus-related complications.[106] El Paso is experiencing mounting pressure as time passes, and more people are admitted to hospitals due to COVID-19. Sixty-five people were hospitalized in El Paso in the first week of May, 17 of which were dependent on ventilators for survival.[107] Local public health officials worry that El Paso will suffer from limited resources, as the county only has 285 licensed ICU hospital beds.[108] Unfortunately, the City Director of Public Health, Robert Resendes, resigned on May 4, and his replacement has not been selected. The city insists that his resignation will not negatively impact preventative action since the Office of Emergency Management handles the public health crisis, but the community is buzzing with concern.[109]

Ciudad Juarez, which sits right next to El Paso on the Mexican side of the border, is also grappling with an upward trajectory of COVID-19 cases and reported a total of 1,047 confirmed

infections on May 28.[110] Nonetheless, the daily number of new cases in the U.S. is diminishing as the fourth wave of the pandemic comes to a close.[111]

Conclusion

The Hispanic community across the United States is already at higher risk of COVID-19 because of institutional discrimination across the sectors of employment, housing, and health. In El Paso, where more than half of Hispanics are of low socioeconomic status (52.1%) and 48% lack medical insurance, their chances of suffering from severe illness related to COVID-19 are even higher. This is particularly dangerous for Hispanics living in El Paso who have pre-existing health conditions, like diabetes, cardiovascular disease, HIV/AIDS, and cancer. It remains unclear whether more Hispanics living in the U.S. will die from COVID-19 than other racial and ethnic groups, as the pandemic is projected to make a return in early autumn. However, preventive measures must be taken in order for the Hispanic community in El Paso, including the proper allocation of health resources and financial support for low-income, homeless, undocumented, and medically uninsured individuals.

It is not a coincidence that infection and death rates of COVID-19 among Black and Hispanic populations in the U.S. are presently among the highest in the world since the beginning of the pandemic. Structural inequalities incurred by institutional racism have created, and continue to create, underlying medical conditions and enable increased exposure to the virus, which puts Black and Hispanic citizens in far more vulnerable positions regarding COVID-19 than their white counterparts. When assessing both preventative and recovery measures, policymakers and public health officials should consider pre-existing health disparities and their heightened likelihood of working essential or frontline jobs.[112,113]

We should take caution in our reporting of racial and ethnic inequities to ensure that data are contextualized within a critical understanding of structural factors that cause disproportionate COVID-19 rates among minority groups. Furthermore, we must ensure that racial minorities are not blamed for these disparities.

We will not know the disparities in mortality rates among racial, ethnic, and religious groups until a higher proportion of the overall population is tested for COVID-19 and all the data have been reviewed and analyzed. What is clear is that cities and towns with higher numbers of working-class African Americans and Latin people should be prepared to conduct extensive community-based health education and outreach through *promotoras de salud* and provide referrals to critical medical care for these populations at higher risk.

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[1] United States Census Bureau. July 1, 2019. "QuickFacts: El Paso city, Texas; El Paso County, Texas." https://www.census.gov/quickfacts/fact/table/elpasocitytexas,elpasocountytexas/PST045219.

[2] "El Paso COVID-19 Cases Surpass 1,000 Mark." May 4, 2020. *KTSM.com*. https://www.ktsm.com/local/el-paso-news/el-paso-covid-19-cases-surpass-1000-mark/.

[3] City/County of El Paso COVID-19 Results." *El Paso Strong,* http://epstrong.org/results.php.

[4] Castañeda, Ernesto, Cristina Morales, and Olga Ochoa. 2014. "Transnational Behavior in Comparative Perspective: The Relationship between Immigrant Integration and Transnationalism in New York, El Paso, and Paris." *Comparative Migration Studies* 2(3): 305-34.

[5] Loza, Oralia, Ernesto Castañeda, and Brian Diedrich. 2017. "Substance Use by Immigrant Generation in a U.S.-Mexico Border City." *Journal of Immigrant and Minority Health* 19(5): 1132-39. DOI: 10.1007/s10903-016-0407-1.

[6] Centers for Disease Control and Prevention 2020. "People Who Are at Higher Risk for Severe Illness." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

[7] CDC 2020. "People Who Are at Higher Risk for Severe Illness."

[8] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[9] CDC 2020. "People Who Are at Higher Risk for Severe Illness."

[10] BCDSS. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020.

[11] Bureau of Communicable Disease Surveillance System. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

[12] Bureau of Communicable Disease Surveillance System. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020. https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity-04162020-1.pdf.

[13] BCDSS. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020.

[14] BCDSS. "Age-Adjusted Rates of Lab Confirmed COVID-19." April 16, 2020.

[15] NYCHealth. June 10, 2020. "COVID-19: Data, Details on Deaths." https://github.com/nychealth/coronavirus-data/blob/master/by-race.csv

[16] NYCHealth. June 10, 2020. "COVID-19: Data, Details on Deaths." https://github.com/nychealth/coronavirus-data/blob/master/by-race.csv

[17] Lovelace Jr., Berkeley. April 7, 2020. "White House Officials Worry the Coronavirus Is Hitting African-Americans Worse Than Others." *CNBC,* https://www.cnbc.com/2020/04/07/white-house-officials-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html.

[18] Nania, Rachel and Carlos Quierós. May 1, 2020. "Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show." *AARP,* https://www.aarp.org/health/conditions-treatments/info-2020/minority-communities-covid-19.html.

[19] Barr, Donald A. 2014. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health, Second Edition.* Baltimore: Johns Hopkins Press.

[20] Barr, Donald A. 2014. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health, Second Edition.* Baltimore: Johns Hopkins Press.

[21] Nania, Rachel and Carlos Quierós. May 1, 2020. "Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show." *AARP,* https://www.aarp.org/health/conditions-treatments/info-2020/minority-communities-covid-19.html.

[22] Lovelace Jr., Berkeley. April 7, 2020. "White House Officials Worry the Coronavirus Is Hitting African-Americans Worse Than Others." *CNBC,* https://www.cnbc.com/2020/04/07/white-house-officials-worry-the-coronavirus-is-hitting-african-americans-worse-than-others.html.

[23] Premji, Stéphanie, Patrice Duguay, Karen Messing, and Katherine Lippel. 2010. "Are Immigrants, Ethnic and Linguistic Minorities Over-represented in Jobs With a High Level of Compensated Risk? Results from a Montréal, Canada Study Using Census and Workers' Compensation Data." *American Journal of Industrial Medicine* 53(9): 875-885. https://doi.org/10.1002/ajim.20845.

[24] Bailey, Zinzi, Nancy Krieger, Madina Agénor, Jasmine Graves, and Natalia Linos. 2017. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *Lancet* 389: 1453-1463. DOI: 10.1016/S0140-6736(17)30569-X.

[25] United States Bureau of Labor Statistics 2019. "Labor Force Characteristics by Race and Ethnicity, 2018." https://www.bls.gov/opub/reports/race-and-ethnicity/2018/pdf/home.pdf.

[26] Passel, Jeffrey S., and D'vera Cohn. 2015. "Share of Unauthorized Immigrant Workers in Production, Construction Jobs Falls Since 2007." *Pew Research Center,* https://www.pewresearch.org/hispanic/2015/03/26/share-of-unauthorized-immigrant-workers-in-production-construction-jobs-falls-since-2007/.

[27] Centers for Disease Control and Prevention 2020. "COVID-19 in Racial and Ethnic Minority Groups." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[28] Villa, Lissandra. March 30, 2020. "Millions of Americans Have Been Laid Off Amid the Coronavirus Outbreak. Here's What It's Like to Be One of Them." *Time,* https://time.com/5812538/coronavirus-economic-damage-workers/.

[29] Smith, Rebecca. March 31, 2020. "Immigrants Workers' Eligibility for Unemployment Insurance." *National Employment Law Project*, https://www.nelp.org/publication/immigrant-workers-eligibility-unemployment-insurance/.

[30] District of Columbia Department of Human Resources 2013. "E-DPM Instruction No. 12-51." *Government of the District of Columbia.* https://dchr.dc.gov/sites/default/files/dc/sites/dchr/publication/attachments/edpm_12_51_guidelines_essential_and_emergency_personnel.pdf.

[31] Stewart, Emily. 2020. "The Essential Worker Trap." *Vox.* https://www.vox.com/2020/5/5/21245713/unemployment-insurance-recalled-workers-voluntary-quit-state-reopening.

[32] Park, Katie, Tom Meagher, and Weihua Li. 2020. "Tracking the Spread of Coronavirus in Prisons." *The Marshall Project,* https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons.

[33] Park, Katie, Tom Meagher, and Weihua Li. 2020. "Tracking the Spread of Coronavirus in Prisons." *The Marshall Project,* https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons.

[34] The Marshall Project. June 4, 2020. "A State-by-State Look at Coronavirus in Prisons." https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons.

[35] Federal Bureau of Prisons 2020. "COVID-19: Coronavirus." https://www.bop.gov/coronavirus/.

[36] Federal Bureau of Prisons 2020. "COVID-19: Coronavirus." https://www.bop.gov/coronavirus/.

[37] Federal Bureau of Prisons 2020. "COVID-19: Coronavirus." https://www.bop.gov/coronavirus/.

[38] Park, Katie, Tom Meagher, and Weihua Li. 2020. "Tracking the Spread of Coronavirus in Prisons." *The Marshall Project,* https://www.themarshallproject.org/2020/04/24/tracking-the-spread-of-coronavirus-in-prisons.

[39] Nellis, Ashley. June 14, 2016. "The Color of Justice: Racial and Ethnic Disparity in State Prisons." https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/.

[40] Data USA 2018. "New Mexico." https://datausa.io/profile/geo/new-mexico.

[41] Nellis, Ashley. June 14, 2016. "The Color of Justice: Racial and Ethnic Disparity in State Prisons." https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/.

[42] Nellis, Ashley. June 14, 2016. "The Color of Justice: Racial and Ethnic Disparity in State Prisons." https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/.

[43] The Sentencing Project 2019. "Latino Disparities in Youth Incarceration." https://www.sentencingproject.org/publications/latino-disparities-youth-incarceration/.

[44] The Sentencing Project 2019. "Latino Disparities in Youth Incarceration." https://www.sentencingproject.org/publications/latino-disparities-youth-incarceration/.

[45] National Immigration Law Center. "Immigrants and the Affordable Care Act (ACA)." January 2014. https://www.nilc.org/issues/health-care/immigrantshcr/.

[46] National Immigration Law Center. "Immigrants and the Affordable Care Act (ACA)." January 2014. https://www.nilc.org/issues/health-care/immigrantshcr/.

[47] The Council of Economic Advisers. September 2019. "The State of Homelessness in America." https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf.

[48] Tsai, Jack, and Michal Wilson. March 11, 2020. "COVID-19: A Potential Public Health Problem for Homeless Populations." *Lancet* 5(4): E186-187. https://doi.org/10.1016/S2468-2667(20)30053-0.

[49] Tsai, Jack, and Michal Wilson. March 11, 2020. "COVID-19: A Potential Public Health Problem for Homeless Populations." *Lancet* 5(4): E186-187. https://doi.org/10.1016/S2468-2667(20)30053-0.

[50] The Council of Economic Advisers. September 2019. "The State of Homelessness in America." https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf.

[51] Lebrun-Harris, Lydie A., Travis P. Baggett, Darlene M. Jenkins, Alex Sripipatana, Ravi Sharma, A. Seji Hayashi, Charles A. Daly, and Quyen Ngo-Metzger. 2013. "Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey" *Health Serv Res*, 48: 992-1017. DOI:10.1111/1475-6773.12009.

[52] Oppenheimer, Sarah, Paula Nurius, & Sara Green. 2016. "Homelessness History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights From Population Data." *Families in Society: The Journal of Contemporary Social Services* 97: 230-242. DOI: 10.1606/1044-3894.2016.97.21.

[53] Tsai, Jack, and Michal Wilson. March 11, 2020. "COVID-19: A Potential Public Health Problem for Homeless Populations." *Lancet* 5(4): E186-187. https://doi.org/10.1016/S2468-2667(20)30053-0.

[54] Centers for Disease Control and Prevention 2020. "High Blood Pressure Symptoms and Causes." https://www.cdc.gov/bloodpressure/about.htm.

[55] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[56] Castañeda, Ernesto, and Blaine Smith. Health and Housing. Forthcoming.

[57] Centers for Disease Control and Prevention 2019. "Know Your Risk from Heart Disease." https://www.cdc.gov/heartdisease/risk_factors.htm.

[58] NIH: National Heart, Lung, and Blood Institute 2020. "High Blood Cholesterol." https://www.nhlbi.nih.gov/health-topics/high-blood-cholesterol.

[59] Centers for Disease Control and Prevention 2019. "Know Your Risk from Heart Disease." https://www.cdc.gov/heartdisease/risk_factors.htm.

[60] This analysis is statistically significant at 0.000 with a standard error of 0.001

[61] American College of Allergy, Asthma & Immunology 2014. "Asthma Attack." https://acaai.org/asthma/symptoms/asthma-attack.

[62] American College of Allergy, Asthma & Immunology 2014. "Asthma Attack." https://acaai.org/asthma/symptoms/asthma-attack.

[63] Centers for Disease Control and Prevention 2020. "Symptoms of Coronavirus." https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.

[64] Centers for Disease Control and Prevention. May 30, 2020. "Weekly Updates by Select Demographic and Geographic Characteristics." https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#AgeAndSex.

[65] Centers for Disease Control and Prevention 2019. “Know Your Risk from Heart Disease.” https://www.cdc.gov/heartdisease/risk_factors.htm.

[66] Centers for Disease Control and Prevention 2019. “Know Your Risk from Heart Disease.” https://www.cdc.gov/heartdisease/risk_factors.htm.

[67] Centers for Disease Control and Prevention 2020. “Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020.” https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[68] American Stroke Association 2020. “Effects of Stroke.” https://www.stroke.org/en/about-stroke/effects-of-stroke.

[69] American Stroke Association 2020. “Effects of Stroke.” https://www.stroke.org/en/about-stroke/effects-of-stroke.

[70] CDC 2020. “People Who Are at Higher Risk for Severe Illness.”

[71] Centers for Disease Control and Prevention 2020. “Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020.” https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[72] American Lung Association 2020. “Emphysema.” https://www.lung.org/lung-health-diseases/lung-disease-lookup/emphysema.

[73] American Lung Association 2020. “Emphysema.” https://www.lung.org/lung-health-diseases/lung-disease-lookup/emphysema.

[74] Boyles, Salynn. May 22, 2019. “COPD Care Suffers with High Insurance Deductibles.” *MedPage Today,* https://www.medpagetoday.com/meetingcoverage/ats/79988.

[75] World Health Organization 2020. “What is Hepatitis?” https://www.who.int/news-room/q-a-detail/what-is-hepatitis.

[76] World Health Organization 2020. “What is Hepatitis?” https://www.who.int/news-room/q-a-detail/what-is-hepatitis.

[77] World Health Organization 2020. “What is Hepatitis?” https://www.who.int/news-room/q-a-detail/what-is-hepatitis.

[78] “U.S. Statistics.” *HIV.gov,* February 16, 2020. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

[79] National Institute of Diabetes and Digestive and Kidney Diseases 2020. “What is Chronic Kidney Disease?” https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease#better.

[80] National Institute of Diabetes and Digestive and Kidney Diseases 2020. “What is Chronic Kidney Disease?” https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease#better.

[81] National Institute of Diabetes and Digestive and Kidney Diseases 2020. "What is Chronic Kidney Disease?" https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease#better.

[82] "U.S. Statistics." *HIV.gov,* February 16, 2020. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

[83] United States Census Bureau. February 1, 2019. "Census Bureau Projects U.S. and World Populations on New Year's Day." https://www.census.gov/newsroom/press-releases/2019/new-years-population.html.

[84] "U.S. Statistics." *HIV.gov,* February 16, 2020. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

[85] Centers for Disease Control and Prevention 2019. "HIV in the United States by Region." https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html.

[86] Centers for Disease Control and Prevention 2019. "HIV in the United States by Region." https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html.

[87] Centers for Disease Control and Prevention 2019. "HIV in the United States by Region." https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html.

[88] Centers for Disease Control and Prevention 2019. "HIV in the United States by Region." https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html.

[89] World Health Organization 2020. "Tuberculosis." https://www.who.int/news-room/fact-sheets/detail/tuberculosis.

[90] World Health Organization 2020. "Tuberculosis." https://www.who.int/news-room/fact-sheets/detail/tuberculosis.

[91] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[92] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[93] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[94] Centers for Disease Control and Prevention 2020. "Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 – COVID – NET, 14 States, March 1-30, 2020." https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w.

[95] Centers for Disease Control and Prevention National Center for Health Statistics 2019. "Health, United States, 2018." Hyattsville, MD. https://www.cdc.gov/nchs/data/hus/hus18.pdf.

[96] Centers for Disease Control and Prevention. 2020. "Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018." https://www.cdc.gov/nchs/products/databriefs/db360.htm.

[97] National Heart, Lung, and Blood Institute. Managing overweight and obesity in adults. Systematic evidence review from the Obesity Expert Panel, 2013. Bethesda, MD.

[98] Reuters. May 5, 2020. "Tracking the Novel Coronavirus in the U.S."https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html.

[99] Reuters. May 5, 2020. "Tracking the Novel Coronavirus in the U.S." https://graphics.reuters.com/HEALTH-CORONAVIRUS-USA/0100B5K8423/index.html.

[100] Reuters. May 5, 2020. "Tracking the Novel Coronavirus." https://graphics.reuters.com/CHINA-HEALTH-MAP/0100B59S39E/index.html.

[101] Reuters. May 5, 2020. "Tracking the Novel Coronavirus." https://graphics.reuters.com/CHINA-HEALTH-MAP/0100B59S39E/index.html.

[102] Reuters. May 5, 2020. "Tracking the Novel Coronavirus." https://graphics.reuters.com/CHINA-HEALTH-MAP/0100B59S39E/index.html.

[103] Coyne, Marley. April 2, 2020. "The U.S. May Be Heading to a Second (Or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means." *Forbes,* https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/#e5af9f016a0a.

[104] Coyne, Marley. April 2, 2020. "The U.S. May Be Heading to a Second (Or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means." *Forbes,* https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/#e5af9f016a0a.

[105] Coyne, Marley. April 2, 2020. "The U.S. May Be Heading to a Second (Or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means." *Forbes,* https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/#e5af9f016a0a.

[106] Coyne, Marley. April 2, 2020. "The U.S. May Be Heading to a Second (Or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means." *Forbes,* https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/#e5af9f016a0a.

[107] "El Paso COVID-19 Cases Surpass 1,000 Mark." May 4, 2020. *KTSM.com.* https://www.ktsm.com/local/el-paso-news/el-paso-covid-19-cases-surpass-1000-mark/.

[108] "El Paso COVID-19 Cases Surpass 1,000 Mark." May 4, 2020. *KTSM.com.* https://www.ktsm.com/local/el-paso-news/el-paso-covid-19-cases-surpass-1000-mark/.

[109] Willard, Keenan. May 4, 2020. "Public Health Director in El Paso Resigns as City Response to COVID-19 Continues." *KFOX14,* https://kfoxtv.com/news/coronavirus/public-health-director-in-el-paso-resigns-as-city-response-to-covid-19-continues.

[110] Cross, David. May 28, 2020. "More Than 70 New Cases of COVID-19, 9 Deaths Reported in Ciudad Juarez." *KFox14,* https://kfoxtv.com/news/local/more-than-70-new-cases-of-covid-19-9-deaths-reported-in-ciudad-juarez.

[111] Coyne, Marley. April 2, 2020. "The U.S. May Be Heading to a Second (Or Even Fourth) Wave of the Coronavirus Epidemic. Here's What That Means." *Forbes,* https://www.forbes.com/sites/marleycoyne/2020/04/02/the-us-may-be-heading-to-a-second-or-even-fourth-wave-of-the-coronavirus-epidemic-heres-what-that-means/#e5af9f016a0a.

[112] Passel, Jeffrey S., and D'vera Cohn. 2015. "Share of Unauthorized Immigrant Workers in Production, Construction Jobs Falls Since 2007." *Pew Research Center,* https://www.pewresearch.org/hispanic/2015/03/26/share-of-unauthorized-immigrant-workers-in-production-construction-jobs-falls-since-2007/.

[113] United States Bureau of Labor Statistics 2019. "Labor Force Characteristics by Race and Ethnicity, 2018." https://www.bls.gov/opub/reports/race-and-ethnicity/2018/pdf/home.pdf.

HOW TO UNDERSTAND PROTEST

By Ernesto Castañeda and Daniel Jenks*

June 7, 2020

Protest on June 1, 2020, in Richmond, Virginia in front of the statue of Confederate General Robert E. Lee, which the Governor has announced will be removed soon © Ed Holten

In all fifty states and numerous countries, protesters are demonstrating against racialized police brutality. In one of the last recorded incidents, a police officer in Minnesota knelt on Mr. George Floyd's neck for over eight minutes while he pleaded for his life, ultimately unable to breathe. Three officers watched on, doing nothing. However, this is not the first time that we have seen protests over the unnecessary murder of unarmed African Americans by police forces in the

United States. The murders of Rodney King, Trayvon Martin, Mike Brown, Philando Castile, Stephon Clark, Eric Garner, and 12-year old Tamir Rice, to name a few, have all similarly sparked outrage and protests across the country.

The disturbing murder of George Floyd, as recorded by many onlookers, is impossible to forget. Cellphone videos have documented calls to the police by white women seeing black people in what sociologist Elijah Anderson calls "the white space," with threats of violence by engaging police. In addition to other recent police murders – those of Breonna Taylor and Ahmaud Arbery have made many of us feel impotent, sad, and overwhelmed. Many have taken to the streets to express their solidarity and to feel a degree of agency. Media coverage of these racist incidents has overwhelmed the public along with powerful images of massive marches, vigils, and gatherings calling for change. We have also seen images of looting and glass breaking in the night, exponentiated by some in an effort to curve the conversation away from the issues that the protesters are calling to light. It is vital that we stay focused and prioritize these issues, and further consider how protests affect change. Below, we provide some sociological terms mainly developed by Charles Tilly to help make sense of these protests as a part of a continuing social movement and to look toward a more equal and prosperous future.

Protest at the base of Lee’s statue in Richmond June 1, 2020 © Jonathan Brooks

CATEGORICAL INEQUALITY: Inequality between groups demarcated by racialized, gendered, or classed categories. While inequality is primarily organized at a group level, we experience inequality between individuals, e.g., we compare ourselves with those who have more than we do. This may be why some white people deny the existence of white privilege. It is easier to see the difference between you and me than it is to see the full picture. Time and time again, studies show that certain groups such as white people or men hold more privilege than their non-white or female counterparts. Categorical groups such as women, transgender individuals, African-Americans, and Native-Americans have historically held less wealth and political power than white men, for instance. Categorical inequality is exhibited when structural instances of racism, sexism, homophobia, classism, nativism, xenophobia, ableism, and other types of oppression are observed. Privilege or exclusion accumulate at the intersections of these categories; for example, black women have been more stigmatized than white women. Categorical inequality, then, is a useful concept because it reminds us that societies often stigmatize and exclude individuals because of their perceived membership in a group with little political power and thus a low-status. The fight against categorical inequality has historically been fought through *contentious politics.*

CONTENTIOUS POLITICS: An umbrella term that includes protests, marches, social movements, rallies, and sit-ins, but also rebellions and revolutions. Those engaged in contentious politics may utilize civil disobedience and peaceful protest, or disruptive means. They are collective performances that publicly demand the continuation or expansion of rights and benefits for certain groups. Contentious politics most often address state and local power holders while simultaneously engaging the broader public for empathy and support. Historically, they impinge on the accumulation and hoarding of resources by the most wealthy and powerful. Therefore, they are resisted by those in power, and the state often uses violence to suppress the voices and demands of citizens engaging with contentious politics. Those in power send police and the military to protect an unequal status quo — we saw this process play out in Washington, D.C. this week. While protests continued to grow and occur in the city each day, even after mandated curfews, Trump sent in the military and national guard against the wishes of the D.C. government. Other states are mobilizing their national guards against their own citizens. Police are used as a

tool to break up and divide protests, signaling that those with power oppose significant changes to the status quo.

Protest in front of the White House, June 6, 2020 © Ernesto Castañeda

LEGALITY/ILLEGALITY: That something is legal does not mean that it is moral and vice versa. For decades, slavery was legal, emancipation illegal. Until 1967 miscegenation (mixed marriage) was illegal in 16 states. Japanese citizens were placed in immoral internment camps during World War II, a practice that was perfectly legal, and in fact, carried out by the government. This is continued today with asylum seekers of all ages put in camps. Some inequality is legislated as Apartheid was in South Africa, but segregation can also occur with real state practices and racist practices even if they are technically illegal for violating anti-discrimination laws in the books but rarely enforced. Contentious politics are indeed contentious because they call for changes in laws

and practices in a way that goes against the interest of those at the very top of society. Historically, the law protects the property rights of the very rich. This is apparent in responses to riots throughout the country, where governments and police are more organized to protect the property of businesses rather than the lives of African Americans.

LEGITIMATE/ILLEGITIMATE VIOLENCE: Whether it comes from state agents or civilian groups, violence is the same. Analytically, it is crucial not to start assuming that those in power have the legal and moral monopoly over violence. At the same time, it is also vital not to idealize armed rebels, and to find out if particular groups may be engaged in violent acts —such as some who identify under the "boogaloo" designation and have been documented going to protests to incite violence for racist purposes.

Nonetheless, the American, Haitian, and French revolutions were possible when large numbers of civilians fought, by all means, possible against those in power who were excluding large percentages of the population in political decisions and economic opportunities. Historically, it is also the case that revolutions have been co-opted by opportunistic groups that set themselves as the new elites. The line between legitimate and illegitimate violence is not as clear as the government would like us to think. What is clear is that violence stemming from social movements is often a result of years of state violence perpetrated against categorical groups.

Protest in front of the White House on June 6, 2020 © Ernesto Castañeda

SOCIAL MOVEMENTS: Social movements appeared as such around the mid-1700s. They are large-scale mobilizations by categorical groups exploited and excluded. Movements do not need to have leaders to be so, nor do they have to get legislation passed in their names to be a movement — though often the end goal is lasting change through legislation or other means. Movements are long-lasting, and they aim for the public display of numbers, unity, commitment, as well as to be taken seriously and supported by people as full citizens. Early examples of social movements include those by religious minorities demanding political equality and the women's suffrage movement. There is a decades-long movement for immigrant rights that have not yet been granted. Black Lives Matter is indeed a continuation of the Civil Rights Movement, whose demands are still to be fulfilled. Many times it has taken breaking the law and engaging in civil

disobedience to bring about serious change. The current movement for Black Lives Matter has already started to bear fruit — there is a bipartisan push for demilitarizing the police in Congress, Los Angeles has moved to lower the funds allocated to the police department, the Minneapolis City Council has started discussions on how to rethink policing in their city. Furthermore, thousands around the country are having conversations about how government funding that goes to police and incarceration could be used for other, more productive purposes, as well as about structural and institutional racism, the criminal justice system, and community development.

Protest next to the White House June 6, 2020 © Ernesto Castañeda

DEMOCRATIZATION: This point is perhaps the most important and represents a summation of the previously listed concepts. According to Charles Tilly, democracy should be thought of as a process with various levels rather than a binary label of democratic or non-democratic. Tilly theorized that democratization increased with the integration of trust networks (sets of interpersonal connections where people are willing to share resources and help one another) into public politics, the insulation of public politics from *categorical inequalities* (discussed above), and decreasing the influence of 'power centers' (such as clans and warlords, but in a modern context maybe multinational corporations and billionaire families) in public politics. It could also happen in reverse.

Applying this framework to the current movement, the United States will become more democratic once its democracy equally includes all people living within it, inclusive of groups previously excluded. Thinking of this broadly, these could be African Americans, undocumented immigrants, or poor rural folks. Democratization does not increase with superficial, lip service inclusion by politicians. Instead, real inclusion where individuals of that group feel heard as a group, and changes are made to ensure they have a real chance at achieving health, economic stability, and wellbeing. Making civil rights a reality and not only a set of discretionally enforced laws would be a way for the United States to become more democratic. Democratization will increase when being white is not a pre-requisite to be broadly treated with respect and have a fair shot at economic success. Furthermore, these changes would not make the average person less wealthy nor decrease the value of their citizenship. On the contrary, as civil rights leader Fannie Lou Hamer noted: "We cannot be truly free, until everyone is free."

Black Lives Matter PLZ NW
EVACUATION ROUTE
6 St NW
WE STILL RISE

Protest at the brand new Black Lives Matter Plaza on 16th St. in DC June 6, 2020 © Ernesto Castañeda

These points are discussed more carefully and at length in the books:

Social Movements 1768-2018 by Charles Tilly, Ernesto Castañeda, Lesley J. Wood. Routledge 2020.

Collective Violence, Contentious Politics, and Social Change: A Charles Tilly Reader by Ernesto Castañeda, Cathy Lisa Schneider. Routledge 2017.

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