



In This Issue

From The Director

Letter from the Acting Director
PAGE 2

Book Reviews

Separated: Family and Community in the Aftermath of an Immigration Raid
PAGE 4

Uninsured in Chicago: How the Social Safety Net Leaves Latinos Behind
PAGE 5

Articles

What Latino Teens can tell us about Social Media and Mental Health
PAGE 6

Latino Patients: Where are the Latino Doctors?
PAGE 10

COVID-19's Impact on Texas-Mexican Musical Community in the Midwest
PAGE 12

Racial/Ethnic Socioeconomic Disparities in Health
PAGE 14

Health Care for Seasonal Farmworkers in Michigan
PAGE 23

¿Qué está pasando en el instituto?

Homage to Dr. Martinez
PAGE 3

New Faces
PAGE 28

Send offs
PAGE 28

JSRI Scholarship Recipients
PAGE 28

New JSRI Affiliates
PAGE 29

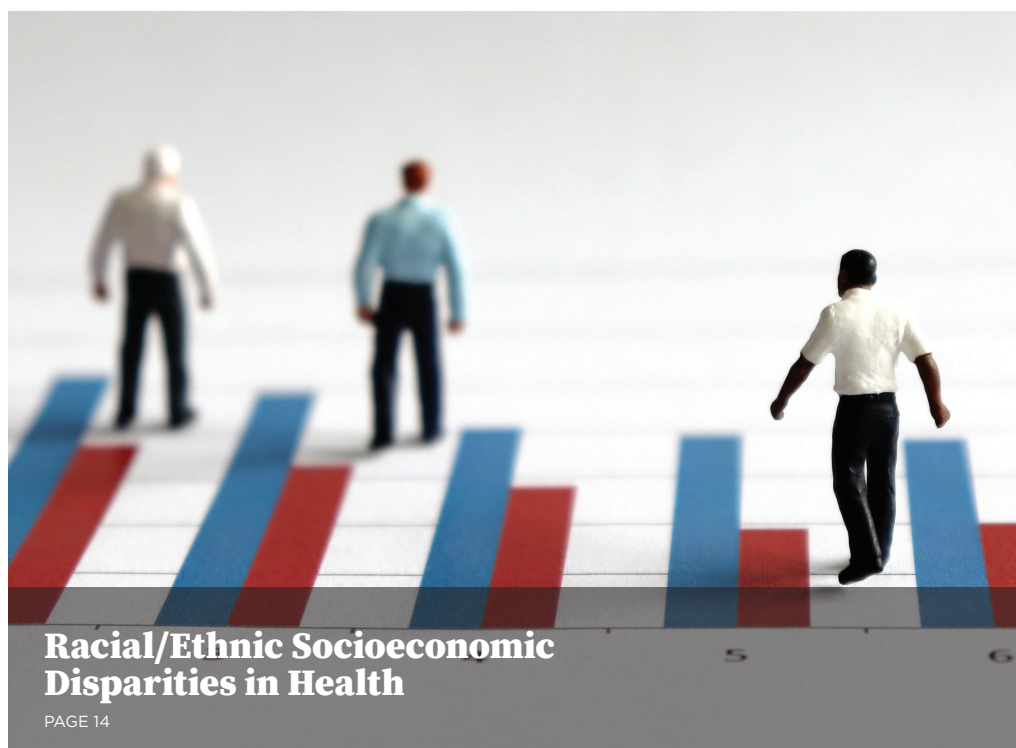
NEXO

The Official Newsletter of **The Julian Samora Research Institute**
The Midwest's Premier Latino Research Center



What Latino Teens can tell us about Social Media and Mental Health

PAGE 6



Racial/Ethnic Socioeconomic Disparities in Health

PAGE 14

NEXO

Vol. XXVI • No. 1 | FALL 2022

NEXO is the official newsletter of the Julian Samora Research Institute (JSRI), University Outreach and Engagement at Michigan State University (MSU) in East Lansing, Michigan. All contents remain the property of the original authors or artists, JSRI, and/or MSU.

Some of the views expressed by contributors may not represent those of JSRI or MSU. Reproduction of this publication without written permission of JSRI is restricted except for educational purposes. Printable copies of the newsletter are available online.

JSRI at Michigan State University is committed to the generation, transmission, and application of knowledge as it relates to Latinos and Latino communities throughout the Midwest and the nation.

Published by:

Julian Samora Research Institute
University Outreach and Engagement
Michigan State University
219 S. Harrison Road, Room 93
East Lansing, MI 48824

Phone: (517) 432-1317

Fax: (517) 432-2221

Email: jsamorai@msu.edu

Web: jsri.msu.edu

Facebook: facebook.com/JSRIMSU

Twitter: twitter.com/JSRIMSU

Interim Director, Julian Samora Research Institute
Francisco A. Villarruel

Editor
Francisco A. Villarruel

Contributing Writers
Celeste Campos-Castillo
Juan D. Coronado
Richard Cruz Dávila
Jean Kayitsinga
Yoshira Donaji Macías Mejía
Marcelo Siles

Graphic Designer
Mike Davis

Letter from the Acting Director

by Francisco A. Villarruel

October 2022. If we take a step back and reflect on what we – as individuals, communities, a state, a nation, and our world have undergone, there is no doubt that words such as stress, turmoil, grief, loss, hardship, and several other terms could be used to describe our individual situations. At the same time the Covid 19 pandemic has reinforced two realities: First, despite the continued disparities that have been known to exist across Latino communities (e.g., income, health, education), Latino communities across the globe are resilient. The pandemic has forced a reimagining of our supports, services, and community building to deal with adversities but at the same time to promote our collective wellbeing.

Researchers have reinforced that one of the reasons that Latino communities have faced such large losses is because of our overrepresentation in industries that have been most impacted by the pandemic – most notably the service industries. During the pandemic, Latinos were not only more likely to contract Covid, but also more likely to be hospitalized and to suffer catastrophic losses. The disproportionate number of Latino households that are either underinsured or uninsured has also impacted Latino families and communities. The economic impact of Covid has also impacted Latinos as noted in higher rates of job loss. While there has been an increase in U.S. employment opportunities, the labor recovery for Latinos continues to show slower return to pre-pandemic levels than other communities of color.

A 2021 Report by the Pew Research Center underscores the impact that the pandemic has had across the U.S., and more specifically, within Latino communities. Despite the realities of the consequences related to the pandemic, one fact is evident. Latino-serving community-based organizations have attempted to fill voids – in areas such as food insecurity, health services, and educational programs to ensure continued academic achievement of Latino youth. This sense of community and of commitment to ensuring well-being offers unique and long-lasting supports to overcome experienced adversities. The Pew Report also highlights that Latinos are optimistic about the future – including economic recovery and family/individual well-being.

In this NEXO issue, we examine but a few issues related to health concerns of Latino communities and priorities that can be adapted to ensure the healthy future of Michigan. More important, the issue honors the longest serving director of the Samora Institute, Dr. Rubén O. Martinez, who has led the Samora Institute since he was hired in 2007. Dr. Martinez' footprint in Michigan, and throughout the Midwest, has fostered a long-lasting legacy through his outreach, bringing together of various sectors of MI and the Midwest, and his unwavering commitment to supporting Latino communities.

Having said this, Michigan State University will be undertaking a search for a new director. The commitment to supporting the Samora Institute remains an institutional priority.



Francisco A. Villarruel, Interim
Director Julian Samora
Research Institute

Pew Research Center (2021). For U.S. Latinos, Covid-19 has taken a personal and financial toll. Washington, D.C.: Author. Last retrieved August 20, 2022, from <https://www.pewresearch.org/race-ethnicity/2021/07/15/for-u-s-latinos-covid-19-has-taken-a-personal-and-financial-toll/>

HOMAGE TO Dr. Rubén Martínez

A DEDICATED LEADER,
SCHOLAR, AND MENTOR AT JSRI

By Yoshira Donaji Macías Mejía,
Juan D. Coronado, and
Richard C. Dávila

From 2007 to 2021, Dr. Rubén Martínez, Professor of Sociology, served as Director of the Julian Samora Research Institute at Michigan State University, from which he will retire in October of 2022. Prior to coming to Michigan State, he worked at institutions in Texas and Colorado, where he gained significant experience in administration and community engagement from his time at the University of Southern Colorado-Pueblo, Colorado University-Colorado Springs, and University of Texas at San Antonio. This rich experience and knowledge are what make him an excellent leader. In addition to his administrative leadership, he also has excelled in the academic sphere. He has many publications in the areas of neoliberalism, Latinos, diversity leadership in higher education, institutional and societal change, education and ethno-racial minorities, youth development, Latino labor and entrepreneurship, and environmental justice. He is also the editor of *Latinos in the United States* book series in the

Michigan State University Press, through which he has produced 15 volumes and counting to increase our knowledge on *Latinos in the United States*. His own books include: as co-author *Chicanos in Higher Education* (1993), *Diversity Leadership in Higher Education* (2007), and *A Brief History of Cristo Rey Church in Lansing, MI* (2012); one edited volume, *Latinos in the Midwest* (2011); and two co-edited volumes: *Latino College Presidents: In Their Own Words* (2013) and *Occupational Health Disparities among Racial and Ethnic Minorities: Formulating Research Needs and Directions* (2017). These

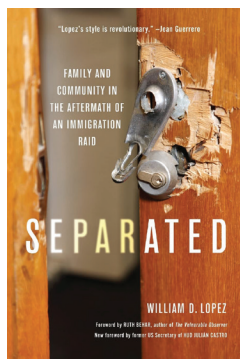
are just some highlighted works from Dr. Martínez as it would take several pages to do all his accomplishments justice.

Beyond his tenure at MSU, Dr. Martínez has also focused on improving the status of Latinos in the Midwest through his service. He has been a part of several task forces at MSU to improve diversity, equity, and inclusion, but he has also done this at the state level here in Michigan. He, along with many others, was part of the founding of the Michigan Association for Latinx in Higher Education (MALHE),



PHOTO BY PAUL PHIPPS

CONTINUED ON PAGE 30 ►►



Separated: Family and Community in the Aftermath of an Immigration Raid

by William D. Lopez 2021. Baltimore, MD: Johns Hopkins University Press.

Reviewed by Yoshira Donaji Macías Mejía

Many authors, journalists, and academics have written and exposed the flawed U.S. immigration system and the impacts it has beyond the individual. This book examines the lives of surrounding individuals that have been deported back to Mexico and the repercussions this has on those left behind in the United States. One interesting take from this book is that the book is not situated in the southern U.S. border, but in the Midwest, in Washtenaw County, Michigan. This is especially impactful because this shows that immigration is not something simply focused on California, Arizona, and Texas, but that Latino population is present throughout the entire U.S. Other compelling aspects of this book are that it does not just focus on the telling of individual stories of individuals impacted by deportation, but it takes both a public health and systemic approach of understanding the underlying causes for why the immigration system in the U.S. is flawed. These perspectives add value to the knowledge some of us possess on the U.S. immigration system and on the lives of Latinos who have been historically impacted by the racialization of such laws.

The book is organized by providing a general overview of the main protagonist of the immigration raid the book is centered on, it is followed by a discussion of before the raid, accounts of the raid itself, and the impact on families and communities after the raid. The prose is developed for broad readership, which is beneficial for academic and non-academic audiences who want to know more about the lives of mixed-status Latino families in Michigan. While I appreciate that this book is aimed at a wide audience, the book would have benefited from a bit more discussion with the academic literature to connect the dots better for non-academics. This would have created a greater impact for the book because non-academics could see the repercussion of government policies on the life of Latino mixed-status families and communities, as well as gotten a stronger understanding of how good health is more than just eating healthy and exercising, but that it is tied to various social determinants of health, such as the political context of the geographical location an individual and community resides.

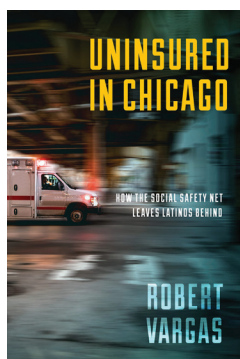
As briefly touched upon, many scholars have discussed the impact of immigration on mixed-status Latino families, but what this book does differently and builds on is that it engages on various sub-themes, such as gender, individual and community levels of impact, and draws in the public health perspective. This book also uses ethnographic and qualitative interviews to tell a compelling story of the lives of these

Latinos. Many articles and manuscripts in public health discuss these issues, but this book really discusses the impacts of witnessing a raid firsthand and the negative effect on physical and mental health. These negative health impacts are relayed by parents, adults, and children who witness the raid. One of the mothers whose husband was deported discusses the trance of her daughter after the raid. How the child was wandering aimlessly and how months later the child suffers from various physical health issues. In addition, Lopez also discusses the health impacts of the men who were detained in immigration facilities. Many of these men suffered drastic weight loss from the type of food they were fed and from their lack of appetite due to the constant worry they had concerning their inability to provide for their families. Similar thoughts were described by the mothers who entered single motherhood instantly after their male partners were removed from the United States. They had fears, pain, and stress that contributed to their poor physical and mental health. These accounts were vividly recounted and impactful for the reader.

Another aspect Lopez beautifully describes is the various layers of impact immigration raids have on Latino families. For instance, the book addresses both the individual and community level impacts. Here the author goes beyond incorporating the individuals affected by the raid and includes members of community organizations to paint a picture of how immigration policies and enforcement do not only change the lives of families, but of communities. He discusses how these women whose partners were deported *marcadas* (marked) or stigmatized by community members. He also discusses the impact of one raid on the whole community. How it increased fears of law enforcement, immigration enforcement, fears to go out to work, take children to school, and look for basic needs, such as food and water. Other important interactions described are the interactions between these women and law enforcement and their landlord. These interactions are particularly important because it shows how gendered immigration is and how the many of the individuals who are deported and arrested are primarily men in comparison to women. It also signals how the landlord exploited his tenants once the raid occurred. The landlord did this by taking value items as payment and removing these women from the premises.

Something else the author does well is examine the parallels between Black and Latino men as it pertains to law enforcement, not just ICE. Lopez discusses how Black men are impacted by police brutality and suffer losing their lives in some situations and compares this to the cooperation between local and immigration law enforcement in the practice of detaining immigrant Latino men. Included among these valuable insights is that Lopez goes beyond interviewing the victims of the immigration raid but also interviews local law enforcement to enhance his understanding between the cooperation of these two agencies.

Overall, this book eloquently brings to light many aspects that are often ignored or not known about the impacts and aftermath of immigration raids on Latino families. It shows that mixed-status families are vulnerable and do not have access to the necessary to help sustain their U.S. citizen children and family members.



Uninsured in Chicago: How the Social Safety Net Leaves Latinos Behind

By Robert Vargas New York, New York University Press, 2022

Reviewed by Marcelo Siles

Robert Vargas conducts a careful analysis to illuminate several constraints and barriers that Latinos face when dealing with health care issues, including the purchasing of health insurance. The book includes four chapters to describe the different types of health concerns and the lack of access to health insurance programs faced by members of the Latino community in Chicago, and the last chapter explains the role that the Latinos' networks can assume in disseminating information about how to get access to these insurance programs.

The first chapter, *How the Uninsured are Criminalized*, includes the stories of two young people, one of them a 28-year-old Latino (Nick) that suffered from asthma and is uninsured. "Living with asthma and without inhalers made it difficult for him to hold down a job." (pp. 22). The other, a 32-year-old black woman, had a very difficult life, "When she was 14, her mother died in a car accident, and Lynette was foisted by an uncle. Her uncle eventually sexually assaulted her, so she ran away. She [currently] struggles with mental health." (pp.34).

The experiences of these individuals have similarities. Both required medical attention, from time to time, had odd jobs throughout their life with no health insurance, needed huge amounts of money to cover their health costs, and accumulated debt due to medical bills. At one point, Nick had accumulated \$60,000 in debt. Due to these circumstances, both entered the informal economy, initially to obtain the necessary medicines in the informal market from drug dealers, and later to gain some money for their living expenses and to cover their health costs. Nick shoplifted and sold these goods. A drug dealer offered a job to Lynette to sell prescription drugs. Both had to serve time in jail due to their participation in the informal economy. Both reported receiving good health care in prison, according to Lynette "When you enter [prison] you see a psychiatrist, counselor, therapist, and a doctor." (pp.36). The two young people not only received medical care, but also the necessary medicines.

Lynette recognized that: "The injustice of the state criminalizing communities with inadequate health care in ways the Latino male hadn't." (pp. 36). "At the same time, she was resourceful and remained open to the idea of receiving health insurance from the government." (pp. 37). Medicaid expansion has extended health care to thousands of often low-income people with criminal records (pg. 43).

The second chapter, *Who deserves Health Care*, highlights that "First impressions matter. Positive first impressions contribute to trust and social cohesion while negative first impressions can lead to fear and avoidance. Latino's impressions of the health care system have been largely overlooked in research on health insurance enrollment." (pp. 44).

According to the author, "Race scholars argue that Black and Latinos' learned avoidance of public benefit programs is not accidental, it's by policy design, while their interactions with the safety net made White people feel more entitled to public benefits and confident in their abilities to successfully navigate government and bureaucracy." (pp. 44-45). Vargas asserts that "In bureaucratic settings, where social structures such as race, gender, and the family intersects, individuals translate their experiences into internalized ideas about their own deservingness. Some come out of their interactions feeling supported, even empowered and motivated, to search additional safety nets. Others leave feeling disrespected, dehumanized, and targeted in ways that amplify system avoidance." (pp. 45). He supports this assertion based on interviews with both Latinos, gays, and Whites.

Chapter 3, *Why Latina Women Sacrifice Their Coverage*, documents the struggles of young Latinos to deal with health issues during their college days and during the "Waithood" period after graduation "In which young people often shuttle back and forth between jobs or postsecondary education programs. Each respondent of this chapter went uninsured for the full duration of the study. . . these respondents felt doubly constrained by their limited opportunities for upward mobility coupled with gendered and racialized family obligations. Some felt—and complied with pressure to prioritize their parents' health and financial well-being over their own." (pp.79). Other respondents "Encountered a complete withdrawal of parental support, a "tough love" effort families hoped would develop financial independence and personal responsibility." (pp. 80).

Chapter 4, *The Role Gender Plays in Access to Health Care*, provides evidence of the gender gap of uninsured between young Latino men and Latina women. "Latino men are more likely to be uninsured (59%) than Latina women (41%)." (pp. 116). This gap could be explained by the fact that Latino families expect their adult sons to become financially independent by obtaining jobs that not only will pay them decent salaries, but also include health insurance. The uninsured Latino men who the author interviewed for this chapter "Received additional support from family referral networks, social workers, or labor unions, while some Latinas seeking to escape abuse, tried but could not get similar institutional support (pp.117). Another challenge faced by Latinos(as) is that some states did not expand Medicaid eligibility under the Affordable Care Act (ACA) or Obamacare, meaning quality and accessible healthcare services were not available and/or serving at or beyond capacity.

Finally, chapter 5 *The Power of Social Networks to Secure Insurance* discusses strategies for enrolling low-income uninsured Latinos in health insurance plans. A director of a nonprofit organization presented his strategy for recruiting college-aged Latinos to enroll in health care programs. "Health insurance is not the most exciting issue." (pp. 137). The author describes many networks that college students used to obtain information about health insurance, such as getting information from a classmate, from roommates, and college organizations. Vargas concludes that "The most powerful campus referral for insurance enrollment seemed to be the mundane word-of-mouth referrals that come from classmates, especially when an individual was enduring a health crisis." (pp. 161).

In conclusion, this is a very interesting and useful book for health program directors, health care workers, researchers, and policy makers interested in understanding the difficulties and constraints uninsured minorities face when trying to enroll in government sponsored programs (ACA – Medicaid), the high cost of these programs, and uninsured minorities deal when they face with a health issue.

What Latino Teens can tell us about Social Media and Mental Health

By Celeste Campos-Castillo

When Frances Haugen alleged that Facebook, now known as Meta, knew its social media platforms were harmful to the mental health of adolescents, she renewed attention to two key trends within the U.S. The first is the trend toward near ubiquitous use of mobile devices and social media among adolescents. The second is the rise in struggles with mental health among adolescents, including rising rates of major depression and suicidality. A substantially large body of research has accumulated over the past two decades that seeks to identify mechanisms linking the two trends. How large? When several studies investigate similar outcomes, researchers conduct systematic reviews and meta-analyses to summarize overall trends in findings. The number of studies conducted on this topic is so large that we are now seeing a new tier of summaries called umbrella reviews, which are summaries of systematic reviews and meta-analyses. In other words, we have numerous summaries of these research studies, and then we have summaries of these summaries because they are so numerous.



Despite what seems at times like an oversaturation of studies asking similar questions, there remains a critical gap: few studies examine adolescents from communities of color and of those, even fewer study Latino adolescents.

The gap in research is surprising for several reasons. Latino adolescents have a higher rate of social media use than their White counterparts. Moreover, they face greater risks of experiencing adverse mental health outcomes and face steeper barriers to accessing mental health care, including the stigma of being labeled a mentally ill person and potential concerns about how their own legal status or that of their guardians may impact receiving care.

Over the past three years, I have made a concerted effort to address this gap and I plan to build on this work when I join Michigan State University in January 2023, in the Department of Media and Information. My work has been funded by a wide range of agencies and foundations, including one run by Meta, which shows how eager people are to hear the voices of these adolescents. Indeed, this work has uncovered the uniqueness of Latino adolescents and how useful their perspectives are to understanding more broadly the nature of the relationship between technology use and mental health among adolescents.

For example, my research team and I conducted interviews with over 40 Latino adolescents about their social media use and mental health. Each interview lasted an hour to an hour and a half. Several questions were geared toward understanding the relationship between mental health and social media use, and the potential implications. The interviewees identified several ways that social media can harm mental health, like providing an additional avenue for bullying. Notably, they also discussed scenarios where the causal arrow went the opposite direction; that is, where they noticed peers who were struggling with mental health turning to social media to access support and cope.

At times, this was described as histrionic and driven solely by a need to attract attention, but they collectively understood a key barrier that Latino adolescents face: sometimes they have no one else to turn to. Mental health is a taboo topic among Latino communities, and so they felt that some of their peers may not feel comfortable going to their own families for help. Some said these individuals should really be going to a therapist or at least a school counselor but noted that this may be difficult without getting marked as “different” by others. They expressed concerns about how families would react and also about the speed at which gossip about their mental health would spread across the school. Those who were struggling with mental health generally would not make a public post that could get read by anyone, but rather would make posts that were targeted toward a narrow set of close friends they could trust. An in-person conversation was seen as more ideal but given that their schedules were often controlled by adults, this was not always an option. Social media was therefore a lifeline for some Latino adolescents who struggle with mental health.

This is an important and often overlooked point in discussions

about the relationship between social media and mental health among adolescents. I have participated in several high school events to provide expertise and answer families’ questions about social media and mental health, and too often I come across an assumption that social media only harms. Yes, it can cause harm, but it can also be beneficial, and this research on Latino adolescents helps drive home the point.

Given how common adolescents like themselves share mental health struggles on social media, we wanted to know how best to support them. We asked them who they would turn to if they were concerned about a friend who, based on their social media account, may be struggling with mental health. The logic here is that we wanted to get a picture of the current mental health resources available to them. To do this, we created a card sorting task. Each card represented something a friend of theirs could share that they are struggling with on social media. The content of the cards were items that are either wellbeing concerns – like self-harm – or issues that could escalate into wellbeing concerns, like getting into trouble with authorities like teachers and law enforcement.

At times, this was described as histrionic and driven solely by a need to attract attention, but they collectively understood a key barrier that Latino adolescents face: sometimes they have no one else to turn to. Mental health is a taboo topic among Latino communities, and so they felt that some of their peers may not feel comfortable going to their own families for help.

We asked the interviewees to separate the items into different piles: those they would tell an adult about and those they would not. We then asked them to discuss general rules guiding their decisions. Participants were asked via open-ended questions what adult they would tell and why, and also which ones they would not tell and why.

Parents and guardians were the most common choice for an adult they would tell. The interviewees recognized the instrumental support that these adults could provide, such as operating as gatekeepers to mental health care. They felt that if the friend needed access to a mental health professional, an adult like a parent or guardian would be the best choice for mediating access.

However, not every interviewee would turn to parents or guardians for help and several gave reasons for why they would avoid telling them. These included concerns that the post would not be taken seriously by the adult.



Others, particularly boys, were concerned that a parent or guardian would get angry and make the situation worse. What matters here is not whether the parents or guardians would actually respond this way, but that Latino adolescents are worried that they would, which then diminishes the likelihood that they would reach out to them in the first place.

My research team and I are grateful we were able to gather such rich data from Latino adolescents. We took several steps to gain access to the Latino community and engender trust, which was particularly important given the possibility that some adolescents or members of their families were undocumented. We collaborated with a non-profit organization, United Community Center, which serves the Latino community in Milwaukee, Wisconsin and regularly mediates access by researchers. Prior to data collection, they helped us convene a focus group of 10 Latino adolescents, which met at the organization, to provide feedback on our study design and assist in making our questions accessible. This step was important for understanding how best to talk about mental health in ways that limits viewing it as a taboo topic and stifling conversation. The focus group also helped us select the topics to be included in the card sorting task. We revised the study based on their feedback and recruited participants from a youth program run by the organization. The interviews were held in a quiet, private room located in the organization, during a time that the adolescent was already scheduled to participate in the youth program. Collaborating with this community organization was integral to our ability to address gaps in existing research by incorporating the experiences of Latino youth.

A focus on working with a specific community does raise questions about how well the findings generalize and depict broader patterns among adolescents. We were able to conduct two national surveys here in the U.S. to evaluate how well these findings from this specific community generalize. In the first survey, we recruited adolescents from across the U.S., creating a sample that is racially diverse. This allows us to examine the degree to which the patterns observed in the interviews are unique to Latino adolescents. It turns out they are quite unique. We gave survey respondents a scenario describing a friend who, based on their social media account, was likely experiencing depression and then asked them who they would turn to in order to help out their friend. The scenario was based on a standard text used in previous surveys, including the General Social Survey, to describe someone experiencing symptoms consistent with depression. We conducted cognitive interviews with adolescents to modify it in ways that aligned with their own expectations for how the scenario would unfold. We found that Latino adolescents were the least likely of any racial group to say they would turn to a parent or guardian. The concerns we found in the interview study, then, appear particularly salient for Latino adolescents across the U.S.

The second survey is of parents and guardians of adolescents in the U.S. We gave them a similar scenario, whereby we asked them to imagine their adolescent child came to them and said that, based on social media, they were

concerned about a friend. We asked them how likely they would help. Interestingly, we did not find any ethnoracial variation in the reported willingness to provide help. Indeed, everyone said they would be highly likely to help.

The results of these studies reveal a discrepancy, in which Latino adolescents think their parents and guardians would not help, but the parents and guardians are just as likely as everyone else to say they would help. The next step in this research program is to work with families to understand and address the source of these discrepancies, and so we are currently talking to various community organizations and are planning on prepping research proposals to develop materials to encourage communication among Latino families to address this issue, and better prepare parents and guardians for operating as gatekeepers to mental health care.

This trajectory of research papers would not have been possible without the initial input from the focus group comprised of Latino adolescents that my research team and I held at the United Community Center to gather input on the design of the interview study. A recent review of research on adolescents found that only 1 out of 8 studies bothered to ask adolescents about their input on research into their lives. Gathering their input is critical to ensure researchers identify ways to approach taboo topics like mental health. Moreover, given the speed at which technologies change, it is important to also learn from them about the most recent ways they use technologies.

To address the dearth of research conducted with their perspectives, my collaborators and I have recently founded a youth advisory board, which is like a standing focus group that will provide input on various research projects. The board is currently known as the Milwaukee Youth Wellness Initiative on Technology (MYWIT). We purposely recruited adolescents from communities of color to join as youth advisors. Currently, MYWIT is comprised of 6 youth advisors (one who identifies as Asian, three who identify as Black, and two who identify as Latino), who have committed to participate for 12 months. In exchange for their input, we are providing them with a stipend and several professional development opportunities, including writing an editorial about their thoughts on the link between social media use and mental health. We also have plans and funding to invite professionals from communities of color to speak with them and share their own experiences navigating college and careers.

MYWIT meets virtually to make it easier for the youth advisors to fit meetings into their schedules throughout the year. This of course introduces a barrier, in that some potential youth advisors may steer away from this opportunity because they do not have access to high-speed internet or an internet-enabled device. Thankfully, we have funding to provide these to any youth advisors in need.

MYWIT is currently providing feedback on the design of a new research study that is funded by Meta, in which we are examining how best to design a chatbot that identifies when adolescents experience bullying on social media and deploys

Latino Patients: Where are the Latino Doctors?

By Yoshira Donaji Macías Mejía

Access to medical professionals is a tremendous problem, which has been exacerbated by the Coronavirus pandemic. This shortage is especially noticeable when examining racial and ethnic minority physicians, who already make a small percentage of the total physician population. According to recent data available from the Association of American Medical Colleges (AAMC) in 2019, 56% of physicians are White, followed by 17% who are Asian, 14% are unknown, 6% Hispanic/Latino, 5% are Black, 1% is multiple races, and 1% are other¹. The data highlight racial and ethnic disparities that exist within the medical community and show that White physicians dominate the medical field. Blacks and Latinos are largely underrepresented in the medical profession. The low percentages of these two groups in the medical field create many problems for patients seeking care, but this is particularly alarming for the Latino population.

Historically researchers state, the medical profession has not been welcoming to racial and ethnic minorities in the United States. Obstacles have been placed to prevent the admittance and matriculation of Blacks and Latinos in the medical profession. Historical accounts find that for Blacks in America it was difficult to break into the medical profession due to slavery and eugenics, which views Blacks intellectually inferior to Whites. Even with these institutional and structural barriers Blacks came together as a community to provide healthcare access to other Blacks. Latinos have faced similar experiences of exclusion because of racial classifications in America. Several Latinos and Latinas were not admitted to medical schools, similarly to Blacks, and were barred from practicing medicine. Latinos also worked tremendously, similarly to Blacks, as a community

1. Percentages are rounded up.

to provide care for underserved Latinos. But the greatest barrier was the existing and dominant racial hierarchy, which places structural and institutional barriers on groups, such as Blacks and Latinos from entering the medical field. These barriers unfortunately are still present in modern day America.

As of 2022, Latinos are the largest underrepresented minority group in the United States and still face several obstacles to medical care. Some obstacles are the lack of Latino physicians that can cater to the Spanish language needs of this population. Studies in the medical field suggest that having doctors who come from the same background is beneficial for patients. Having access to Latino doctors can provide adequate care for Latinos through cultural awareness and language proficiency. Latino doctors that speak Spanish benefit Latino patients because they can establish trust with their patients, can explain medical results or procedures in the patients preferred/dominant language to better communicate steps to treat a disease or to maintain existing good health, explain medical issues, etc. When Latino patients are faced with doctors who do not speak Spanish, they are less likely to trust their medical care because they do not know if the translations given by medical staff are accurate or they are not sure the medical staff is relaying all their concerns to the doctor. Having a Spanish speaking doctor promotes trust can push Latinos to seek medical care.


Latino doctors bring with them cultural knowledge of the Latino community. This is especially useful because they can best treat their patients based on their cultural needs. One example is obesity. Many diets to help treat obesity in the United States are based on an American diet and do not cater to other cultural groups. This makes it more difficult when treating obesity among the Latino community. With a Latino doctor, patients can have better access to tailored care with diets, such as telling patients to swap flour tortillas for corn or whole grain or the types of rice that are eaten, etc. Latino doctors can discuss with their patients how to cook their cultural foods to make them more nutritiously dense. An understanding of cultural mores and stressors can also minimize the misdiagnosis of mental health issues that may be related to cultural experiences or stressors of adapting to a society where Latino culture is undervalued and misunderstood. These are just some examples of how culture matters when treating Latino patients.

Other dimensions of health surrounding the importance of Latino doctors is biases in care. Studies suggest that Latinos received less preferential treatment from White doctors due primarily from a lack of understanding of Latino patients' culture, language, among other things. This poor treatment is not only faced by Latinos, but by other non-Whites, which increases health disparities among non-White patients. Some examples include the lack of pain management among Latino patients. Latinos often received lower doses or do not receive any doses of pain medication because their pain is not taken seriously by White doctors. Additionally, Latino patients in prior studies also face misdiagnosis in the mental health sphere. One study comparing the mental health diagnosis of Latinos when compared to non-

Latinos found that Latinos were less likely to receive an adequate mental diagnosis, which led to inadequate treatment. These issues with negative quality of care persist even when accounting for socioeconomic status and health insurance status. This demonstrates how important having Latino doctors is for the Latino community and for improving their health outcomes.

These shortages of Latino doctors are faced across the country, but especially in states with large Latino populations. One study found that in California, Latino physicians have a caseload of 55 percent Latino patients when compared to 22 percent of non-Latino patients. This shows that Latino doctors are in demand and needed for patient health.

Current health policies have increased the attention and need for Latino doctors. For instance, the passage of the Affordable Care Act in 2010 (ACA) allowed for an increased funding for qualified health centers and providers, created health insurance exchanges, Accountable Care Organizations, and reductions in hospital readmissions. By increasing funding for health centers and providers the ACA has expanded healthcare access to vulnerable populations, which greatly impacts Latinos who are vulnerable because of lower SES status, but also due to lack of citizenship status. These community health centers have had to adapt by providing care for undocumented Latinos, non-English speaking Latinos, and created care surrounding the Latino cultural experience. Additionally, the ACA is aimed at preventative care, which reduces health care costs, with an increase of Latino Spanish speaking doctors there can be an increase of Latino patients that seek medical care because there is an increase in trust and comfort that someone who speaks their language and understand their needs is treating them. This is why Latino doctors are imperative for creating a healthy Latino community.

Lastly, the UCLA Latino Public Policy Institute (LPPPI), as well as a scholarly study by Daar et al. (2018), identify several steps that can be taken to increase the number of Latino doctors. Identified areas of focus include: 1) increasing the number of Latino students admitted to medical school, 2) retaining Latino medical graduates who attend medical schools out-of-state, 3) developing k-12 pipeline programs, 4) expanding the number of international medical graduates in CA, 5) expanding (California) medical programs, and 6) increasing the number of CA residency slots. Other steps not included in the UCLA study are allowing DACA recipients the opportunity to practice medicine because the members of these communities are more likely to go back to their communities to practice medicine, increasing the number of Latinos in academic medicine, and improve medical school curriculum to include programs aimed training physicians to work in underserved communities. While some of these recommendations are tailored to CA with the exception to the second study, these steps can still be applied to other states to increase and retain Latino doctors. Thus, this can be the beginning of a healthier future for Latinos in the United States. 

COVID-19's Impact on Texas-Mexican Musical Community in the Midwest

By Richard Cruz Dávila

As COVID-19 lockdowns went into effect across the United States in the spring of 2020, one of many industries disrupted was the live music industry. Tours and festivals were postponed or canceled and many performance venues, forced to close their doors, did not recover from the lost revenue. Performers and fans alike had to adapt to experiencing live music through streaming services, performers separated from audiences and audience members separated from one another, inhibiting the communal spirit that often marks the live musical experience. These socioeconomic

and communal impacts of the pandemic have been deeply felt by the Tejano music industry, both in its native Texas and in Tejano diasporic communities in places such as the Midwest. This article focuses on the impact of COVID-19 on Tejano musical communities in the Midwest, where Texas-Mexican music has historically played a key role in Tejano placemaking and community cohesion and sustainability.

On March 5th, 2020, as the novel coronavirus was in the earliest stages of community spread in the United States, the Texas Talent Musicians Association (TTMA), the organization behind the annual Tejano Music Awards FanFair festival, announced that the 2020 festival would go on as planned from March 12th-15th in San Antonio's Market Square. By March



PHOTO BY LEONARDO MANJARREZ / PEXELS.COM

11th, the same day that the World Health Organization declared COVID-19 a pandemic, around 30 acts scheduled to perform or appear at Fan Fair had canceled their appearances due to COVID concerns. The festival still began on March 12th as planned, but on March 13th, the same day the U.S. government declared a national emergency, San Antonio city officials declared a health emergency that prohibited gatherings of over 500 people, forcing TTMA to cancel the remainder of the festival. In 2021, the event, which typically draws crowds of over 100,000 people from across the U.S. each year, was postponed from March to July of that year, and finally returned to its regular March dates in 2022. One of the largest celebrations of Tejano music, a Texas-Mexican regional style that traces its origins to the early 1900s, these disruptions were a major economic setback for vendors and others who rely on the festival for a significant portion of their annual income, as well as a cultural loss for Tejana/os across the nation who flock to the festival each year to celebrate through music a shared sense of identity and community.

Searches for “coronavirus” and “COVID” on the Tejano-focused entertainment news website *Tejano Nation* further detail losses experienced within the Tejano music industry over the course of the pandemic. These include many canceled or postponed concerts, tours, festivals, and awards shows due to coronavirus concerns and public health orders, as well as in some cases performers testing positive for COVID-19. The website has also reported on multiple hospitalizations of Tejano musicians due to COVID infections, and, sadly, on numerous deaths from COVID or COVID-related complications. The first of twelve such notices, posted to *Tejano Nation* on July 3rd, 2020, reported the passing of Joe Gonzalez, lead vocalist of El Dorado Band and veteran of multiple other San Antonio-based groups. Most recently, on January 22nd, 2022, the site reported the passing of Chris Gonzalez, founder, vocalist, and guitarist of the San Antonio band Grupo Cielo, who was only 38 years old at the time of his passing. These reports demonstrate the enormous economic and human cost of the pandemic within Tejano communities.

More locally, Tejano communities and the Tejano music industry in the Midwest have also been deeply impacted by the pandemic in a variety of ways. Though the happenings of the industry in the Midwest rarely make it onto Texas-centric *Tejano Nation*, in my own ongoing research on Texas-Mexican music in the Midwest numerous interviewees have spoken about the impact of COVID on the community and, in multiple cases, their own experiences of COVID infections. While I am not aware of any musicians active before the start of the pandemic who have since died of COVID, infections have been common. For instance, a vocalist from Northwest Ohio noted that the symptoms of her COVID infection was both severe and long-lasting. Though her infection has now passed, the severity of her illness has left her unable to sing for extended periods of time, which significantly delayed completion of several songs she was in the process of recording prior to her infection. Before the pandemic, she had been building a name for herself through the release of a string of well received digital singles. This momentum was brought to a

halt by her illness, which is a major setback in an industry with a short attention span, especially for a Midwestern artist trying to both build a local following and break into the market in Texas.

Beyond the prevalence of infections, many of the COVID-related disruptions in Midwest Tejano music mirror those in Texas. For example, on March 13th, 2020, the same day that the City of San Antonio banned gatherings of over 500 people and TTMA was forced to cancel the remainder of FanFair, Governor Gretchen Whitmer banned gatherings of over 250 people and, on March 17th, further restricted gatherings to 50 people or fewer. As in Texas, this inevitably led Tejano promoters and bands to cancel or postpone concerts, tours, and festivals. Likewise, the few remaining Tejano clubs in the Midwest, such as the Blue Diamond in Southwest Detroit, which hosts live bands every Saturday, were hard hit by COVID lockdowns and have struggled to return to pre-pandemic attendance levels. Producer and promoter Rudy Peña attributes this partially to the fact that these venues tend to attract older crowds and many older people have been reluctant to resume certain activities out of ongoing COVID concerns. Peña notes that the dances he promotes have also not returned to pre-pandemic attendance levels. While he is certain that this shift is in part COVID-related, he is uncertain if it is also related to moving his events from Saginaw, Michigan, where he says pre-pandemic dances were packed, to Flint, where attendance has been more limited.

Compared to Texas, though, disruptions caused by COVID present unique challenges for the Tejano music industry and Tejano communities in the Midwest. Whereas the industry in Texas has remained vibrant into the 21st Century, economic shifts and changing migration patterns have led to a precipitous decline in musical activity in the Midwest since the 1990s. Thus, the economic and cultural impacts of the pandemic have only exacerbated existing challenges to the sustainability of Tejano musical community in the Midwest. In Saginaw, for instance, the annual Midwest Tejano Music Festival, organized by Louie Garcia of Midwest Tejano Radio, was canceled in 2020 due to COVID concerns and has yet to resume. In 2019, the sixth year of the festival, a crowd of around 200 gathered at the Huntington Event Park in downtown Saginaw to dance to acts from Saginaw, Lansing, and Adrian, Michigan, as well as a homecoming performance from Miguel Hernandez, a Detroit native who relocated to Texas to be closer to the heart of the Tejano industry. The loss of events such as the Midwest Tejano Music Festival are significant because, unlike many Tejano dances held in clubs or rented halls across the Midwest that tend to draw older crowds, festivals, many of which are free to attend, tend to draw more mixed crowds. These events are one of increasingly few opportunities for younger generations of Tejanos in the Midwest, many of whom have largely assimilated into the dominant culture, to be exposed to the cultural traditions that have historically held Midwestern Tejano communities together. Though it is too early to understand the long-term impacts of the pandemic on the economic and cultural vitality of these communities, they will no doubt be significant. 🌱

Racial/Ethnic and Socioeconomic Disparities in Health

By Jean Kayitsinga, Ph.D.

INTRODUCTION

Racial/ethnic and socioeconomic differences in health have persisted in the United States. Recent mortality data provide a glimpse of health status in the United States. The age-adjusted death rate in 2018 was highest among African Americans (892.6 per 100,000 population), followed by American Indian and Alaska Natives (AIAN) (790.8 per 100,000 population), Whites (748.7 deaths per 100,000 population), Native Hawaiian and Pacific Islanders (NHOPI) (675.7 per 100,000 population), Latinos (524.1 per 100,000 population), and Asians (381.2 per 100,000 population). The age-adjusted mortality rate was higher for males than for females in each racial/ethnic group. The highest age-adjusted mortality rate was highest among African American males (1,102.8 per 100,000 population) (Murphy et al., 2021).

In 2019, life expectancy at birth was 78.8 years in the United States. The Asian population had the highest life expectancy at birth (85.6 years), with an advantage of 3.7 years over the Latino population (81.9 years), 6.8 years over the White population (78.8 years), 10.8 years over the African American population (74.8 years), and 13.8 years over the American Indian and Alaska Native population (AIAN)

(71.8 years) (Aries E and Xu JQ, 2022). Life expectancy at birth varies significantly by gender and race/ethnicity. In 2019, Asian females had the highest life expectancy at birth (87.4 years), followed by Latinas (84.4 years), Asian males (83.5 years), White females (81.3 years), Latino males (79.1 years), Black/African American females (78.1 years), White males (76.3 years), AIAN females (75.0 years), African American males (71.3 years, and AIAN males (68.6 years) (Aries E and Xu JQ, 2022).

There is significant variation across racial/ethnic groups in the top 10 leading causes of death in 2018. Heart disease was the first leading cause of death for White, African American, AIAN, and Native Hawaiian and Other Pacific Islander (NHOPI) populations, but it was the second leading cause for Asian and Latino populations. Cancer was the first leading cause of death for Asian and Latino populations, but it was the second leading cause for White, African American, AIAN, and NHOPI populations. Unintentional injuries, stroke, diabetes, and kidney disease also ranked among the top 10 causes of death for each racial/ethnic group (Heron, 2021).

What has been consistent for much research regarding the relationship between race/ethnicity and health is that African Americans have higher mortality and poorer health status than does any other groups, as do

Native Americans. Mortality rates are also higher for Whites than for Latinos or Asians, although relative mortality varies for



specific causes of death (Adler and Rehkopf, 2008; Singh and Hiatt, 2006; Williams et al., 2010). A large body of research and reviews also show that socioeconomic status (SES) remains a fundamental cause of health disparities. Individuals at higher SES tend to do better on most measures of health than their lower SES counterparts (Lynch and Kaplan, 2000; Braverman et. al., 2010; Williams and Collins, 2016). Although SES often account for a large part of racial/ethnic differences in health, racial/ethnic disparities in health persist (Kayitsinga and Martinez, 2008; Adler and Rehkopf, 2008; Williams, 1999; Williams, Priest, and Anderson, 2016).

This study is important for policymakers and scholars to understand and highlight the continued and persistent racial/ethnic and SES disparities in health in the United States. The main objective of this study is to determine the main, relative, and combined influences of race/ethnicity and SES on the health status of adults in the United States. This study addresses three main questions: (1) What is the influence of race/ethnicity on health? (2) What is the influence of SES on health? and (3) To what extent does SES explain racial/ethnic disparities in health?

BACKGROUND

RACE/ETHNICITY AND HEALTH

A large body of research highlights racial/ethnic differences in health (Williams and Collins, 1995; Williams and Sternthal, 2010). Williams and Sternthal (2010) showed that the racial gap in health is large and persistent overtime. Race/ethnicity is a socially constructed category that has a tremendous effect on health. Factors such as racism, segregation, discrimination, and lack of better economic opportunities, create social and spatial contexts that may expose individuals to poor health conditions and death. There is mounting evidence that racism adversely affects health through multiple mechanisms (Williams and Mohammed, 2013; Williams and Mohammed, 2009). Racism, in both its institutional and individual forms, remains an important determinant of racial/ethnic disparities in health (Williams, 2012).

Williams and Collins (2016) argue that racial residential segregation is a fundamental cause of racial disparities in health. Using the example of African American segregation, they argue that the physical separation of the races by enforced residence in certain areas is an institutional mechanism of racism that was designed to protect whites from social integration with African Americans. Despite its legal nature, residential segregation remains extremely high for most African Americans in the United States. They also show that segregation is the primary cause of racial differences in SES by determining access to education and employment opportunities.

For Latinos, especially those of Mexican background, it remains a paradox why they exhibit better health than Whites despite having lower levels of SES and relatively lower levels of access to health insurance in the United States (Markides and Eschbach, 2005). What has been evident is that newly arrived immigrants exhibit better health than similar natives do, and immigrants' health advantage deteriorates with increasing duration in the

U.S. and greater levels of acculturation (Cho et al., 2004; Hummer et al., 2007). The rationale is that the longer immigrants stay in the U.S. the greater the likelihood of losing their traditional lifestyle, which buffers against unhealthful behaviors. There is some evidence that second generation Latinos have poorer health than Latino immigrants despite having higher levels of SES than their first-generation peers (Collins et al., 2001).

SOCIOECONOMIC STATUS (SES) AND HEALTH

Another social construct that captures differential exposure to conditions of life that have health consequences is SES. A large body of research evidence shows that SES remains a fundamental cause of health disparities (Williams and Collins, 2016). Individuals at higher SES do better on most measures of health than their lower SES counterparts (Lynch and Kaplan, 2000; House, 2000; Braverman et. al., 2010). Braverman and colleagues (2010) show that individuals with the lowest income and who were least educated were consistently unhealthy, but for most indicators, even groups with intermediate income and education levels were less healthy than the wealthiest and most educated. They showed that gradient patterns were seen often among African Americans and Whites, but less consistent among Latinos.

The pathways through which SES affects individuals' health include exposure to both health-damaging conditions and health-protecting resources (Adler and Rehkopf, 2008). Some exposures have direct effects on health, while others influence psychosocial and behavioral factors such as cognition and emotion (e.g., depression, hopelessness, hostility, and lack of control) and behaviors (e.g., use of cigarettes, alcohol, and other substances) (Adler and Rehkopf, 2008). Health-damaging exposures include early life conditions, inadequate nutrition, poor housing, exposure to lead and other toxins, inadequate health care, unsafe working conditions, uncontrollable stressors, social exclusion, and discrimination (Adler and Rehkopf, 2008; Williams and Collins, 1995).

Living in disadvantaged neighborhoods also expose individuals to greater uncertainty, conflict, and threats for which there are often inadequate resources to respond effectively. These experiences accumulate to create chronic stress among individuals subjected to prolonged exposure to such conditions (Adler and Rehkopf, 2008). Poor and low-income individuals are disadvantaged with respect to lifestyles, as they are more likely to engage in unhealthy behaviors such as smoking, unhealthy eating and drinking practices, and lower levels of physical activity across adulthood (Cockerham, 2005). In contrast, the upper and middle classes tend to adopt healthier lifestyles by engaging in leisure-time sports and exercise, healthier diets, moderate drinking, less smoking, more physical checkups by their physicians, and greater opportunities for rest, relaxation, and coping with stress (Cockerham, 2005; Robert and House, 2000; Snead and Cockerham, 2002).

INTERSECTION OF RACE/ETHNICITY AND SES AND HEALTH

Race/ethnicity and SES are interlinked and both influence conditions of life that have health consequences. SES accounts for a large part of racial/ethnic differences in health.



Nonetheless, racial/ethnic disparities in health persist (Kayitsinga and Martinez, 2008; Adler and Rehkopf, 2008; Williams, 1999; Williams, Priest, and Anderson, 2016). Williams and colleagues (2010) reviewed studies that show that differences in SES across racial groups are a major contributor to racial disparities in health. However, they add that race reflects multiple dimensions of social inequality and individual and household indicators of SES capture relevant but limited aspects of this phenomenon. Therefore, to understand the widening gaps in health status, one must look at the separate and combined effects of race/ethnicity and SES on health.

HYPOTHESIS

Because SES remains a fundamental cause of health disparities (Williams and Collins, 2016), this study hypothesizes that individuals with higher SES will likely report better health than their lower SES counterparts. This study further hypothesizes that SES will account for a large part of racial/ethnic differences in health, but racial/ethnic differences in health will remain. More specifically, this study hypothesizes that gaps in self-rated health are more likely to narrow among African Americans than Whites and among Asians than Whites but are likely to increase more among Mexicans and other Latinos than Whites once SES is taken into consideration. The intent of this paper is to estimate racial/ethnic differences in health, SES differences in health, and how much SES might contribute to racial/ethnic disparities in self-rated health.

DATA AND METHODS

DATA

Data are from the National Health Interview Survey (NHIS) in 2019 to 2021. The three years were merged together to provide enough sample size to assess racial/ethnic and socioeconomic status (SES) differences in health. The 2016–2025 NHIS sample design is a multi-stage probability sample of U.S. households with new households interviewed each year. The survey conducts household interviews throughout the United States (U.S.) and collects information on health status, health-related behaviors, and information on sociodemographic and economic characteristics, including race/ethnicity, gender, SES, and other household characteristics from the U.S. civilian non-institutionalized population. The NHIS interview begins by identifying everyone who usually lives or stays in the household. One adult aged 18 years and older and one child aged 17 years and younger are randomly selected for an interview. Information about the sample child is collected from a parent or adult who is knowledgeable about and responsible for the health care of the sample child.

Due to the COVID-19 pandemic, NHIS data collection in 2020 switched to a telephone-only mode beginning March 2020. Personal visits resumed in September 2020. In addition, from August through December 2020, a subsample of adult respondents who completed the NHIS in 2019 were re-interviewed by telephone and asked to participate again in the survey. The 2020

sample adult file is hence composed of both the re-interview cases and the 2020-sampled cases ($n = 31,568$). Adding the 2019 NHIS sample of 31,997 adult respondents, and the 2021 sample adults ($n = 29,482$), the 2019–2021 combined sample is composed of 93,047 adults age 18 years and older. This study uses data on 91,713 Latino, African American, Asian, and White respondents, excluding other races ($n = 2,334$ (2.5%).

MEASURES

Health. The dependent variable is self-rated health status. Self-rated health is measured with the question that captures the subjective measure of general health status: “Would you say your health in general is excellent, very good, good, fair, or poor?” Responses to the item were reverse coded so that higher values indicate better health: 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent. The reliability and validity of self-rated health is well established (Idler and Benyamini, 1997).

Race/ethnicity. Race/ethnicity is constructed from self-reported ethnicity and race categories. First, Latino adults are distinguished from non-Latino adults. Among Latinos, Mexicans are distinguished from Other Latinos. For non-Latinos, race is categorized as White, Black, Asian, or Other race categories. Other races include Native Americans and Alaska natives, and other single or multiple races. For this study, Other race groups are excluded in the analyses.

Socioeconomic status (SES). SES is measured by two variables: educational attainment and family income-to-poverty ratio (IPR). Educational attainment was measured in the number of years completed and was coded into four dummy variables: less than high school, high school diploma or equivalent, some college, and bachelor’s degree or higher (reference category). IPR is a categorical variable based on family income and poverty thresholds. IPR was coded into six dummy variables indicating percentages of family income to poverty ratio: less than 100, 100–149, 150–199, 200–299, 300–399, and 400 percent or more (reference group).

The following sociodemographic variables are controlled in all analyses: age (in years), gender (1 = female, 0 = male), immigrant (1 = foreign born, 0 = U.S. born), marital status (married (reference group), cohabiting, widowed, divorced/separated, and never married dummy variables (1 = yes, 0 = no)), employment status (1 = employed, 0 = not employed), housing ownership (1 = yes, 0 = no), length of residence in house/apartment (less than one year to 3 years, 4–10 years, and 10 years or more (reference group) dummy variables (1 = yes, 0 = no)), and residential location (1 = nonmetropolitan, 0 = metropolitan (reference group)). The following health-related variables are also controlled: weight status categories based on body mass index (BMI): underweight ($BMI < 18.5 \text{ kg/m}^2$), healthy weight ($18.5 \text{ kg/m}^2 \leq BMI < 25 \text{ kg/m}^2$) (reference group), overweight ($25 \text{ kg/m}^2 \leq BMI < 30 \text{ kg/m}^2$), and obese ($BMI \geq 30 \text{ kg/m}^2$) dummy variables (1 = yes, 0 = no), and smoking (three dummy variables indicating current smoker, former smoker, and never smoker (reference group)). Descriptive statistics (mean and standard errors) for variables used by race/ethnicity are presented in Table 1.

Table 1. Descriptive Results: Means (SE)/Percentages by Race/Ethnicity (Weighted)

Variables	All (n = 62,004)	Mexican (n = 4,478)	Other Latino (n = 3,399)	African American (n = 6,684)	Asian (n = 3,330)	White (n = 44,113)
Self-rated health (1 – 5)	3.65 (.007)	3.57 (.02)	3.65 (.02)	3.50 (.02)	3.83 (.02)	3.68 (.01)
Race/Ethnicity						
Mexican, %	9.90 (.52)					
Other Latino, %	6.70 (.34)					
African American, %	11.67 (.42)					
Asian, %	6.01 (.26)					
White, %	65.53 (.76)					
Age (18 – 85)	48.06 (.13)	41.19 (.34)	43.75 (.38)	45.78 (.27)	45.74 (.42)	50.24 (.16)
Female, %	51.09 (.24)	51.00 (.87)	51.53 (1.05)	55.12 (.73)	51.88 (.96)	50.27 (.28)
Foreign born, %	7.99 (.26)	32.53 (1.03)	25.94 (1.01)	4.35 (.40)	27.02 (1.03)	1.37 (.07)
Educational attainment						
Less than high school, %	10.80 (.27)	32.43 (1.05)	19.59 (1.05)	12.43 (.64)	8.61 (.78)	6.56 (.19)
High school, %	27.84 (.31)	31.62 (.91)	28.79 (.97)	33.53 (.80)	17.08 (.97)	27.14 (.37)
Some college, %	29.35 (.28)	24.30 (.71)	28.26 (.89)	31.57 (.71)	20.21 (.86)	30.67 (.34)
College or higher, %	31.94 (.41)	11.65 (.51)	23.35 (.81)	22.45 (.70)	54.10 (1.30)	35.63 (.47)
Income-to-poverty ratio						
Less than 100%, %	9.76 (.22)	17.55 (1.01)	16.39 (.83)	17.92 (.68)	8.76 (.60)	6.56 (.18)
100 – 149%, %	8.89 (.17)	16.39 (.83)	13.61 (.67)	13.92 (.56)	8.39 (.63)	6.44 (.16)
150 – 199%, %	8.91 (.16)	14.12 (.54)	11.79 (.66)	11.44 (.46)	7.72 (.57)	7.49 (.16)
200 – 299%, %	16.60 (.20)	21.40 (.70)	19.26 (.74)	19.12 (.61)	15.12 (.76)	15.30 (.22)
300 – 399%, %	13.65 (.17)	11.56 (.52)	12.67 (.63)	12.78 (.49)	12.04 (.63)	14.37 (.20)
400% or greater, %	42.07 (.44)	19.05 (.85)	26.28 (.89)	24.83 (.82)	47.97 (1.35)	49.84 (.48)
Marital status						
Married, %	52.50 (.29)	43.34 (.86)	48.68 (1.00)	33.12 (.76)	62.89 (.93)	56.16 (.33)
Cohabiting, %	8.47 (.15)	11.24 (.56)	10.65 (.65)	8.42 (.18)	3.78 (.36)	8.42 (.18)
Widowed, %	5.89 (.10)	3.31 (.28)	3.61 (.32)	6.43 (.30)	4.12 (.35)	6.58 (.12)
Divorced/Separated, %	10.16 (.13)	9.03 (.44)	12.21 (.53)	13.79 (.41)	5.07 (.42)	9.94 (.15)
Never married, %	22.87 (.26)	28.08 (.74)	24.85 (.91)	39.47 (.73)	24.13 (.85)	18.90 (.28)
Employed, %	62.94 (.29)	68.60 (.90)	66.71 (1.02)	60.12 (.81)	64.90 (.99)	62.02 (.34)
Homeowner, %	68.47 (.39)	57.63 (1.21)	50.34 (1.30)	47.52 (.99)	64.82 (1.10)	76.01 (.35)
Length time of residence						
Less than 3 years	34.59 (.33)	36.42 (.94)	43.08 (1.15)	40.91 (.86)	39.25 (1.18)	31.89 (.34)
4 -10 years	25.07 (.22)	28.62 (.75)	27.38 (.88)	24.98 (.65)	29.14 (.97)	23.95 (.24)
11 years or more	40.28 (.33)	34.96 (1.07)	29.54 (1.09)	34.11 (.88)	31.60 (1.09)	44.15 (.37)
Weight status						
Underweight, %	1.59 (.06)	.93 (.14)	1.22 (.20)	1.02 (.13)	3.59 (.30)	1.65 (.07)
Healthy weight, %	31.62 (.27)	22.96 (.75)	28.14 (.90)	23.10 (.64)	54.32 (1.02)	32.64 (.31)
Overweight, %	34.00 (.22)	36.76 (.75)	36.64 (.96)	31.86 (.69)	31.53 (.94)	33.92 (.25)
Obese, %	32.84 (.28)	39.35 (.87)	34.00 (.96)	44.01 (.74)	10.56 (.66)	31.79 (.32)
Current smoker, %	12.50 (.19)	7.70 (.43)	8.491 (.50)	13.79 (.54)	6.94 (.55)	13.91 (.23)
Former smoker, %	22.97 (.23)	14.80 (.53)	16.18 (.65)	13.48 (.46)	12.26 (.57)	27.55 (.28)
Never smoker, %	64.79 (.32)	77.66 (.66)	75.95 (.70)	73.11 (.67)	81.14 (.79)	58.59 (.37)
No health insurance, %	10.41 (.25)	29.34 (1.10)	20.51 (.96)	11.74 (.56)	6.14 (.54)	6.68 (.19)
Nonmetropolitan, %	13.75 (.54)	7.46 (1.94)	2.63 (.39)	8.69 (1.29)	2.23 (.54)	17.78 (.76)



ANALYTICAL PLAN

The analysis proceeds in four steps. First, descriptive statistics of health differences by race/ethnicity are presented. Second, descriptive statistics of health differences by different dimensions of SES are presented. Third, regression models of health status are estimated to highlight the relative and combined influences of race/ethnicity, SES, and control variables. Finally, interaction terms between racial and ethnicity and SES are added to the final model to better estimate racial/ethnic differences in health that may be attributed to racial/ethnic differences in SES. To account for the NHIS sampling design, all analyses are weighted using the final annual sampling weights (WTFA_A). Both weights were divided by 3 to produce correct population estimates in the pooled analysis. Point estimates and estimates of their variances were calculated using STATA 15.1 software to account for the complex sampling design of NHIS, considering stratum and sampling unit identifiers. The Taylor series linearization was chosen for variance estimation.

RESULTS

DESCRIPTIVE ANALYSIS

Figure 1 displays mean self-rated health by race/ethnicity. The results show that Mexicans and African Americans have on average lower health than Whites whereas Asians exhibit higher average health than Whites. There was no significant difference between the average health of Other Latinos and that of Whites (Figure 1). Figure 2 displays self-rated health by educational attainment. As expected, education is positively associated with self-rated health. The mean health among college-educated adults is significantly higher than the mean health among adults with less than a high school, high school or equivalent, and some college education, respectively (figure 2). Figure 3 displays self-rated health by family income-to-poverty ratio (IPR). As expected also, income-to-poverty ratio is positively associated with self-rated health. Adults in poverty (< 100% IPR) have significantly lower mean health than those at the end of the income spectrum ($\geq 400\%$ IPR) (figure 3). Table 1 presents summary statistics for all variables in the analysis by race/ethnicity.

MULTIVARIATE ANALYSIS

Table 2 shows odds ratios for self-rated health by race/ethnicity from ordered logistic regression models. The results in model 1 (table 2) show that there are significant racial/ethnic differences in self-rated health. The odds of reporting excellent health decreases 19 percent (i.e., $[(1 - .810) \times 100]$ more for Mexicans and 27 percent more for African Americans than for Whites, respectively. In contrast, the odds of reporting excellent health increases 26 percent (i.e., $[(1.26 - 1) \times 100]$ more for Asians than for Whites. The main effects of race/ethnicity in subsequent models in table 2 reflect the baseline model of the self-rated health differences between Latinos, African Americans, and Asians and Whites. Other covariates in table 2 can be interpreted in the same way that conventional ordered logistic regression models are interpreted. Exponentiation of the values for intercept 1 – 4

Figure 1. Self-Rated Health by Race/Ethnicity, 2019 – 2021

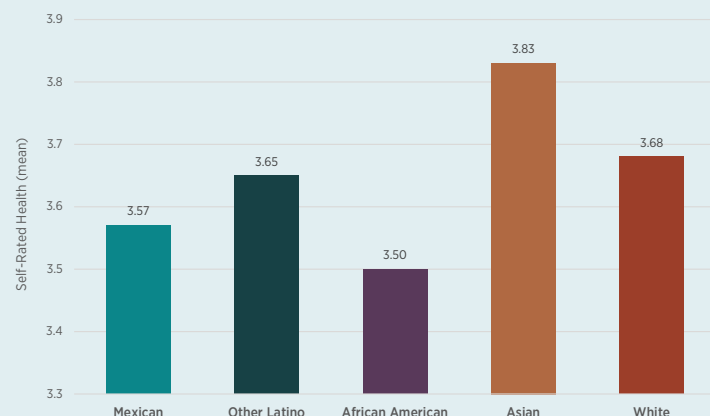


Figure 2. Self-Rated Health by Educational Attainment, 2019 – 2021

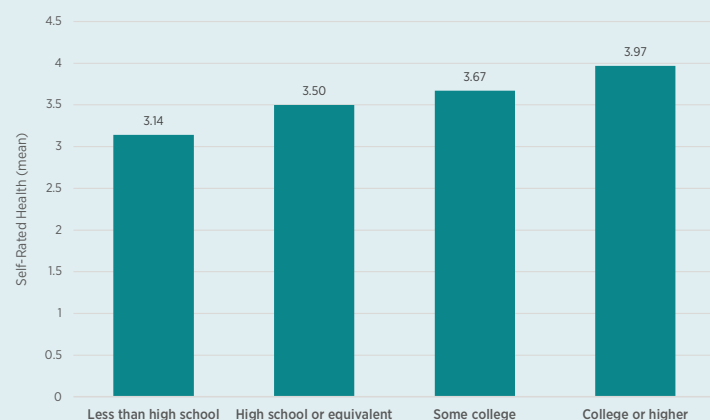


Figure 3. Self-Rated Health by Family Income-to-Poverty Ratio (IPR), 2019 – 2021

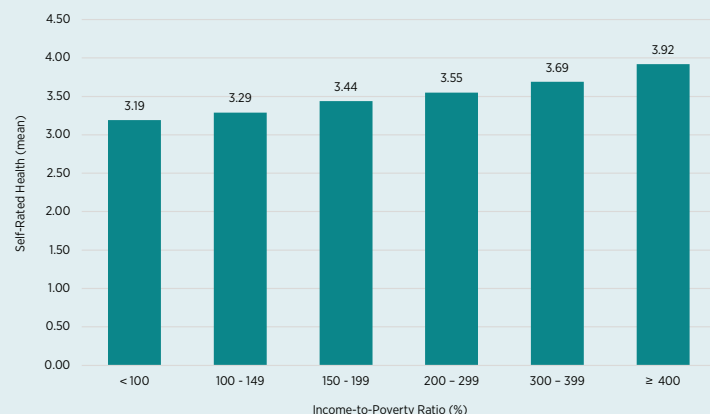


Table 2. Ordered Logistic Regression Models (odds ratios) of Self-Rated Health on Race/Ethnicity and Socioeconomic Status, 2019 - 2021

	Model 1	Model 2	Model 3	Model 4	Model 5
Race/Ethnicity (0 = white)					
Mexican	.810***	1.198***	1.370***	.873***	.688***
Other Latino	.957	1.172***	1.336***	.963	.928
African American	.726***	.834***	.970	.889***	.745***
Asian	1.260***	1.156***	1.236***	.787***	.736***
Educational attainment (0 = college graduate)					
Less than high school		.224***	.333***	.471***	.461***
High school		.444***	.562***	.689***	.665***
Some college		.598***	.698***	.787***	.779***
Income-to-poverty ratio (IPR) (0 = 400% or greater)					
Less than 100%			.395***	.463***	.435***
100 – 149%			.457***	.534***	.490***
150 – 199%			.564***	.661***	.647***
200 – 299%			.632***	.694***	.681***
300 – 399%			.748***	.800***	.785***
Control variables					
Age (in years)				.974***	.974***
Female				.997	.999
Foreign born				1.122**	1.109**
Marital status (0 = married)					
Cohabiting				.818***	.830***
Widowed				1.056	1.060
Divorced/Separated				.866***	.871***
Never married				.919**	.921**
Employed				1.570***	1.569***
Homeowner				1.127***	1.130***
Time of residence (0 = > 10 years)					
Less than 3 years				.922***	.922***
4 -10 years				.923***	.923***
Weight status (0 = healthy weight)					
Underweight				.635***	.631***
Overweight				.726***	.728***
Obese				.346***	.346***
Smoking (0 = Never smoker)					
Current smoker				.482***	.486***
Former smoker				.720***	.721***
Nonmetropolitan				.912**	.918**
Interaction terms					
Mexican x less than high school					1.366**
Mexican x high school					1.419***
Mexican x some college					1.259*
Other Latino x high school					1.226*
African American x less than 100% IPR					1.283*
African American x 100 - 149% IPR					1.556***
African American x 150 – 199% IPR					1.229*
African American x 200 – 299% IPR					1.225*
African American x 300 – 399% IPR					1.260**
Asian x less than 100% IPR					1.639***
Asian x 100 - 149% IPR					1.398**
Intercept 1	-3.454	-4.036	-4.210	-6.089	-6.118
Intercept 2	-1.861	-2.409	-2.566	-4.355	-4.383
Intercept 3	-.387	-.870	-.997	-2.601	-2.628
Intercept 4	1.091	.669	.665	-.836	-.861
Model fit/F test	F(4, 602) = 46.05***	F(7, 599) = 378.44***	F(12, 594) = 278.87***	F(29, 576) = 426.68***	F(40, 565) = 308.73***

Two-tailed tests: *** p < .001; ** p < .01; * p < .05.



represents the odds of reporting different levels of health status for the reference group.

Next, model 2 adds educational attainment as one of the covariates to determine how education contributes to differences in self-rated health by race/ethnicity. A comparison of models 1 and 2 shows that controlling for respondent's education results in substantial change in self-rated health by race/ethnicity. These results suggest that racial/ethnic differences in education partially explain differences in self-rated health between Latino, African American, and Asian racial/ethnic groups and Whites. Specifically, the odds ratios of excellent health for Mexicans increases more by 20 percent, 17 percent for Other Latinos, and 16 percent more for Asians than for Whites, respectively, net of the effects of educational attainment on self-rated health. In contrast, the odds of excellent health for African Americans decreases 17 percent more than Whites, net of the effects of educational attainment on self-rated health. The results in model 2 also show that the odds ratios of excellent health for adults with less than a high school education decreases 78 percent more, 56 percent more for adults with a high school diploma or equivalent, and 40 percent more for adults with some college education than for adults with a college degree or higher, respectively.

Model 3 (table 2) adds another SES measure: the income-to-poverty ratio to see if it too explains racial/ethnic differences in health. The results suggest that adding income-to-poverty ratio results in substantially change in self-rated health by race/ethnicity. The odds ratios of excellent health increases 37 percent more for Mexicans, 34 percent more for Other Latinos, and 24 percent more for Asians than Whites, respectively, net of the effects of both educational attainment and income-to-poverty ratio on health. The odds of excellent health for African Americans further decreases and become not significantly different from those of Whites once the effects of education and income-to-poverty ratio are taken into consideration in model 3 of Table 2. As expected, the results in model 3 show that the odds ratios of excellent health incrementally decrease as income-to-poverty ratio increases, i.e., as one moves from poverty and lower class to middle and then upper classes. More specifically, the odds of excellent health decreases 60 percent more for adults in poverty (IPR < 100%), 54 percent more for adults with IPR between 100 – 149 percent (i.e., those near poverty), 44 percent for those with IPR between 150 and 199 percent, 37 percent more for IPR between 200 – 299 percent, and 25 percent more for adults with 300 – 399 percent than adults with IPR greater or equal to 400 percent, respectively, net of the effects of race/ethnicity and educational attainment. Educational attainment also remains negatively associated with self-rated health.

Estimated effects of all the other covariates, displayed in model 4 (Table 2), are in the expected direction. Specifically, the odds of reporting excellent health decline with age, and they are smaller for cohabiting, divorced/separated, and never married compared to married adults. They are also lower for adults who had resided in their homes/apartments for less than 10 years compared to those who resided in their homes more than ten

years. They are also lower for adults who were underweight, overweight, and obese compared to those with a healthy weight status. They are also lower for current smokers and former smokers compared to never smokers, and those residing in nonmetropolitan areas compared to those in metropolitan areas. In contrast, the odds of reporting excellent health were higher for adults currently employed compared to those not employed and not working, and higher for homeowners compared to renters.



RACE/ETHNICITY AND SES VARIATIONS IN SELF-RATED HEALTH

Model 5 (Table 2) adds interaction terms between race/ethnicity and education, and between race/ethnicity and income-to-poverty ratio. The odds of reporting excellent health remain smaller for Mexicans, African Americans, and Asians than those of Whites, net of the effects of other covariates in the model. The odds of reporting excellent health remain significantly lower for respondents with lower levels of education and lower income-to-poverty ratios. Only significant interaction terms ($p < .05$) were retained in the final model. To illustrate the results in model 5, figure 4 displays the estimated predicted probability of reporting excellent health by educational attainment and race/ethnicity, whereas figure 5 displays the estimated predicted probability of reporting excellent health by income-to-poverty ratio and race/ethnicity. The results show that the probability of reporting excellent health increased rapidly by education levels among whites, followed by other Latinos, African Americans, and Asians while it increased at a fairly rapid and almost a

constant rate among Mexicans, leading to an increasing gap in self-rated health between Mexicans and Whites. The probability of reporting excellent health for African Americans and Asians significantly increased as education increases. Nonetheless, gaps in self-rated health between African Americans and Whites, and between Asians and Whites slightly increase as education levels increase, leading to larger gaps for those with college education or more than those with less than high school education (Figure 5).

Figure 4. Self-Rated Health by Educational Attainment, 2019 – 2021

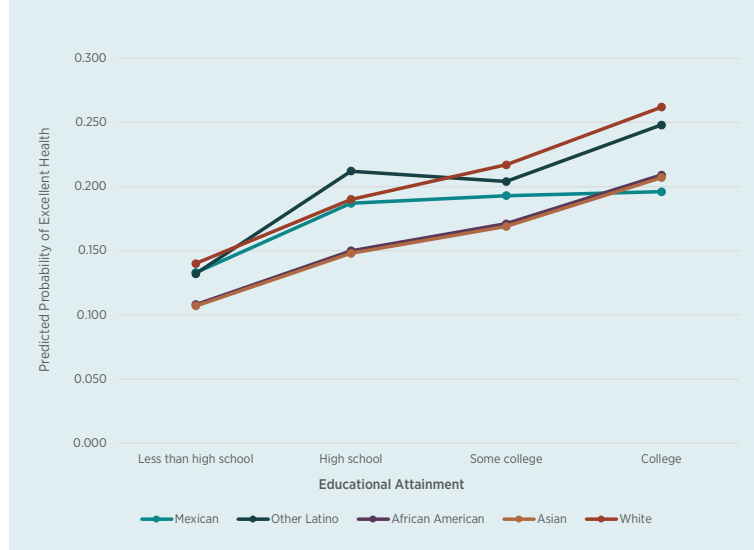


Figure 5. Self-Rated Health by Family Income-to-Poverty Ratio (IPR), 2019 – 2021

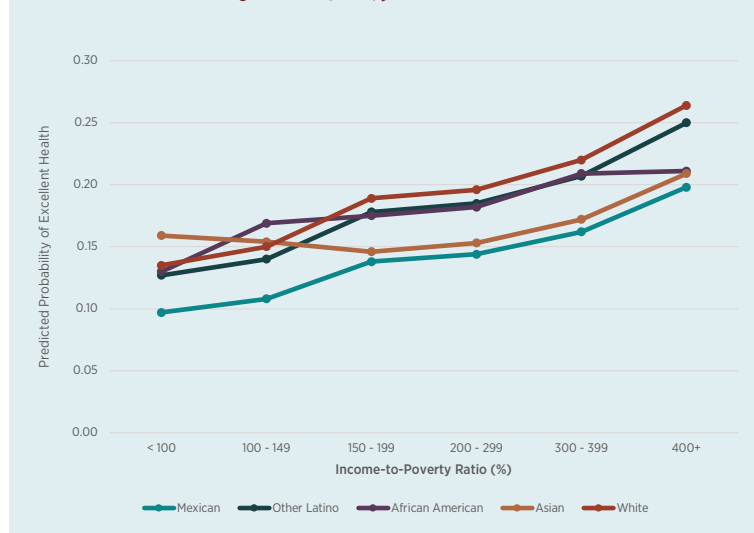


Figure 5 displays the estimated predicted probability of reporting excellent health by income-to-poverty ratio and race/ethnicity. Mexicans in poverty (< 100% IPR) are less likely than Whites to report being in excellent health. However, the predicted probability of reporting excellent health increases at a slower

rate for Mexicans relative to Whites as income-to-poverty ratio increases, leading to larger gaps in self-rated health at the higher end of the income spectrum ($\geq 400\%$ IPR). The predicted probability of reporting excellent health for Other Latinos increases significantly as income-to-poverty ratio increases, but it increases at the same pace relative to whites, leading to no significant differences at the higher end of the income spectrum. The predicted probability of reporting excellent health for African Americans also increases as income-to-poverty ratio increases. However, it increases almost at the same pace relative to whites, except from poverty to near-poverty (100 – 149% IPR) where it increases at a slightly higher rate than Whites and then at the end of income spectrum, where it dramatically decreases, leading to a larger gap in self-rated health relative to Whites. The predicted probability of excellent health for Asians is higher than that of Whites at poverty level, but it decreases thereafter up to a 150 – 199% IPR and then increases as income-to-poverty ratio increases but remains lower than that of whites at the end of the income spectrum.

DISCUSSION

The analysis in this paper based on the pooled data from NHIS 2019 – 2021, shows that there are significant differences in self-rated health by race/ethnicity. The odds of reporting excellent health are significantly lower for Mexicans and African Americans than they are for Whites. In contrast, the odds of reporting excellent health are significantly higher for Asians than Whites. As expected, the odds of reporting excellent health increase as SES increases both in terms of education and family income social classes. One important conclusion is that SES accounts for a large proportion of racial/ethnic disparities of self-health, but in the end racial/ethnic disparities remain. The odds of reporting excellent health significantly increase more for Mexicans, Other Latinos, and Asians than Whites, whereas the odds of excellent health for African Americans decreases more than Whites once education is accounted for in explaining self-rated health. Similarly, the odds of reporting excellent health significantly increase more for Mexicans, Other Latinos, and Asians than Whites, whereas the odds of excellent health for African Americans decreases to being non-significant as compared to those of Whites once family income-to-poverty ratio is factored in explaining self-rated health. The contribution of SES to racial/ethnic self-rated health gap remains substantial and statistically significant across subsequent models that control for other sociodemographic characteristics such as age, gender, immigrant status, marital status, employment status, home ownership, length of residence, and health indicators such as weight status and smoking, and nonmetropolitan/metropolitan residence. In the end, the odds of reporting excellent health remain smaller for Mexicans, African Americans, and Asians than those of Whites, net of the effects of SES and those other covariates.

The other conclusion for this study is that accounting for SES and its interaction with race/ethnicity provide further explanation

for persistent racial/ethnic disparities in self-rated health. The probability of reporting excellent health increases rapidly by education levels among whites, followed by other Latinos, African Americans, and Asians, but it increases at a fairly rapid pace and then at almost a constant rate among Mexicans, leading to a large gap in self-rated health between Mexicans and Whites for those with college education or higher. Gaps in self-rated health between African Americans and Whites and between Asians and Whites slightly increase as education levels increase but remain larger for those with higher education than those with lower education. Gaps of reporting excellent health persist across family income levels and become significantly larger between Mexicans and Whites and between African Americans and Whites at the higher end of the income spectrum. Gaps of reporting excellent health between Asians and Whites vary by family income levels with Asians reporting higher probability of excellent health than Whites at poverty and lower income levels, but lower than that of Whites at the end of the income spectrum.

These findings are consistent with results from studies that show that race/ethnicity and SES are interlinked and both influence conditions of life that have health consequences. Although SES accounts for a large part of racial/ethnic differences in health, racial/ethnic disparities in health persist (Kayitsinga and Martinez, 2008; Adler and Rehkopf, 2008; Williams, 1999; Williams, Priest, and Anderson, 2016). In summary, individuals with higher SES are likely to report better health than their lower SES counterparts. This study further shows that SES accounts for a large part of racial/ethnic differences in health, but racial/ethnic health gaps remain and become larger at higher SES levels for Mexicans, African Americans, and Asians relative to Whites.

This study is limited in focusing on subjective health. Future studies on racial/ethnic and SES health disparities need to look at other health outcomes such as mortality rates, chronic health conditions, mental health, and activity limitations. This study is also limited in focusing only to individual and family characteristics' effects on health. Future research should link NHIS data to other census data to account for neighborhood/community residential contexts and their potential effects on racial/ethnic health disparities. 🌐

REFERENCES

- Adler, N. E., & Rehkopf, D. H. (2008). US disparities in health: descriptions, causes, and mechanisms. *Annual review of public health*, 29, 235.
- Arias, E., & Xu, J. (2022). United States Life Tables, 2019. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, 70(19), 1-59.
- Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: what the patterns tell us. *American journal of public health*, 100(S1), S186-S196.
- Cho, Y., Frisbie, W. P., Hummer, R. A., & Rogers, R. G. (2004). Nativity, duration of residence, and the health of Hispanic adults in the United States. *International Migration Review*, 38(1), 184-211.
- Cockerham, W. C. (2005). Health lifestyle theory and the convergence of agency and structure. *Journal of health and social behavior*, 46(1), 51-67.
- Collins, J. W., Papacek, E., Schulte, N. F., & Drolet, A. (2001). Differing post neonatal mortality rates of Mexican-American infants with United-States-born and Mexico-born mothers in Chicago. *Ethnicity & Disease*, 11(4), 606-613.
- Heron, M. P. (2021). Deaths: leading causes for 2018. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, 70(4), 1-115.
- Hummer, R. A., Powers, D. A., Pullum, S. G., Gossman, G. L., & Frisbie, W. P. (2007). Paradox found (again): infant mortality among the Mexican-origin population in the United States. *Demography*, 44(3), 441-457.
- Idler, E. L., & Benyamini, Y. (1997). Self-rated health and mortality: a review of twenty-seven community studies. *Journal of health and social behavior*, 21-37.
- Kayitsinga, J., & Martinez, R. (2008). The Impact of Race/Ethnicity, Household Structure, and Socioeconomic Status on Health Status in the Midwest.
- Lynch, J., & Kaplan, G. (2000). *Socioeconomic position* (Vol. 2000, pp. 13-35). Social epidemiology. New York: Oxford University Press.
- Markides, K. S., & Eschbach, K. (2005). Aging, migration, and mortality: current status of research on the Hispanic paradox. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 60 (Special_Issue_2), S68-S75.
- Murphy, S. L., Xu, J., Kochanek, K. D., Arias, E., & Tejada-Vera, B. (2021). Deaths: final data for 2018. *National Center for Health Statistics (U.S.). Division of Vital Statistics. National vital statistics reports*, 69(13): 1-
- Robert, S. A., & House, J. S. (2000). Socioeconomic inequalities in health: Integrating individual-, community-, and societal-level theory and research. *The handbook of social studies in health and medicine*, 115, 35.
- Singh, G. K., & Hiatt, R. A. (2006). Trends and disparities in socioeconomic and behavioral characteristics, life expectancy, and cause-specific mortality of native-born and foreign-born populations in the United States, 1979-2003. *International journal of epidemiology*, 35(4), 903-919.
- Snead, M. C., & Cockerham, W. C. (2002). Health lifestyles and social class in the deep South. In *Social inequalities, health and health care delivery*. Emerald Group Publishing Limited.
- Williams, D. R., & Collins, C. (1995). US socioeconomic and racial differences in health: patterns and explanations. *Annual review of sociology*, 349-386.
- Williams, D. R. (1999). Race, socioeconomic status, and health the added effects of racism and discrimination. *Annals of the New York Academy of Sciences*, 896(1), 173-188.
- Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences*, 1186(1), 69-101.
- Williams, D. R., & Sternthal, M. (2010). Understanding racial-ethnic disparities in health: sociological contributions. *Journal of health and social behavior*, 51(1_suppl), S15-S27.
- Williams, D. R., Priest, N., & Anderson, N. B. (2016). Understanding associations among race, socioeconomic status, and health: Patterns and prospects. *Health Psychology*, 35(4), 407.

Health Care for Seasonal Farmworkers in Michigan

By Lacie Dawn Ellithorpe (DHHS), Dale Freeman (DHHS) and Marcelo Siles (JSRI)

A Migrant farmworker is an individual that works at local farms and is required to be absent from his/her permanent residence to perform different tasks for pay in the agricultural sector. They may also be referred as “migratory agricultural workers” or “mobile workers.” Seasonal farmworkers are those employed for short periods, but do not necessarily need to move from their permanent residency to seek work in farms and could have other types of employment. Some estimations contemplate up to 2.43 million farmworkers in the United States, including migrant, seasonal, year-round, permanent, and international guest workers (2017 Census of Agriculture).

The contributions of farmworkers to the United States and Michigan’s economies are vast and extremely important, they work hard producing the food that we consume, pay taxes, contribute to the local economy through purchase of durable products as well as accessing local services for individual and/or family sustainability and recreation, share their culture at local events. It is estimated that migrant workers in Michigan generate over \$2.3 billion in farm revenues that benefit Michigan’s economy.



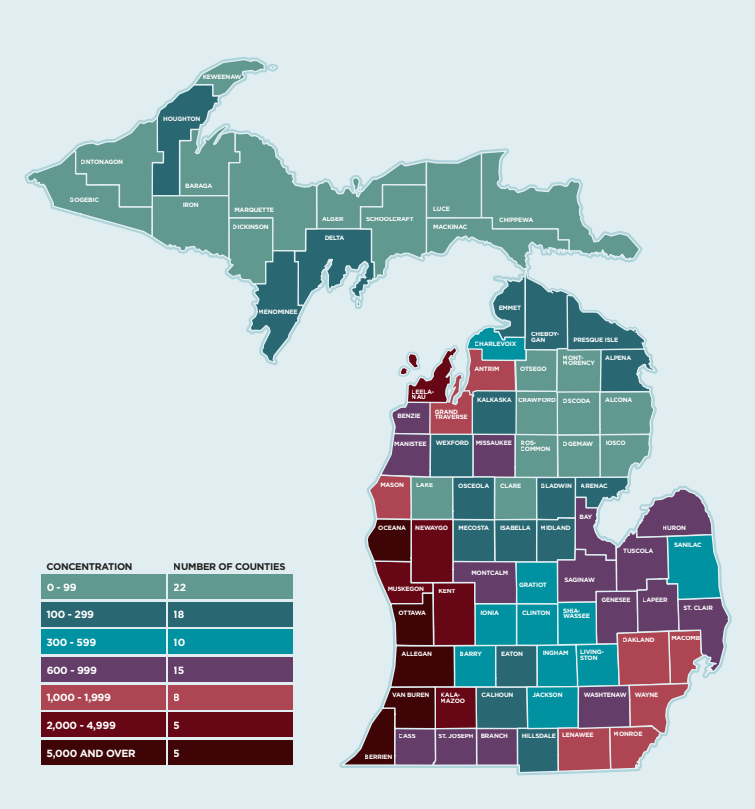
PHOTO BY ZEN CHUNG / PEXELS.COM



As of 2020, there were roughly 49,000 Migrant and Seasonal Farmworkers working in Michigan’s agricultural sector (Food and Agriculture Task Force, 2021), 18 of the 83 Michigan counties house over 1,000 farmworkers, their families, and more than 12,000 farmworkers and their families located in Oceana and Van Buren counties. The State ranks tenth in the nation for migrant and seasonal farmworkers registered for employment (source?). Figure 1 shows a map of Michigan, which includes a concentration (concentrated) number that describes the number of migrant and seasonal farmworkers; these numbers include family members that accompany the farmworkers to different counties.

Farmworkers in Michigan directly participate in the cultivation of more than 162 commercial crops, making the state one of the most agriculturally diverse in the nation. Farmworkers labor in planting, cultivating, harvesting, and packaging of 41 labor-intensive crops. They become essential to the farming industry, due to their strong work ethic and dedication working under very harsh/difficult conditions.

Figure 1. Michigan Counties



PREVENTIVE HEALTHCARE

A report from Campbell County Health (2017) citing data from the Center for Disease Control (CDC) asserts that preventive health care is necessary and important because it improves health outcomes. According to this report “Estimates show that over 100,000 deaths could be prevented annually just by

increasing access to primary care physicians.” Studies that describe the benefits of primary care discuss the lower overall cost of providing health care when preventive care is in place. Most farmworkers do not have access to preventive healthcare due to lack of funds for medical appointments, cannot visit medical facilities due to lack of transportation, the type of work they perform based on long workdays, or because they think it is not necessary. For farmworkers seeking health care often translates into loss of income, due to the type of work they do with low hourly salaries or under contract based on piece rate.

Tables 1 and 2 are based on a recent health survey conducted in Ottawa county. It illustrates the stark differences in access to health and preventive care for farmworkers compared to the county’s general population.

The two tables show results of a survey taken in Ottawa county, we expect that these results would be comparable to data obtained from other counties related to health care access for migrant and seasonal farmworkers. Preventive health care does not only benefit farmworkers, but also to farmers, and state budgets. For farmers, it means a healthy workforce that is able to work every day completing their work assignments to their fullest ability. It also means a more secure and predictable workforce that will be able to return to the same farms every year as a reliable and experienced (healthy) worker. The return of farmworkers to the same farm will improve work efficiency and enhance profitability.

Table 1. Access to Health Care

Description	Migrant Farmworkers (2021)	General Population (2020)
No Health Care Coverage	68.9%	8.2%
No Personal Health Care Provider	73.9%	11.9%
No Health Care Access Due to Cost	23.3%	8.6%
Delays in Getting Health Care	29.6%	26.5%
Problems Learning About Health Condition (Rarely/Never)	43.4%	84.9%
Difficulty Understanding Written/Verbal Information from Provider (Rarely/Never)	40.6%	87.5%
Urgent Care/ ER Use in Past 12 Months (1 + Times)	17.5%	36.6%

Source: Ottawa County Survey.

The benefits to the state government are primarily financial. A well planned preventive health system could reduce the visits to Emergency rooms of uninsured farmworkers who are unable to

Table 2. Clinical Preventive Practices

Description	Migrant Farmworkers (2021)	General Population (2020)
No Dental Visit for Teeth Cleaning in Past Year	64.9%	22.6%
Had Routine Physical Exam/Check-up in Past Year	38.6%	81.3% (2017)
Had Flu Vaccine in Past Year (All Adults)	32.1%	54.2%
Ever Had Mammogram (Female 40+)	76.9%	94.2%
Had Mammogram in Past Year (Female, 40+)	29.2%	55.7%
Ever Had Pap Test (Female)	78.8%	92.1%
Had Pap Test in Past Three Years (Female)	60.2%	63.8%
Ever Had Sigmoidoscopy or Colonoscopy (50+)	40.7%	85.4%
Had Sigmoidoscopy or Colonoscopy in Past 5 Years (50+)	35.7%	61.8%
Had Blood Cholesterol Checked (ever)	52.8%	77.4% (2014)

Source: Ottawa County Survey.

pay the high costs of these visits while decreasing reliance on state budgets for these costs. Many studies that describe the benefits of primary care point to the lower overall cost of providing health care to a population (Hostetler, et. Al., 2020, Smith, Y., 2019, and Writing, 2017). This cycle continues and could get worse if follow-ups to the emergency room visits are scheduled, thus avoiding return trips to an ER which are more costly.

HEALTH DISPARITIES

Migrant and seasonal farmworkers are at a higher risk of experiencing health disparities for many reasons. As noted by Sanne, et al. (2004):

“In older studies it has been shown that farmworkers have better health than their peers in other professions. Recently this has begun to change, and now farmworkers are at higher risk to face health concerns associated with their occupations. Some reasoning for this change includes rationalization, mechanization, social isolation, and financial strain.”

The study considers that the current heavy use of machineries by the agricultural sector is one of the key elements for the increased health disparities between farmworkers and their peers working in other industries. Inadequate training and familiarity with new technologies increases the likelihood of injuries. The low wages that farmworkers receive force them to make choices between paying for health care services, familial subsistence, as well as remittances to support extended families in other states or abroad. For this reason, access to preventive health care becomes a low priority – which exacerbates chronic health issues (i.e., untreated high blood pressure can impact carpological issues that if undetected and untreated, can become life-threatening or fatal).

Social isolation has emerged as another important preventive care issue. Due to the type of work farmworkers perform, the farms’ location in which they work, the lack of transportation, cultural problems such as language barriers and the lack of trust in the public health system, make it difficult for farmworkers to obtain preventive care.

There are also many other barriers that farmworkers face to receive preventive health care, these include but not limited to: the prevailing high cost of healthcare, shortage of healthcare services especially not enough doctors and nurses working in the rural areas, lack of culturally and linguistically appropriate services, lack of information about healthcare coverage options, unclear and confusing eligibility requirements, inability to get sick leave, concern of losing paid work time, and social exclusion. The health care gap for undocumented farmworkers is even larger, since they cannot apply for any government health sponsored program, Farmworkers fear that their immigration status will affect the eligibility and program access.



Another major constraint that farmworkers encounter in accessing quality healthcare is their frequent relocation. Because they travel each cropping season from state to state to sustain their work and income, the cohesiveness between providers and sharing of medical information presents additional and unique challenges. Diabetes, cancer, and HIV are the most commonly identified health issues that farmworkers experience that require ongoing care to manage more serious health impacts.

“The State of Michigan’s agricultural sector is one of the largest and more diversified in the country, it practices and relies on the hard work of migrant and seasonal farmworkers. In the previous years the composition of this workforce has been shifting from families to individualized workers.”



ADDRESSING DISPARITIES



TO ADDRESS HEALTH DISPARITIES

There are only a few things farmers, migrant workers, and health promoters (volunteers) can do to help address these health disparities. They need to work closely with local health providers promoting the access of farmworkers to preventive care, facilitating the elimination of cultural barriers, and increasing health professionals that are fluent Spanish speakers who can effectively communicate with patients. Farm owners should facilitate free and flexible transportation of farmworkers to health facilities. Medical transportation covered through Medicaid is only for those farmworkers who qualify for Medicaid support.

Migrant outreach staff can facilitate increased accessibility and information sharing through their efforts. Asking farmworkers, for example, can result in simple modifications of existing efforts to increase accessibility and facilitate access to local health care facilities. At the same time, migrant outreach provides regular updates about policies and the type of services that are local and used by other farm laborers. Health promoters can also gather information from farms about their pressing health needs, which in turn can be shared with medical providers to identify those agencies willing to offer services. This type of reciprocal information sharing can ensure

Additionally, advocating for more comprehensive health insurance from employers and the State’s Medicaid program could significantly facilitate the access of migrant and seasonal farmworkers to seek preventive and regular medical services. Currently, undocumented and immigrant workers are excluded from full Medicaid coverage. While there are private health insurance options, the financial requirements render them inaccessible for most migrant farmworkers. At this time, a permanent advocacy program is needed for the expansion of comprehensive health services under the Emergency Services Only Medicaid Program.

Other challenges could exist among health care practitioners. It is not uncommon for emergency room physicians or urgent care practitioners to recommend follow-up treatments. However, not all migrant farmworkers that need to access

urgent or emergency services have the financial resources or accessible follow-up options to address health concerns. Without federal/state support, farmworkers would not be able to access needed follow-up care to ensure their recovery.

As an example, in an interview with a female migrant program worker, we learned that she worked hard to get authorization for a follow-up specialist for an injured farmworker. Despite a broken arm and chipped elbow, he decided to continue working to ensure needed income that was needed to support his family. This is an example of how farmworkers need to work around their health needs. This worker feared that if he stopped working he would be fired or not allowed to come back in subsequent years. The migrant outreach worker understood that in order to support this injured laborer, she needed to contact several health professionals to find someone who could visit the laborer at their worksite rather than to require them to miss valuable working hours. An outcome of this experience was that the migrant outreach worker felt empowered to prioritize and establish networks to provide healthcare services.

COPING WITH HEALTH ISSUES

There are many reasons that explain the difficulty that farmworkers face dealing with health disparities. Many United States citizens deal with these disparities by simply going to a doctor, but for farmworkers the most obvious option is not always a plausible option. For some farmworkers a form of dealing with these disparities, especially those dealing with unaddressed aches and pains, is through excessive drinking. It is not unusual to find one or more trash cans overflowing with empty alcohol containers. Drinking is a coping mechanism, it is not recognized by workers, but can be observed by program workers, volunteers, and others that may visit farmworkers' camps. Many farmworkers need to utilize mental health care services, but given the type of work they perform, the lack of transportation, time constraints, and the financial burden they create, these care services do not offer easy access for these workers. This is why farmworkers are unlikely to participate in mental care health services.

Great Lakes Bay Health Centers, a nonprofit organization, provides health care to individuals and communities, especially those who are underserved, uninsured or underinsured. This organization has mobile clinics, both medical and dental, that travel to different camps across the state, where farmworkers temporarily live, to provide access to basic health care. A distinguishing characteristic of this organization is that they go where the patient is instead of waiting for the patient to come to them in an effort to close the health gap.

A migrant health program worker who works for this organization considers transportation from camps to health centers as a major barrier for accessible care. Since there are a large number of people (farmworkers and their families) living at camps, and since the available transportation only comes from buses or larger vehicles, accessibility and the use of shared vehicles can have unintended consequences

for community and family members. This migrant health worker wishes more health facilities would introduce outreach efforts within migrant communities to increase health access. This would have the added benefit of providing ongoing treatment visits to address ongoing illnesses or diseases.

CONCLUSION

The State of Michigan's agricultural sector is one of the largest and more diversified in the country, it practices and relies on the hard work of migrant and seasonal farmworkers. In the previous years the composition of this workforce has been shifting from families to individualized workers. Nevertheless, the new composition of the workforce for health care is still relevant. Increased options for preventive and continued health care are available through federal and state sponsored programs (i.e., ACA, extended Medicaid, etc), non-profit organizations, and private insurances, which combined with better transportation options would increase the utilization of preventive care services.

A more consistent use of preventive care services could decrease emergency room visits, which are not cost-effective and strain the provision of other needed services to farm laborers and the community at large.

Farmworkers are highly interested in the different health care options for them and their families. At outreach events held during peak season at several camps, farmworkers expressed their health concerns and their reasonings for not seeking health services. To avoid duplications in the provision of health services to farmworkers, it will be necessary to form an interagency team to plan, coordinate, and offer the necessary health services to farmworkers and their families. Finally, the need for accessible, affordable, and quality health services is continually challenged and evolving. 🌱

REFERENCES

- Clarke, Karen, 2017, Campbell County Health, "Preventive Care Saves lives," Campbell County Health, <https://www.cchwyo.org/news/2017/november/preventive-care-saves-lives/#:~:text=According%20to%20the%20Centers%20for,What%20is%20preventive%20care%3F>
- Census of Agriculture, 2017, <https://www.nass.usda.gov/AgCensus>
- Lada, Sophia, 2021, *Farmworkers need more off-site housing*, Michigan Task Force says. cites a report from Migrant Labor Housing Advisory Board, Great Lakes Echo. <https://greatlakesecho.org/2021/03/15/farmworkers-need-more-off-site-housing-michigan-task-force-says/>
- Sanne, B., Mykletun, A., Moen, B.E., Dahl, A.A., and Tell, G.S., 2004, *Farmers are at risk for anxiety and depression: the Hordaland Health Study*, Journal of Occupational Medicine, Vol. 54, No. 2. (pp. 92-100).
- Smith, Yolanda, 2019, *Benefits of Primary Health Care*, News Medical Life Sciences, Benefits of Primary Health Care (news-medical.net)
- Writing, Alexis, 2017, *Advantages and Disadvantages of Primary Health Care*, Healthfully, Advantages & Disadvantages of Primary Health Care (healthfully.com)



¿Qué está pasando en el instituto?

NEW FACES



Abigail Cardona is a Freshman at Michigan State University and is interested in Business Finance. She was born in Lansing but relocated to Texas and after High school she knew she wanted to go back to Michigan State University to do her undergraduate studies. At only 3 years old, she was already marching the steps of the Lansing capital for Hispanic rights; she is not new

to helping raise awareness! For her 15th birthday she created a fundraiser in lieu of birthday presents, where she collected toys for Mayan children. While on her birthday cruise her and her guests delivered these toys to Yucatan Mexico. Every year since then, she is proud to keep fundraising to help get more toys to Mayan villages. Abigail is looking forward to going to Europe and Mexico next year so she can continue to learn about different ways of life and hopes to find inspiration during her travel on where to start another toy fundraiser. After graduation she hopes to continue to travel and start her own business.

SEND OFFS



Jennifer Padilla, student Clerical assistant, graduated with a Bachelors in Interdisciplinary Studies and a Minor in Chicano Latino Studies and second minor in Theater. Padilla hopes to work as a paralegal focusing specifically on immigration issues. For now, she is focusing on expanding her lash business "Isashe". She is proud to be one of the few Latinas

in Flint, MI to operate a business. Through her business packaging she spreads her culture and religion. Jennifer worked at JSRI from October 2021 through July 2022.

JSRI SCHOLARSHIP RECIPIENTS



Ereisa G. Morales is a first-generation student from Washington state. In 2019, she graduated from Eastern Washington University with a Bachelor of Arts in Criminal Justice & Sociology. Upon graduating, Ereisa moved across the country to pursue a PhD in Sociology at Michigan State University. Throughout her academic journey she has identified three phenomena of interest: race and ethnicity, substance use, and family.



Ana Lucrecia Rivera is a Mexican-American Ph.D. Candidate in the Department of Geography, Environment, and Spatial Sciences, a member of the Global Health and Medical Geography Laboratory, and a recipient of the Michigan State University Enrichment Fellowship. She is studying to become a health and medical geographer, utilizing geospatial technologies

to analyze climate-social interactions in urban settings, specifically, how extreme heat weather events impact health and how these effects vary by demographic, socioeconomic, and institutional issues. Ana has collaborated with various research teams, including the NASA-Health and Air Quality Applied Science (HAQAST) Team, the Mexican Government, UC Berkeley, and the Chinese University of Hong Kong.



Robin Morales, the working-class son of two Havana immigrants, was born in Lansing, Michigan and is currently a junior in the teacher preparation program at Michigan State University with a major in social science education and a minor in Chicano/Latino Studies. Having had no Latino teachers in his own K-12 education, and in reflecting on the countless ways that Chicano/Latino students can benefit

from representation in the teaching profession, Robin was motivated to pursue public school education and aspires to teach future generations of students about Chicano/Latino history and activism as praxis for their own educational liberation.

NEW JSRI AFFILIATES



Linda C. Halgunseth joined the Department of Human Development and Family Studies (HDFS) at Michigan State University (MSU) as an associate professor in 2022. Professor Halgunseth held a joint appointment in HDFS and El Institute of Latina/o, Caribbean, and Latin American Studies at the University of Connecticut (UConn) from 2012-2022 where she also served

as the Director of Academic Affairs at UConn Hartford. Her research focuses on parenting and children's well-being in Latinx, African American, and Asian American families. She is an Associate Editor for the *Journal of Research on Adolescence* (JRA), and Lead Editor for JRA's special issue, *Truth is on the Side of the Oppressed: Oppressive Systems Affecting BIPOC youth*.

Dr. Halgunseth is Past Chair of the Latinx Caucus of the Society for Research in Child Development (SRCD), a member of the

SRCD Ethnic Racial Issues Committee, and a co-organizer of the SRCD Special Topics Meeting, Construction of the "Other": Development, Consequences, and Applied Implications of Prejudice, Discrimination, and Racism (Puerto Rico). She received two Early Career Awards: one in teaching from American Association of University Professors (AAUP), and one in research from the SRCD Latinx Caucus.

Professor Halgunseth has worked closely with the Latinx community by serving on the Boards of the Connecticut Community Foundation and Madre Latina Inc. in Waterbury, CT; and by creating youth programs with *Centro Latino de Salud Educación y Cultura* in Columbia, MO. She also served as a faculty advisor for the Latin American Student Organization (LASO) at the University of Connecticut. One of the reasons she joined MSU is because of the opportunity for strong academic and community collaborations that support and highlight Latinx families.



Dr. Celeste Campos-Castillo is currently an Associate Professor in the Department of Sociology at the University of Wisconsin-Milwaukee. Her research examines how new information and communication technologies may widen or narrow existing inequalities, with outcomes dependent on how well the design and implementation addresses digital divides and privacy concerns. The technologies

she examines include social media, telehealth, patient portals, and electronic health records. The inequalities she examines are those along ethnoracial lines and gender, and she studies different age groups, but has a particular focus on high school aged adolescents. She is a methodologist and uses a range of research methods, including experiments, surveys, archives, interviews, and focus groups. Her research appears in academic journals such as *Annual Review of Sociology*, *Health Affairs*, *Journal of Adolescent Health*, *Journal of the American Medical Informatics*, *Journal of Medical Internet Research*, *Journals of Gerontology*, and *Sociological Theory*. Her research has received funding from Meta Research, National Endowment for the Arts, National Science Foundation, and Technology and Adolescent Mental Wellness program. In addition, she has received several professional accolades and most recently received the 2022 Early Career Award from the Midwest Sociological Society. She received a PhD in Sociology from the University of Iowa in 2012 and from 2012 to 2014 she was a post-doctoral research fellow in the Institute for Security, Technology, and Society at Dartmouth College. In January 2023, she will join the faculty in the Department of Media and Information at Michigan State University.

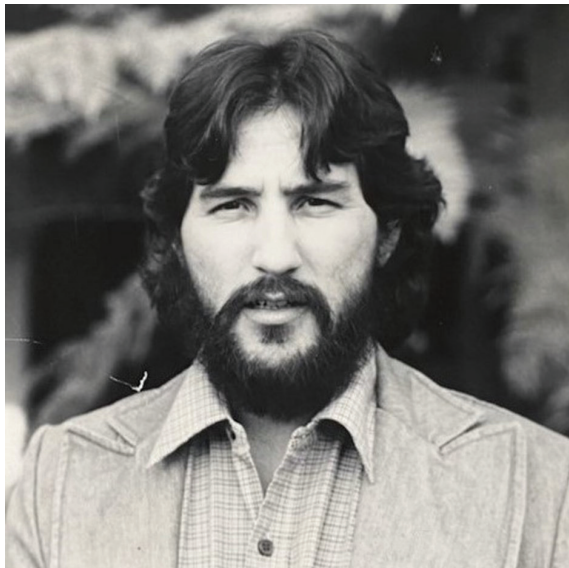


CONTINUED FROM PAGE 3

an organization aimed at improving the conditions and opportunities of Latinos in higher education in Michigan. He was able to bring together Black and Latino faculty, community leaders, students, and many others to work collaboratively toward an organization North Star Alliance for Justice aimed at harnessing the collective power of communities of color in Michigan to promote a more inclusive society. The mission of the NSAJ is:

“... a collaborative of organizations and individuals committed to the pursuit of freedom, independence, prosperity, and equal rights for communities of black and brown people with histories of enslavement, territorial theft, genocide, racial and ethnic victimization, and government repression. We advocate targeted measures to make whole the black and brown communities in the state of Michigan.”

This is just one of the many examples of Dr. Martinez's commitment to improving the conditions of Latinos in Michigan, the Midwest, and the nation. As such, Dr. Martinez will be missed, and it will be very difficult to fill his shoes as he has left an everlasting mark on the Julian Samora Research Institute. Le brindamos la mejor de la suerte en esta nueva etapa de su vida.



Dr. Martinez:
Graduate School

MENTORSHIP ANECDOTES

During his time at MSU, Dr. Martinez worked with many scholars at the institute, such as research faculty, research assistants, and postdoctoral scholars. To these individuals he was not just a director, but also a mentor and friend. Thus, we include some recent scholars in this tribute to share a few words of what Dr. Martinez's mentorship and guidance meant to each of them.

YOSHIRA DONAJI MACÍAS MEJÍA

I would like to continue this homage to Dr. Martinez by saying that his experience in academia as well as his own personal experiences and most of all his patience is what makes him not only an exemplary academic and leader, but also mentor. I echo what other colleagues have said about Dr. Martinez and will add that upon starting my postdoc here at MSU, I not only felt welcomed by him, but he took the time out of this busy schedule to get to know me, which is imperative for a good mentoring relationship. I learned from him what being a great mentor is and that mentoring is a relationship, which takes great care and time to cultivate. Mentoring is also about allowing your mentee to have the freedom to pursue what best suits their needs and not to push your own views or thoughts on them. A mentor also guides those they are mentoring, something that Dr. Martinez is well versed in, which allows them to grow. This is something I take with me in my future career endeavors.

I was able to grow into the scholar I am today because he gave me the academic freedom to pursue projects I was genuinely interested in and helped me sharpen my research and teaching skills. He would push me and encourage me to think big and theoretically. All these skills have helped me to mature as a scholar and to develop the confidence to be vocal and challenge issues I would never have before. While, I have always been told that you cannot have everything in a mentor and that you need different mentors. I will say that to some extent this is true, but Dr. Martinez has been the well-rounded mentor that I needed and for that I am grateful.



Dr. Martinez with 2 others: Colorado

JUAN D. CORONADO

In August 2015, I arrived in Michigan to work as a postdoctoral scholar at JSRI. For the next four years, I shadowed and learned much from Dr. Martinez. Being housed in University Outreach and Engagement, JSRI worked extensively to address the needs of the Latino Community in the greater Lansing area, in Michigan, and in the Nation. Under Dr. Martinez's direction, faculty at JSRI produced research and scholarship on Latinos with the aspirations of improving the lives of those marginalized. Needless to say, the tasks at hand required dedication and time. It became normal to work over twelve hours a day as Dr. Martinez's multidimensional approach called for total commitment. The man literally works every hour that he is awake, and his work ethic motivated the rest of the unit to work harder.

I quickly realized that Dr. Martinez was one of leading scholars in Michigan as we traveled the state in his quest to inform the public, government officials, and other scholars on the living situation of Latinos. The settings for his talks were extremely diverse, from university settings to government buildings, to local restaurants, but the message was always serious and influential. Pretty soon, he had me presenting in these circles as well which grew my experience as a young scholar.

One of Dr. Martinez's most prized projects became *Éxito Educativo*, a pathway to college program that he spearheaded. We cofacilitated the program in Lansing Schools empowering Latino families interested in sending their children to college. The program has since grown to several other locations throughout Michigan and has garnered interest in other states as well.

As a scholar, Dr. Martinez holds a book series with Michigan State University Press, *Latinos in the United States Series*. Almost twenty volumes have been published, including mine *"I'm Not Gonna Die in this Damn Place:" Manliness, Identity, and Survival, of the Mexican American Vietnam Prisoner of War*. Collectively, we also Co-edited a journal issue of *Diálogo, Latinas and Latinos in the Midwest: Historic and Contemporary Issues*.

The experience working with Dr. Martinez prepared me for my first tenure-track job, a position I currently hold at Central Connecticut State University. Yet, his mentorship has challenged me beyond the academic setting and has inspired me to create a better world for all. Dr. Rubén Martinez is a true representation of a scholar activist and the work throughout his career is testament of his noble dedication to the sustainment of Latinos in higher education and for the improved living conditions of all.

RICHARD CRUZ DÁVILA

I first met Dr. Martinez in July of 2016 at the summit, "The Mass Media and Latinos: Overrepresentation and Underrepresentation," sponsored by JSRI, the MSU College of Communication Arts and Sciences, and the Michigan Alliance for Latinos Moving toward Advancement. I had defended my doctoral dissertation in the spring of that year and was serving



JSRI 30th Anniversary Event at the Marriott

as an AmeriCorps VISTA member, working to build capacity for local organizations involved in President Obama's My Brother's Keeper initiative, and reached out to Dr. Martinez in relation to that work. He invited me to the summit and afterward invited me and my supervisor to join a group that would eventually become the task force behind the Black/Brown Dialogues summit series, hosted by JSRI and African American and African Studies. After a task force meeting in the summer of 2017, when my term of service as a VISTA had ended and I had yet to find an academic appointment, Dr. Martinez offered me the chance to work for JSRI as a research assistant.

Since joining JSRI, Dr. Martinez has actively supported my research and offered many opportunities for professional development. Through bi-weekly manuscript meetings with JSRI faculty, Dr. Martinez fostered a space to collectively think through ideas and work past barriers, helping me to get two articles published in academic journals. Further, my ongoing research on Texas-Mexican music in Michigan and the Midwest evolved from his suggestion of a topic for my first lead article in *NEXO*. JSRI has since financially supported numerous presentations of my research at professional conferences, research travel, and obtaining permissions to quote song lyrics in publications. Dr. Martinez has also encouraged and supported my participation in professional development activities and has created many opportunities for me to expand my professional network. His support has been instrumental as I work to make a name for myself as a scholar. 🌟

YES, I/WE WANT TO SUPPORT JSRI

PLEASE SUBMIT FORM WITH YOUR GIFT.

- ☐ I/We support the JSRI Enrichment Fund (AB 9921)
- ☐ I/We Support the Julian Samora Endowed Scholarship Fund (AB 9920)
- ☐ I/We support the P. Lea Martinez Endowed Scholarship Fund (AB 9923)
- ☐ I/We support the JSRI Scholarship Fund (AB 9922)

Amount of Gift/Pledge: \$ _____

MY/OUR TOTAL GIFT WILL BE PAID AS INDICATED:

- ☐ A check payable to Michigan State University

Enclosed in my first payment of: \$ _____

- ☐ A credit card charge to: (check one)

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Card Number:

Expiration Date: _____

Name on Card: _____

- ☐ A pledge of the following duration: _____
(maximum of five years)

SEND ME/US PLEDGE REMINDERS:

(check one)

- ☐ Annually ☐ Quarterly ☐ Semi-annually

Beginning: Month _____ Year _____

- ☐ This is a joint gift with my spouse

Spouse's Name: _____

- ☐ Matching Company Gift: _____

MSU FACULTY/STAFF ONLY

- ☐ Deduct my pledge in equal monthly installments

- ☐ 12 Months ☐ 24 Months ☐ 36 Months

- ☐ Deduct my gift in one lump sum from my paycheck in the month of:

ZPID _____

(Required for Payroll Deduction)

Pay Group: ☐ Salary ☐ Labor ☐ Grad

PERSONAL INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Telephone: Office () _____ - _____

Home () _____ - _____

Email: _____

PLEASE MAKE CHECKS PAYABLE TO: MICHIGAN STATE UNIVERSITY

PLEASE NOTE FUND NAME OR ALLOCATION CODE IN
THE MEMO LINE AND RETURN TO:

Julian Samora Research Institute
Michigan State University
219 S. Harrison Rd, Room 93
East Lansing, MI 48824

*Thank You!
¡Gracias!*

Or make your gift on-line at: givingto.msu.edu

GIFTS TO JSRI

PLEASE CONSIDER MAKING A GIFT TO THE JULIAN SAMORA RESEARCH INSTITUTE

Through your support you can enhance JSRI's research, symposia, and cultural and scholarship activities.

Each gift enhances JSRI's capacity to promote research on Latino communities in Michigan, the Midwest and across the nation and to disseminate and contribute to the application of the findings.

YOUR GIFT CAN BE DESIGNATED FOR:

- The **JSRI Enrichment Fund**, which supports research projects, student research assistantships, and public forums on critical Latino issues;
- The **Julian Samora Endowed Scholarship Fund**, which supports two awards annually to undergraduate and graduate students with research and teaching interests on Latino issues;
- The **P. Lea Martinez Endowed Scholarship Fund**, which supports students studying health issues among Latinos;
- The **JSRI Scholarship Fund**, which supports students with short-term financial needs;
- Or any combination thereof.

INDIVIDUAL COMMITMENT LEVELS

- Platino Circle ~ \$5,000 or more
(payable over two years)
- Padrinos/Madrinas Circle ~ \$2,500 to \$4,999
(payable over two years)
- Amigo/Amiga Circle ~ \$1,000 to \$2,499
- Aficionado/Aficionada ~ \$100 to \$999

CORPORATE COMMITMENT LEVELS

- Platino Circle ~ \$10,000
- Padrinos/Madrinas Circle ~ \$7,500
- Amigos/Amigas Circle ~ \$5,000
- Aficionados/Aficionadas Circle ~ \$2,500

If you need additional information on giving to JSRI, including planned giving, please contact:

Francisco Villarruel, Ph.D.

Julian Samora Research Institute

Phone: (517) 432-1317

Fax: (517) 432-2221

Email: jsamorai@msu.edu

Web: jsri.msu.edu

**MICHIGAN STATE
UNIVERSITY**

University Outreach
and Engagement
Julian Samora
Research Institute