A COMMUNITY-ENGAGED NARRATIVE INQUIRY PHOTOVOICE PROJECT EXAMINING THE HEALTH-IMPACTING EXPERIENCES OF OLDER ADULT RUSSIAN AND SPANISH-SPEAKING IMMIGRANTS IN SOUTHEASTERN WISCONSIN, UNITED STATES.

by

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ABSTRACT

A COMMUNITY-ENGAGED NARRATIVE INQUIRY PHOTOVOICE PROJECT EXAMINING THE HEALTH-IMPACTING EXPERIENCES OF OLDER ADULT RUSSIAN AND SPANISH-SPEAKING IMMIGRANTS IN SOUTHEASTERN WISCONSIN, UNITED STATES.

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Maren Maria Hawkins

The University of Wisconsin-Milwaukee, 2022
Under the Supervision of Professor Lance Weinhardt

Background: Among the nearly 10 million older adult immigrants in the United States, most come from Mexico and speak Spanish. Moreover, in addition to the hundreds of thousands of Russian-speaking immigrants from the Former Soviet Union already residing in the United States, the current war in Ukraine is fueling mass emigration of Ukrainian and Russian-speakers from Ukraine. Thus, in this study we sought to examine the health-impacting experiences of older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin. Design & Methods: This was a Community-Engaged Participatory Narrative Inquiry Photovoice Project and applied the Older Adult Immigrant Adapted Model for Health Promotion. Participants took or selected 10 photos, and then through an in-depth semi-structured interview we discussed the stories and experiences related to the photos, and how those experiences were related to their health. Moreover, given the multiple languages in this study, we created adapted cross-language research methods, which we followed in this study. These adapted cross-language methods were: (1) What and why? Considerations for Study Design, (2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation, (3) Who? The role of the translator/interpreter during the research process, (4) Who again? Translator/interpreter credentials and positionality, (5) What are you really saying? Dynamic equivalence, (6) Do your

ears deceive you? Reflexive reflective reflexivity, and (7) Triality, not just Duality, of the role of the Researcher. Data analysis was conducted in the languages of participants (Russian or Spanish). Data analysis was conducted by the research team to understand the metastory. Data analysis was an iterative process of listening and re-listening to interviews, as connected with the photos, assessing not only what was said, but how it was said. Results: The two overarching metastories were related to the environment and healthcare access. In this dissertation, the two sections of results are titled as follows: (1) "Your soul will rest in the fresh air" Health-Influencing Experiences of Older Adult Russian and Spanish-Speaking Immigrants in Southeastern, Wisconsin, United States, and (2) "You Die or You Get Better" Conceptualizations of Health-Seeking Behavior and Health Care Encounters among Older Adult (Im)migrants in Wisconsin, the United States. These results demonstrate the importance of the environment as both facilitating and inhibiting the health of older adult Russian and Spanish-speaking immigrants. For example, social support, as well as access to parks and lakes positively affected participants physical and mental health, while limited access to health care negatively affected their physical and mental health. Significance: This study elucidated the experiences of older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin and explicates their own viewpoints through the use of their own photos. These findings underscore the importance of the built environment as it impacts health. They also underscore the importance of improved cross-cultural training for health care and public health professionals. Finally, these findings are novel and nuanced in that through the use of the Older Adult Adapted Model for Health Promotion the results illustrated the specific pathways that interact among older adult immigrants and thereby also illuminate potential areas for intervention.

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Dedicated to my beloved brother, Joshua Banda,

Whose curiosity and storytelling will always inspire me.

To my aunt, Kristine Jacobson,

Whose gentle and consistent presence will always encourage me.

To my friend, Matt Briggs,

Whose persistence and promotion of justice will always motivate me.

TABLE OF CONTENTS

LIST OF FIGURES……. vii

LIST OF TABLES……... viii

LIST OF PHOTOS…….. ix

LIST OF ABBREVIATIONS…….. x

ACKNOWLEDGEMENTS……. xi

Introduction: The Project……. 1

Article One: Background & Model Development…….. 8

Barriers and Facilitators of Health among Older Adult Immigrants in the United States: An Integrative Review of 20 Years of Literature

Article Two: Methodology ……. 52

The Triality of Roles for the Trilingual Researcher: Processes from a Community-Engaged Qualitative Cross-Language Health Study

Article Three: Results…….. 84

"Your soul will rest in the fresh air" Health-Influencing Experiences of Older Adult Russian and Spanish-Speaking Immigrants in Southeastern, Wisconsin, United States

Article Four: Results…… 121

"You Die or You Get Better" Conceptualizations of Health-Seeking Behavior and Health Care Encounters among Older Adult (Im)migrants in Wisconsin, the United States

Conclusion……... 166

Appendices…….. 174

Appendix A: Mini-Cog Translation into Russian
Appendix B: Interview Guide
Appendix C: Additional Background Information - Migration of Jews to Milwaukee from the Former Soviet Union, Examining the Arc of Migration with an emphasis on 1970 to the Present

LIST OF FIGURES

Figure Number	Figure Title	Page
1.	PRISMA diagram	19
2.	The Older Adult Immigrant Adapted Model for Health Promotion (OAHM)	34
3.	Racial and Ethnic Composition of Milwaukee County	89
4.	Parks and Trails in Milwaukee	89
5.	Recruitment locations in Milwaukee County	89
6.	Milwaukee Parks and Trails with Recruitment Locations Overlayed	89

LIST OF TABLES

Table Number	Table Title	Page
1.	Inclusion and Exclusion Criteria	18
2.	Barriers and Facilitators of Health and Well-Being among Older Adult Immigrants in the United States	21
3.	Community-Based Participatory Research Principles	58
4.	Adapted Cross-Language Methods	64
5.	Example of Dynamic Equivalence	75
6.	Excerpts from the 2019 Focus Groups	133
7.	Demographic Results	140

LIST OF PHOTOS

Photo Number	Photo title	Page
1.	Photo one	98
2.	Photo two	98
3.	Photo three	99
4.	Photo four	99
5.	Photo five	100
6.	Photo six	100
7.	Photo seven	102
8.	Photo eight	103
9.	Photo nine	104
10.	Photo ten	104
11.	Photo eleven	106
12.	Photo twelve	106
13.	Photo thirteen	108
14.	Photo fourteen	142
15.	Photo fifteen	142
16.	Photo sixteen	144
17.	Photo seventeen	147

LIST OF ABBREVIATIONS

OAHM	Older Adult Immigrant Adapted Model for Health Promotion
US	United States
FSU	Former Soviet Union
WI	Wisconsin
SCT	Social Cognitive Theory
SAT	Successful Aging Theory
AT	Acculturation Theory
SES	Socioeconomic Status
ELP	English Language Proficiency
PRWORA	Personal Responsibility and Work Opportunity Act
CBPR	Community-Based Participatory Research
CEnPR	Community-Engaged and Participatory Research
SDOH	Social Determinants of Health
CLAS	National Standards for Culturally and Linguistically Appropriate Services

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INTRODUCTION: THE PROJECT

Mpola Mpola

This project was developed and conducted over the four years of my[1] PhD program. The Lusoga expression, *mpola mpola*, or slowly slowly, has been my approach to this project: *Volunteer, talk with people, write about an aspect of the topic, volunteer, conduct focus groups, talk with people, co-develop idea, repeat*. This led down many rabbit holes leading to the present one, which developed into my dissertation. This project, *A Community-Engaged Narrative Inquiry Photovoice Project Examining the Health-Impacting Experiences of Older Adult Russian and Spanish-Speaking Immigrants in Southeastern Wisconsin*, sought to broadly examine the factors, both positive and negative, that influence the health of older adult Russian and Spanish-speaking immigrants.

While older adult immigrants represent a large and growing population in the United States (7.3 million and growing[1]), there is a lack of literature on the topic. Only 30 articles from 2000-2020 addressed barriers and facilitators of health among older adult Russian and Spanish-speaking immigrants in the US. Yet, there is some local understanding of the needs of these populations. For example, Milwaukee County is home to the largest concentration of Russian-speaking and Spanish-speaking immigrants in the state of Wisconsin, and in regions home to many Russian and Spanish-speaking immigrants, social service organizations have developed or adjusted to support them. For example, in Milwaukee, Jewish Family Services, which partnered with the Milwaukee Jewish Federation to settle thousands of refugees from the Former Soviet

[1] In this introduction, I use 'we' instead of 'I' or 'my' when I discuss the articles, which will be multi-author, and when I discuss co-development of the project with community members.

Union, offers free dental services for holocaust survivors.[2] For Latinx, Spanish-speaking immigrants, organizations such as Sixteenth Street Community Health Centers and the United Community Center serve the needs of tens of thousands.[3,4] Although there are local understandings of the needs of these populations, the literature is sparce, and the voices of these older adult immigrants have not been elevated.

Therefore, based on my review of the literature, and an iterative process with community members, advisors, and organizations, we developed the following Specific Aims and Research Questions for this project:

Specific Aims and Research Questions

Older adult Russian and Spanish-speaking immigrants in Southeastern, Wisconsin, contend with unique challenges. Moreover, the needs that facilitate health and wellbeing of these older adults, beyond medical and dental needs, are not well understood, nor are the factors that might influence medical and dental health. The purpose of this descriptive qualitative study was to better understand the lived realities of older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin in relation to health and wellbeing. Using these complementary frameworks, a Community-Engaged Participatory approach and the Older Adult Immigrant Adapted Model for Health Promotion (OAHM), we had the following aims and questions:

Specific Aims:

1. Gain a better understanding of the experiences (examples from one's life) in relation to health of Russian-speaking and Spanish-speaking older adult immigrants through a Community-Engaged and Photovoice approach.

2. Assess the health and wellbeing needs and views of Russian-speaking and Spanish-speaking immigrants through Narrative Inquiry, emphasizing storytelling in interviews when discussing the photos.
3. Gain a better understanding of the factors impacting the health and wellbeing of Russian-speaking and Spanish-speaking immigrants through the application of Older Adult Immigrant Adapted Model for Health Promotion.

Research Questions:

(1) What are the lived experiences in relation to health and wellbeing of older adult Russian and Spanish-speaking immigrants in Southeastern, WI? (2) how do those lived experiences influence health outcomes? To explore these overarching questions, we had additional questions:

a. What stories are important to older adult Spanish and Russian-speaking immigrants?
b. What do these older adult immigrants view as the advantages and disadvantages of living in Southeastern Wisconsin in relation to health?
c. Where do these older adult immigrants get most of their health-related information regarding how things are done? (ex: scheduling a doctor's appointment)
d. Who do these older adult immigrants trust to get most of their information from?

…

To answer these aims and questions, and orient the reader regarding the structure of this dissertation, I organized my dissertation into the following sections:

(1) Article One – Background and Model Development: Barriers and Facilitators of Health among Older Adult Immigrants in the United States: An Integrative Review of 20 Years of Literature. In this article we examine the literature on barriers and facilitators of health among older adult immigrants, and created a table, situated in the Social Ecological Model[5], explicating the barriers and facilitators of health according to the literature. Following the literature review section, we then explain our new model, adapted from Social Cognitive Theory,[6,7] Acculturation,[8–10] and Successful Aging Theory[11,12]: The Older Adult Immigrant Adapted Model for Health Promotion.[13] This is the guiding model in all articles of my dissertation.

(2) Article Two – Methodology: The Triality of Roles for the Trilingual Researcher: Processes from a Community-Engaged Qualitative Cross-Language Health Study. In this article, we describe the Community-Engaged approach of this project and our adapted cross-language methods. Given the number of languages used in this study, we created these adapted cross-language methods to maximize rigor, trustworthiness, and transparency in our methods. These adapted cross-language methods include seven steps: (1) What and why? Considerations for Study Design, (2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation, (3) Who? The role of the translator/interpreter during the research process, (4) Who again? Translator/interpreter credentials and positionality, (5) What are you really saying? Dynamic equivalence, (6) Do your *ears* deceive you? Reflexive reflective reflexivity, and (7) Triality, not just Duality, of the role of the Researcher.

(3) Article Three – Results: “Your soul will rest in the fresh air” Health-Influencing Experiences of Older Adult Russian and Spanish-Speaking Immigrants in Southeastern, Wisconsin, United States. In this set of results, we explore the relationship between older adult Spanish and Russian-speaking immigrants and their environment in Southeastern Wisconsin. The metastory of the results was illuminated through the following three arcs: (1) *The Environment – Your soul can rest in the fresh air*, (2) *Social Support - You think you are by yourself but you’re not alon*e, and (3) *Outsiderness – We’re human.* In essence, access to parks, trails, and the natural environment positively impacted their health. Social support, which included friends, but also maintaining ties to one’s history, was also a positive impact among participants. Yet, feeling of Outsiderness – or persistent discrimination and feeling like “guests” despite decades of residence in Wisconsin – was a source of stress among participants.

(4) Article four – Results: “You Die or You Get Better” Conceptualizations of Health-Seeking Behavior and Health Care Encounters among Older Adult (Im)migrants in Wisconsin, the United States. In this final article, we discuss participants experiences and ideas of health, health-seeking behavior, health care expectations, and encounters with the healthcare system. We organized the metastory in the following manner: (1) “Whom can I trust if not my son?” From whom do participants trust to get information, (2) “You’re already old, you’re already sick” When and why did participants seek out medical care, and (3) “You die or you get better” Difficulties with the healthcare system. In essence, participants did not rely nor necessarily trust their doctors for health advice; first, they asked their children or trusted staff at a

social service organization. Then, when they did go to the doctor there was an expectation of treatment as curative. However, the healthcare system as a whole was nearly inaccessible. Participants struggled to make appointments, contended with long (several months) waits for appointments, then even after having the appointment, they waited weeks or months for results.

(5) The Conclusion. In this brief final section, I will briefly summarize my dissertation and concisely explain how the results addressed the specific aims and research questions.

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ARTICLE ONE: BACKGROUND

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Hawkins2022_Article_
BarriersAndFacilitators

Barriers and Facilitators of Health among Older Adult Immigrants in the United States:

An Integrative Review of 20 Years of Literature

Abstract

Background: There are over seven million older adult immigrants in the United States, and that number is expected to increase. Older adult immigrants in the United States have unique factors that influence their health.

Methods: In this integrative review, we systematically review 20 years of peer-reviewed literature on the barriers (i.e. isolation, lack of English Language Proficiency, low health literacy, lack of SES resources, discrimination) and facilitators (i.e. English Language Proficiency and maintaining ones native language, social support, culturally sensitive providers, healthcare access) of health among older adult immigrants in the United States.

Results: We found differing uses of the term 'older adult', emphasis on the lack of homogeneity among older adult immigrants, social support and isolation as significant barriers and facilitators of older adult immigrant health, and inconsistencies in uses and definitions of acculturation. We also examined relevant theories in the literature. Based on the literature review, focusing on Acculturation Theory, Social Cognitive Theory, and Successful Aging Theory, combining these three theories with findings from the literature to create the Older Adult Immigrant Adapted Model for Health Promotion.

Conclusions: Public health strives to promote health and prevent adverse health outcomes. Our integrative review not only systematically and thoroughly explicates 20 years of literature, but the Older Adult Immigrant Adapted Model for Health Promotion, provides guidance for future research and interventions.

Keywords: Older adult health, immigrant health, integrative review

Background

In 2018, there were 52.5 million older adults in the United States (US)(1). Additionally, of the 44.8 million immigrants in the United States (US)(2), 7.3 million (13.9%) were older adult immigrants, meaning they were not born in the US or its territories(1). By 2060, the US's older adult immigrant population is anticipated to increase to 22 million(1). In addition to the general challenges associated with aging, older adult immigrants in the US contend with unique factors impacting their health(3).

Hence, in this integrative review, we examine the factors, both barriers and facilitators, influencing older adult immigrant health in the US. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines(4), and Torraco's(5), and Whittemore and Knalf's(6), recommendations for writing integrative reviews. In summary, an integrative review, "reviews, critiques, and synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated."(5) Specifically, integrative reviews contribute to, "theory development"(6) and are applicable to research, "policy and practice."(6) Integrative reviews differ from traditional literature reviews in their generation of additional frameworks, theories, and applications.

As no previous integrative review has been done on the health of older adult immigrants in the US, this is a topic that benefits from "holistic conceptualization and synthesis"(5) to explicate innovative approaches, and to inform public health research. Furthermore, there is need for synthesis from health equity and social justice perspective. Braveman and Gruskin write, "equity means social justice"(7), and equity cannot be achieved unless there is an absence of "systematic disparities in health"(7). As this review will demonstrate, older adult immigrants' content with factors that drive systematic disparities in their health, thereby inhibiting health

equity. We further position the importance of health equity from a public health and human rights perspective.

Thus, in this review, we will: (1) Provide background on immigrants generally and older adult immigrants in the US and situate this topic within a public health and human rights lens. (2) Explicate our methods for the literature search. (3) Review the existing body of literature on older adult immigrant health in the US. In the literature review, we synthesize main themes, and the most common health barriers and health facilitating factors among this group. We also note the main theories used and the immigrant groups of focus. (4) Discuss Acculturation Theory, Social Cognitive Theory, and Successful Aging Theory, and illustrate the benefits of integrating aspects of these theories to create the unified conceptual model, the Older Adult Immigrant Adapted Model for Health Promotion (OAHM). Finally, (5) We will provide recommendations for future research.

…

In 2018, 13.7% (44.8 million) of the US population were immigrants(2), and of that 44.8 million, 7.3 million were older adults(1), the largest number of immigrants in any country in the world(2). Among older adult immigrants, meaning those over 65 years of age according to the American Community Survey(1), 58.2% identified themselves as female, and 41.8% identified themselves as male(1). The top ten countries of origin among older adult immigrants were: Mexico, China, the Philippines, Cuba, Germany, India, Canada, the United Kingdom, Vietnam, and Italy(1). Interestingly, older adult immigrants in the US are typically naturalized citizens(1); 71.7% of those over the age of 65 are naturalized citizens, compared to 46.4% of those under 64(1). This could be due to older adult immigrants immigrating at younger ages, residing in the US longer, and hence completing the naturalization requirements(3), or because older adult

immigrants who have resided in the US for several years may seek to complete the naturalization process to be eligible for benefits restricted to citizens by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)(3,8). This will be further explored in the literature review section. It should be noted that one must be a legal permanent resident in the US for at least five years before they are eligible for naturalization(9).

There are several demographic differences between older adult immigrants and older adult US-born individuals. According to the American Community Survey (2012-2016), among older adult immigrants, only 44.6% spoke English 'very well'(1). Regarding education, while older adult immigrants tend to be less well educated than younger immigrants(1), immigrants overall have higher levels of post-secondary education than US-born individuals(10). Among older adult immigrants, 27.5% have a bachelor's degree or greater, compared to 25.2% of US-born individuals(1). However, 31.3% of older adult immigrants had less than a high school education, compared to 15% among US-born individuals(1). Yet, level of education varies greatly among immigrant groups. For example, only 10.6% of older adult immigrants from Latin America had a bachelor's degree or greater, compared to 37% of older adult immigrants from Africa(1).

Furthermore, in regard to disability, the older foreign-born population was less likely to report having a disability (34.2 percent) than their US-born counterparts (36.0 percent)(1). Thirty-six percent of US-born older adults reported a disability compared to 32.4% of older adult immigrants(1). However, older adult immigrants had a lower prevalence of owning a home than US-born older adults(1), and older adult immigrant males had a greater prevalence of still being in the work force, even when eligible to retire, compared to US-born individuals(1). Older adult immigrants also had a greater prevalence of living in poverty, 15.8%, compared to 8.1% among

US-born older adults(1). Finally, older adult immigrants had a higher prevalence of being uninsured, 4.9%, compared to 0.4% among US-born older adults(1). Therefore, while older adult immigrants may report less disability, they may have fewer resources, which are important to preventing and addressing health concerns.

Yet, depicting the struggles of immigrants is insufficient, as it may unintentionally reinforce racist and isolationist sentiments. Hence, we will also note that refugees (defined on page 5) paid $21 billion in taxes in 2015(11), and undocumented immigrants paid over $11.6 billion in taxes in 2013(12). Additionally, immigrants are more often entrepreneurs than US-born individuals, thereby creating jobs(11). Immigrants, including undocumented immigrants, are also less likely to commit crimes than US-born individuals(13,14). Moreover, the US-born population is aging, and population growth has stagnated(15), which is leading to a workforce shortage in many states(15). While there is debate as to whether high levels of immigration could completely solve this problem(16), it is one proposed solution as, "immigrants are more likely to be of working age, more likely to start their own business, and are more likely to work unusual hours or move for new job opportunities."(17) However, what about older adult immigrants?

Older adult male immigrants are more likely to still be in the workforce compared to US-born older adults(10). Although older adult immigrants are more likely to have a low income and rely on government assistance programs(10,18), *they provide unseen support. For example, some older adult immigrants migrate to support their children and grandchildren, often providing child-care*(19), *and this extended family can provide valuable support*(20). *Additionally, as we will discuss in the literature review section, older adult immigrants have much to teach US-born individuals, such as traditional or holistic medicine*(19)*; and opportunities to share their knowledge is important to promoting their overall health*(19). *Moreover, while the debate over*

deservingness in the US is hotly contested, there is also the argument that everyone, no matter from whence or where they came, deserve healthy lives. However, before continuing this review, it is necessary to clarify several definitions and terms.

Health

In this review, we use the term health to refer to the many factors, from health insurance coverage, to the availability of public transport, which facilitate "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(21). Therefore, we use the term health to reference access to health care and associated determinants of health. Hence, we use the term health rather broadly.

Public Health and Human Rights

Public health, "promotes and protects the health of people and the communities where they live, learn, work and play."(22) Moreover, in order to address inequities and injustice in public health, we must understand the intersecting causes of these challenges. Older adult immigrants, as we will elucidate, have a nuanced relationship with the factors impacting their health. Thus, addressing and preventing negative health outcomes and promoting the factors that promote health among older adult immigrants in the US, "where they live"(22) is crucial. Health, which is impacted by access to necessities, such as social services and medical care. According to the United Nations (UN) Universal Declaration of Human Rights (UDHR):

> *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widow-hood, old age or other lack of livelihood in circumstances beyond his control."*(23)

Employing a Human Rights perspective is vital to Public Health(24). Thus, promoting health, and preventing and addressing health inequities, requires examining not just the individual or interpersonal factors that impact health, but structural factors such as racism and other types of marginalization common in the United States. Human Rights, woven in public health, also necessitates a view that people deserve to be healthy, and have access to the resources that facilitate health.

Immigrant versus Refugee versus Migrant

According to the United Nations High Commissioner for Refugees (UNHCR), the definition of a migrant is one who elected to leave their home for a number of reasons, including family reunification, education, or work(25). While a refugee is, "fleeing armed conflict or persecution,"(25) an immigrant is someone living in a country in which they were not born(26). However, in regard to 'migrant' versus 'refugee', Castañeda and Holmes note that "[w]hether a person is identified as a refugee or as some other socially constructed category... depends on historical, sociocultural, political, and economic contexts"(27). Thus, the question of choice remains debated among migrants and refugees and the definitions are not "rigid"(27–29). This is not to say that there is not a difference between a refugee fleeing persecution and a migrant accepting a job in another country, rather that the matter is easily defined. For example, if someone is forced to flee their home due to a natural disaster, this may be forced migration(30), but they may not meet the definition of a refugee(25). In the literature we reviewed, refugees and immigrants (including but not limited to naturalized citizens, visa-holders, and undocumented persons) are often grouped together(29). Hence, for the purpose of this review, the term 'immigrant' will be used to refer to individuals considered either immigrants or refugees.

Older Adult versus Elderly

In this literature review, we found a shift in 2000-2021 from the use of the term 'elderly' to the term 'older adult'. The article, "Use of the Term 'Elderly'"(31) published in 2012, reflects this shift, arguing that the term 'elderly' may be considered ageist and is laden with value judgements(31). Therefore, throughout this review, we use the term "older adult."

Methods

Search Methods

We conducted a systematic search of the literature following PRISMA guidelines.(4) We used the following six search engines: CINAHL, Global Health, Google Scholar, PsycINFO, PubMed, and Sociological Abstracts, and restricted our search to the years 2000-2021. We also used citation chaining to identify additional relevant articles. As we wrote this review at the beginning of 2021, the only works included from 2021 are those published between January 1st and February 7th of 2021.

For our search, we used the following 12 search terms: For our search, we used the following 12 search terms:

(1) "older adult immigrants" OR "older adult refugees" AND "health",

(2) "older adult immigrant" OR "elderly immigrant" OR "older adult refugee" OR "elderly refugee" AND "health",

(3) "older adult immigrants" OR "older adult refugees" AND health concerns or health problems or health consequences,

(4) "older adult immigrant" OR "elderly immigrant" OR "older adult refugee" OR "elderly refugee" AND health concerns or health problems or health consequences,

(5) "older adult immigrants" OR "older adult refugees" AND health facilitators or facilitators to health promotion, and

(6) “older adult immigrant” OR “elderly immigrant” OR “older adult refugee” OR “elderly refugee” AND health facilitators or facilitators to health promotion.

For PubMed we used the addition terms of:

(7) “older adult” AND “older adult immigrant” OR “older adult refugee” AND “health”,

(8) “older adult” OR “elderly” OR “older adult immigrant” OR “elderly immigrant” OR “older adult refugee” OR “elderly refugee” AND “health”,

(9) “older adult OR elderly” OR “older adult immigrant” OR “elderly immigrant” OR “older adult refugee” OR “elderly refugee” AND health concerns of health problems of health consequences.

(10) “older adult OR “elderly” “older adult immigrant” OR “elderly immigrant” OR “older adult refugee” OR “elderly refugee” AND health facilitators or facilitators to health promotion.

Finally, for Google Scholar, we used the additional terms:

(11) “older adult immigrant” OR “elderly immigrant” OR “older adult refugee” OR “elderly refugee” AND “Health” AND “United States” NOT “Canada” NOT “Israel” NOT “Europe”

(12) “older adult immigrant” OR “elderly immigrant” OR older adult refugee” OR “elderly refugee” AND health concerns of health problems or health consequences AND “United States” NOT “Canada” NOT “Israel” NOT “Europe”. In addition to terms #1, #3, #5, and #6.

We conducted the searches with and without the inclusion of the term ‘elderly’ because there was a transition around 2010 from the use of the term ‘elderly’ to the term ‘older adult.’ We had several inclusion and exclusion criteria depicted in table 1:

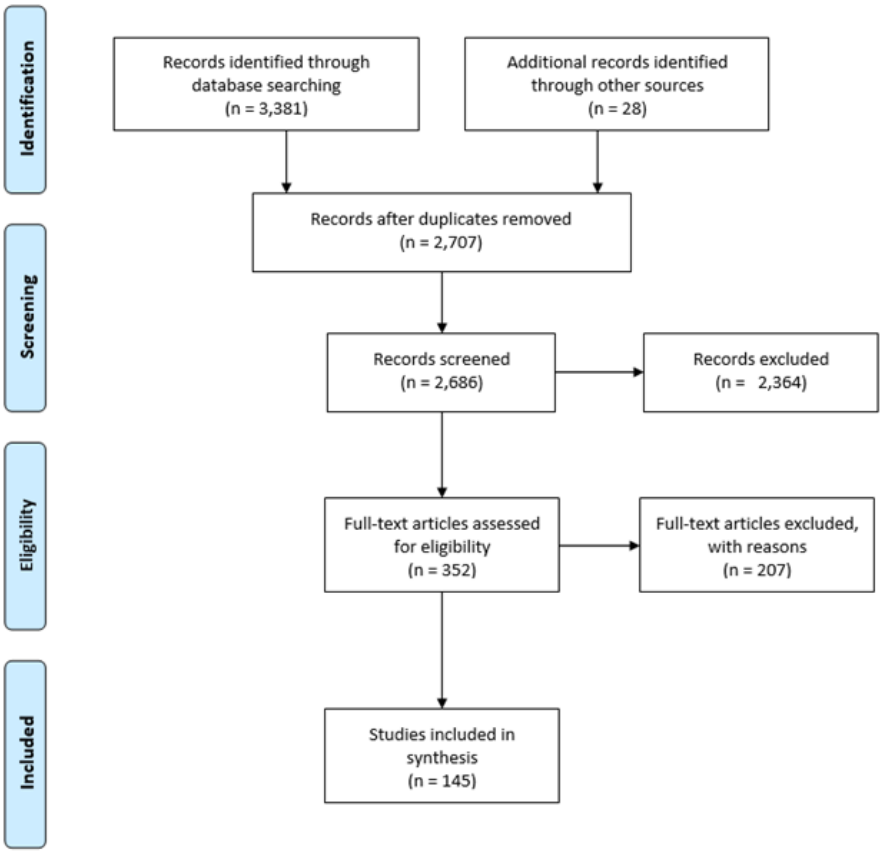
Table 1. Inclusion and Exclusion Criteria	
Inclusion Criteria	Exclusion Criteria
• Peer-reviewed articles, including quantitative, qualitative, reviews, and conceptual articles. • Published between January of 2000 and February 7th of 2021. • Specific to, or included, the United States. • Focused on health, or a health facilitating factor such as social service provision. • Focused on health, or a barrier to health, such as lack of transportation. • Focused solely on, or included, older adults. • Focused on immigrants or refugees.	• Non-peer reviewed papers, such as theses and dissertations. • Commentaries. • Opinion pieces. • Instrument validation. • Educational guides (ex: exercise curriculum, or on pedagogy for teaching students about older adult immigrants.) • Not specific to older adults. • Not specific to immigrants or refugees. • Specific to minority US-born citizens. For example, older adult Latinos born in the U.S. • If the article focused solely on the caregivers of older adult immigrants but did not include the older adult immigrants. • Specific to Puerto Ricans moving from the island of Puerto Rico to the continental US. • Clinical practice recommendations. • Specific to return migration.

Search Outcome

Our search in the six databases using 12 search terms yielded 3,381 results. We screened these results based on their title and abstract to determine what to include for full-text screening. Among those 3,381 results, there were 693 duplicates, and based on our inclusion and exclusion criteria, we screened 352 full-text articles. In total, 145 articles met our inclusion criteria.

For the 145 articles included, we created an excel spreadsheet, which includes key information about the articles included, specifically: The citation, year of publication, type of article, population of focus, health topic of focus, number of participants, age of participants, reported sex or gender of participants, theory, framework, or model used, methods, and whether the study was an intervention. We created a PRISMA flow-chart (figure 1) to document our search.

Figure 1. PRISMA Diagram created by research team



Results

Of the 145 articles included, 85 were quantitative, 44 were qualitative, three were mixed methods, eight were reviews, and five were conceptual.

Populations of Focus

There were 32 different groups of focus in the articles. Overall, the top three immigrant groups of focus, after older adult immigrants generally, were those from the People's Republic of China, the Republic of Korea (South Korea), and those from the Former Soviet Union (FSU). Other groups discussed in the articles included, Hispanic/Latinx, Asian, and African people generally, and Kurdish people. As well as those from Mexico, the Dominican Republic, Colombia, Guatemala, Cuba, Taiwan, the Philippines, Vietnam, Japan, Bhutan, Afghanistan, India, Iran, Somali, Nepal, Myanmar (Burma), Liberia, Burundi, and Liberia.

Health Topics of Focus

In the studies, more than 50 health conditions and factors impacting health were examined. Overall, access to and use of healthcare services; health insurance coverage; mental health; including depression; activity participation; and English language proficiency, were the most common health inhibiting and facilitating topics discussed. In some studies, a single health outcome, such as diabetes, was discussed. Other articles instead examined the relationships between multiple factors, such as examining the relationship between acculturation, health beliefs, and health care use(32). Social support and acculturation were the two most common factors examined in relation to health and health conditions. Both social support and acculturation will be discussed in the subsequent findings section.

Theories and Frameworks of Focus

In five of the 145 studies, authors developed their own conceptual framework. Additionally, in 47 studies the authors explicitly discussed and drew upon a specific theory, framework, or model to inform the study. Nearly every theory, framework, or model, explicitly used by the authors was different. Only four frameworks were used in more than one study. An Ecological framework was used in five studies, and only two of those studies used the same one, those frameworks were: An Ecological Framework(19,33), an Ecological Model(34), Ecological Systems theory(35), and an Ecological Theory of Aging(36). A Life Course Perspective was used in five studies(37–41). Finally, three different studies used Acculturative frameworks(42–44) and two studies used Kleinman's Exploratory Model(45,46). Notably, acculturation was commonly mentioned, yet seldom used as an explicit framework. This is further discussed in the findings section.

Drawing from the 145 articles, we created Table 2 to show the barriers and facilitators of health and well-being for older adult immigrants in the US. These barriers and facilitators are organized using the Social-Ecological Model (SEM)(47). Three of the barriers and facilitators appear in more than one level. Following this table, we discuss the main themes, which were: (1) More females than males, (2) differing uses of the term 'older adult', (3) older adult immigrants are not homogeneous, (4) isolation and social support, (5) age-at-migration matters, (6) acculturation inconsistencies, and (7) learning from older adult immigrants.

Table 2.	**Barriers and Facilitators of Health and Well-Being among Older Adult Immigrants in the United States**	
	Barriers	**Facilitators**
Individual	- Lack of English language proficiency. - Refugee status (as a proxy for trauma). - Loss of independence. - Low health literacy. - Loss of a spouse. - Lack of SES resources. - Loss of independence. - Dementia/memory loss. - Poor physical health. - Depression. - Chronic pain. - Chronic conditions. - Sleep issues/Insomnia.	- Owning a personal vehicle/ability to drive. - English language proficiency. - Formal education in the U.S. - Resilience. - Positive emotions (ex: optimism, positive affect) and psychological well-being. - Maintaining one's native language and traditions. - Traditional medicine/Holistic approaches to health. - Life satisfaction. - Proper nutrition. - Leisure time. - Sexual health knowledge.
Interpersonal	- Isolation. - Social exclusion. - Discrimination based on racial/ethnic/gender identity. - Loss of previous social status. - Financial abuse. - Older adult abuse. - Healthcare providers misinterpreting immigrants health service expectations and feeling unprepared to work with immigrants. - Expectational role friction.	- Social support. - Culturally sensitive providers/culturally appropriate care. - Receiving professional care. -Provider and treatment trust. - Opportunities for them to share their life experiences and knowledge with others, such as teaching cuisine/food. - Liaisons, "helpers" from the immigrant community to aid other immigrants. - Social capital. - Trust.
Organizational	- Discrimination based on racial/ethnic identity. - Limited access to support services. - Lack of preventative care.	- Healthcare access. - Translated materials - that are culturally relevant. - Provision of culturally relevant information.

	- High cost of medical care/financial concerns. - Issues accessing medical care.	- Traditional medicine/Holistic approaches to health. -Health education. - Participation in activities (ex: social, cognitive, spiritual/religious, physical). - Culturally meaningful activities. - Resource access (in addition to healthcare). - Group excursions, or "field trips"[18]. - Home health care services.
Community	- Lack of available, and inaccessible, transportation. -The built environment – Lack of safety and walkability. - Poverty. - Discrimination based on racial/ethnic identity.	- Neighborhood cohesiveness. - The built environment. - Available public transport. - Healthcare access. - Availability of care. - Community trust.
Structural	- Discrimination based on racial/ethnic/gender identity. - The 1996 Personal Responsibility and Work Opportunity Reconciliation Act. - Lack of citizenship/temporary status. - Lack of insurance.	- Citizenship. - Health insurance.

More Females than Males

In 2018, 58.2% of older adult immigrants in the US identified as female, and 41.8% identified as male(1). However, in the 145 studies, in only 13 studies were there more females than males.

Differing uses of the term 'Older Adult'

There were several different ages used to encompass 'older adults' in the literature. According to the US Census Bureau, the American Community Survey, and HealthyPeople.gov, an older adult is one 65 and older(1,48). Yet, according to a 2012 report from the Centers for Disease Control and Prevention (CDC), an older adult is someone age 60 or older(49). Differing definitions and age limits in were present in the studies reviewed. While many articles used 65 years or older as their inclusion criteria, others selected a lower age, still categorizing the age as

the threshold for ‘older adult.’ For example, Cofie et al.(50), Zhang and Zhan(38), Nandan(51), and Gautam et al.(52), included those 50 and older; while Guo et al.(53), Lee and Eaton(54), Sohng et al.(55), and Aroian and Vander(56), included those 60 and older. This creates concerns when comparing studies, especially when assessing health insurance, as one needs to be at least 65 to qualify for Medicare unless qualifying via disability status or in few other conditions(57). It also elicits a more conceptual question, who is an older adult?

Older Adult Immigrants are not Homogeneous

The literature emphasized that older adult immigrants are not a homogeneous group, and interventions cannot treat all older adult immigrants the same. Nandan(51) noted in their qualitative study with older adult immigrants from India that, not only are immigrants from the continent of Asia not homogeneous, but Indian immigrants are unique in that many already speak English before arriving in the US(51). However, tensions in values still exist(51); and many participants in Nandan’s study felt that their spiritual needs were not met(51). Similarly, Kang et al.(58), in their qualitative study with older adult Korean and Chinese immigrants, found that for the two groups, different factors impacted their healthcare utilization. For older adult Chinese immigrants, gender and length of stay in the US impacted healthcare use, while for older adult Korean immigrants, marital status was a stronger predictor of healthcare use(58). However, for both groups, lack of English language proficiency, lack of health insurance, cultural tensions, and the presence of depressive symptoms all negatively impacted healthcare service use(58). Additionally, Mui et al.(39), in their quantitative study with older adult Korean immigrants, Chinese-immigrants, and US-born individuals, found that more older adult Korean immigrants reported that religiosity was a coping mechanism than older adult Chinese immigrants(39). Yet,

similarly to Kang et al., Mui et al. found that for both immigrant groups poor English proficiency was associated with worse health outcomes(39).

Notably, the emphasis on the lack of homogeneity in immigrant groups reflected a tension in the literature regarding an emic versus etic approach(59), and a broader debate about the generalizability of findings. Essentially, there was tension between the studies which grouped older adult immigrants together (30 studies grouped older adult immigrants together), and those focusing on a specific immigrant group. Furthermore, there was also tension in the studies that focused on a single specific group of older adult immigrants. This was the case with many studies focusing on older adult Chinese immigrants. Some studies specified that Chinese immigrants included those from China, Taiwan, or Hong Kong, or that Chinese immigrants included Mandarin, Fujianhua, and Cantonese speakers(60,61). Some studies differentiated immigrants from mainland China and those from Taiwan(62). Older adult immigrants are not homogeneous, and future studies should be clear about how they define groups. Nonetheless, these emic and etic studies provide valuable information on factors impacting health among older adult immigrants in the US, especially when the same findings (listed in Table 2) were echoed in small qualitative studies and studies using large nationally representative samples.

Isolation and Social Support

Isolation and social support were two of the most common health-influencing factors discussed in the literature. Social support is especially interesting because, while over 20 studies found that social support was an important factor, only 10 studies focused on social support in their article conceptualization. This means that even when researchers did not set out to examine the importance of social support, it continued to emerge as a crucial factor. Social support is a broad concept and is generally conceptualized as having friends or family on whom one can

rely(63). Additionally, in the literature, social support also included social networks and social relationships. One study by Rhee(64). found that social support, or a lack thereof, “was the strongest predictor of depression”(64) for older adult Korean immigrants, moreso than somatization and acculturative stress. Cummings et al.(65), found the same finding among older adult Kurdish refugees, that a lack of social support was a significant predictor of depression. A key caveat however, found by Liu et al.(66), was that social support needed to be healthy, and that negative social support could be detrimental to one’s mental health.

Isolation lies opposite of social support. Isolation, meaning to be separate from others(67), was linked to English language proficiency. Tran et al.(68), found that isolation combined with a lack of English language skills resulted in older adult immigrants from the FSU being unable to complete tasks or participate in “social activities.”(68) Furthermore, Serafica(69), identified isolation as contributing to emotional distress among older adult Filipino immigrants. In another study by, Serafica(70), they found that improved English language skills and social relationships were protective against isolation among older adult Filipino immigrants. However, while Wang(71), found that isolation was worsened after the death of a spouse among older adult Chinese immigrants, they importantly noted that isolation was not necessarily alleviated by residing with others, even with family members. Zhang and Zhan(38), found in their study with older adult Chinese immigrants that many described feeling like they were in a “prison”(38) even though they lived with family members. This was due to a lack of English language proficiency, few friends, shifting roles with their children, and a “lack of belonging”(38). This suggests that studies should include robust measures of isolation, not simply physical isolation.

Age-at-Migration Matters

Age-at-migration, or the age at which one migrates, was related to overall health. Gubernskaya wrote that age-at-migration was a proxy measure that captures, "the degree of health selectivity upon arrival…and the length of exposure to the environmental conditions in countries of origin"(18). In essence, if one immigrates at an older age, they were exposed to potentially adverse conditions in their country-of-origin for a longer period of time. Yet, if one immigrates at an older age, this may also reflect a degree of good health, as the immigration process is neither easy nor stress-free. In their 2015 study, Gubernskaya found that Hispanics who immigrated after age 50, had a more rapid decline in their health compared to non-Hispanic immigrants and US-born older adults(18). Yet, interestingly, Hispanics who immigrated at age 18 still experienced sharp declines in their health after 50, which Gubernskaya partly explains as a consequence of discrimination, poor, hazardous, and low-paying working conditions, and "underinsurance, and limited access to non-emergency health care"(18) in the US.

In a 2013 study, Gubernskaya also explored age-at-migration within the context of naturalization. They use naturalization in two ways, first as a proxy for social integration, and second that naturalization is "a key indicator of social and political inclusion"(3). They found that among naturalized citizens, those who immigrated after age 50 had worse health than those who immigrated as children or young adults(3). They also posited that older adult immigrants who naturalize may do so because of old age and accompanying health issues, in a phenomenon called negative health selection(3). Many benefits, such as TANF and Medicaid, were restricted to citizens by the 1996 PRWORA(3,8), hence older adult immigrants may seek to complete the naturalization process to be eligible for benefits restricted to citizens. Hence, Gubernskaya posits that negative health selection is why naturalized citizen older adult immigrants may have greater odds of functional limitations than non-citizen older adult immigrants(3). They also make the

important point than immigrants who migrate at older ages have very limited opportunities for building resources, specifically socioeconomic resources, such as savings or retirement funds(3). Other authors found similar and differing results.

Alemi et al.(72), in their study with older adult Afghan refugees, found that migrating at an older age was associated with worse health, specifically, psychological distress. Similarly, Nkimbeng et al.(73), in their review of correlates of disability among older adult immigrants, also found that migrating at an older age was associated with worse health. Yet, Mehta et al.(74), found different results. They found that, not only did immigrants who migrated at older ages have a longer life expectancy (+2.4 years) than US-born older adults, but that immigrants who migrated at older ages also had lower rates of mortality than US-born older adults(74). Mehta et al., found the increase in life expectancy was present across all immigrant groups: those from Asia, "Central America, western/eastern Europe, and Africa."(74) Moreover, Holmes et al.(75), examined the impact of age at migration, nativity, and length of time in the US, on mortality, specifically within older adult Hispanic immigrants, who migrated at different ages, and US-born Hispanics. They found a "mortality advantage"(75), among older adult Hispanic immigrants who migrated after age 24, compared to Hispanics who migrated before the age of 18(75).

Furthermore, Thomson et al., similar to Gubernskaya, found that Hispanic immigrants who were citizens had higher rates of disability compared to non-Hispanic White immigrants(76). Choi, similar to Mehta, found that older adult immigrants who migrated at older ages had better health than immigrants who migrated at younger ages and US-born older adults(77). Yet, several factors, such as different approaches, research questions, health topics of focus, and methods of dividing immigrant groups for analysis, could drive the difference in

findings between these strong studies. Overall, it seems that age-at-migration matters, although whether it is related to greater or reduced mortality warrants further exploration.

Acculturation Inconsistencies

Acculturation was the most discussed concept in the literature, but not the most explicitly applied framework. Nineteen studies examined acculturation, either as the outcome of interest or in relation to the outcome of interest, such as the impact of acculturation on health service use(78). Additional studies heavily emphasized it in the literature review section. Yet, only three studies named an acculturative model or acculturative framework as their guiding framework. Those three studies discussed three frameworks, which were: The Bidimensional Acculturation Model(42,79,80), the Acculturation Model(44,81), and the Ecological Acculturative Framework (EAF)(43,82). Berry(79,80,83–86), was the most commonly cited author on acculturation.

Moreover, the measures of acculturation differed in nearly every study. For example, some studies simply measured acculturation as length of stay in the US and English Language Proficiency (ELP)(65,87), while others, such as Mao et al.(60), used robust measures of acculturation. Under the umbrella of acculturation, Mao et al. examined Behavioral Acculturation, Cognitive Acculturation, and Identificational Acculturation(60). Behavioral Acculturation included daily habits, language concerns, and dependence on interethnic networks(60). Cognitive Acculturation included, “self-contentment, fatalism, and collectivism”(60), and “individualism and independence”(60). Finally, Identificational Acculturation included maintenance of ethnic identity(60). Additionally, in the studies that measured acculturation, they found that acculturative stress, the stress caused by this cultural, linguistic, economic, and role re-negotiation, can lead to adverse health outcomes. Rhee found that acculturative stress was a “significant risk factor for depression”(64) among older adult

Korean immigrants not residing in ethnic enclaves(64). Similarly, Serafica found that older adult Filipino immigrants who had high levels of acculturative stress, "reported lower physical and mental health scores."(70) However, it is difficult to make claims on the impact of acculturation and acculturative stress due to the differences in measurement.

The inconsistencies in the measurement of the concept acculturation echoes the writings of others. For example, Gubernskaya wrote that, "the concept of acculturation is not well defined"(18,88,89) and it is difficult to differentiate between the impact of length of stay in the US and normal "age related health declines."(18) For these reasons, in Table 2, we never explicitly list 'acculturation', rather we list the specific elements measured in the studies, such as ELP. Due to this inconsistency in this concept, we will clearly define acculturation in the theoretical section, and seek to avoid common concerns with acculturation, such as inadvertent stereotyping(89).

Learning from Older Adult Immigrants

Finally, an important point made in the articles was what others must learn from older adult immigrants. Not only do older adult immigrants provide a wealth of knowledge on language, culture, and history, preserving that which is important to their health(19,32,90–95), but they also have different methods of approaching health. For example, Martin found that among older adult Iranian immigrants, health not only included physical, but also spiritual and emotional health(95). Martin discussed the tensions caused by the biomedical model in US healthcare(95), and overall, they argue that a holistic approach to health, which recognizes that spiritual and mental health can impact physical health, and visa-versa, is important for promoting health.

In addition to holistic health, herbal medicine, or traditional medicine, when used safely with provider knowledge(93,96), is not only important for providing culturally congruent care but are also beneficial for non-immigrant groups. For example, acupuncture has been found to aid in cancer pain management(97). Chinese herbal medicine has also been found to be beneficial in the treatment of cardiovascular disease(98). Additionally, in the treatment of ulcerative colitis, some herbal medicines are quite safe(96). Van Son found that older adult immigrants from the FSU preferred herbal remedies, but emphasized the safety risks involved in mixing medications without support from a physician(93). Ivanov and Buck found in their study with older adult immigrants from the FSU that participants also valued herbal medicine, but also spoke highly about medical care in the US when they had clear communication with providers**(94)**. Furthermore, in a study with older adult Korean immigrants, Kim also found that participants preferred a mix of traditional Korean medicine (hanbang) and Western medicine(92). In their study with older adult Chinese immigrants about traditional Chinese medicine (TCM)（中医）, Dong et al. found that, "TCM users are unlikely to disclose use to their physicians" and "Chinese older adults who report better quality of life also report use of TCM, suggesting the cultural relevance of TCM."(91) These findings demonstrate a need for providers to have honest conversations with their patients about traditional/herbal medicine, and the need for greater integration of traditional medicine approaches in medicine and public health practices in the United States.

A Unified Conceptual Model

As demonstrated in the literature review section, many factors influence older adult immigrant health, and there is a lack of commonly used models for the health of older adult immigrants. For the unified conceptual model, we combine aspects of Acculturation Theory

(AT), specifically using Ward and Geeraet's process model of acculturation(99), Social Cognitive Theory (SCT), focusing on socioenvironmental influences, Successful Aging Theory (SAT), and key concepts from Table 2. We selected these three frameworks for several reasons. First, we selected AT because it is common in the literature on immigrant health. Moreover, as AT has been criticized in recent years for its focus on individual and cultural explanations(100,101), we draw on Ward and Geeraet's model as it includes ecological and Ecosocial dimensions. Only one study we reviewed on older adult immigrants' health explicitly named SCT(102). However, we selected SCT because, as demonstrated in Table 2, the key constructs in SCT were present in the literature, making SCT unstated but present. Specifically, the SCT socioenvironmental influences of social support, normative beliefs, such as the benefits of traditional medicine, and barriers and opportunities, such as the role of public transport or ELP on health were present in the literature. Finally, the concept of successful aging, was present in several studies we reviewed. SAT is a useful concept to incorporate because it focuses on the process of aging.

Acculturation Theory

Broadly defined, acculturation is the process by which one changes their behavior, values, and even primary language used, as they are immersed in another culture(83,84,99,103). In the literature, acculturation was applied as a definition, model, or framework. According to Berry, the most cited author on acculturation in the studies we reviewed, acculturation is bidimensional, meaning it involves negotiation with the new culture, and re-negotiation with the culture of origin(79,81). However, as we noted in the literature review section, there is a lack of clear and consistent definition of acculturation and application as a framework. Hence, we refer to Acculturation Theory (AT) as it denotes a multidirectional process of integration, negotiation,

and potentially biculturalism(84,99,100), and we adapted, Ward's and Geeraet's(99) process model of acculturation. While Ward and Geeraet's model is overall a comprehensive model, it has several limitations, which we address in the adapted model. First, the model is not specific to older adult immigrants, who are affected by aging-related challenges. Second, in our model, we place greater emphasis on one's immigration history as a distinct phenomenon. The specific circumstances of one's acculturation process, such as immigration history, should be considered(104). Third, the model does not depict the manners that acculturative stressors may impact behaviors and influence health barriers and facilitators.

Social Cognitive Theory

Social Cognitive Theory (SCT) has three major constructs: cognitive influences, socioenvironmental influences, and behavioral factors(105,106). We focus on socioenvironmental influences including observational learning, normative beliefs, barriers, opportunities, and social support(105,106). Socioenvironmental influences include not only how the physical environment promotes or hinders health, but also how the social environment, such as the social acceptability of behaviors as influenced by culture, which is especially pertinent for older adult immigrants, impacts health(105,106). AT relates to socioenvironmental influences as one's pre-immigration and immigration experiences shape their socioenvironmental influences. While SCT is also a comprehensive theory, it has several limitations, which we seek to address in the adapted model. Specifically, while SCT considers socioenvironmental factors, it considers how those factors impact an individual's behaviors(105).

Successful Aging Theory

Successful Aging Theory (SAT) emphasizes three tenets of well-being, "low risk of disease and disease-related disability; maintenance of high mental and physical function; and

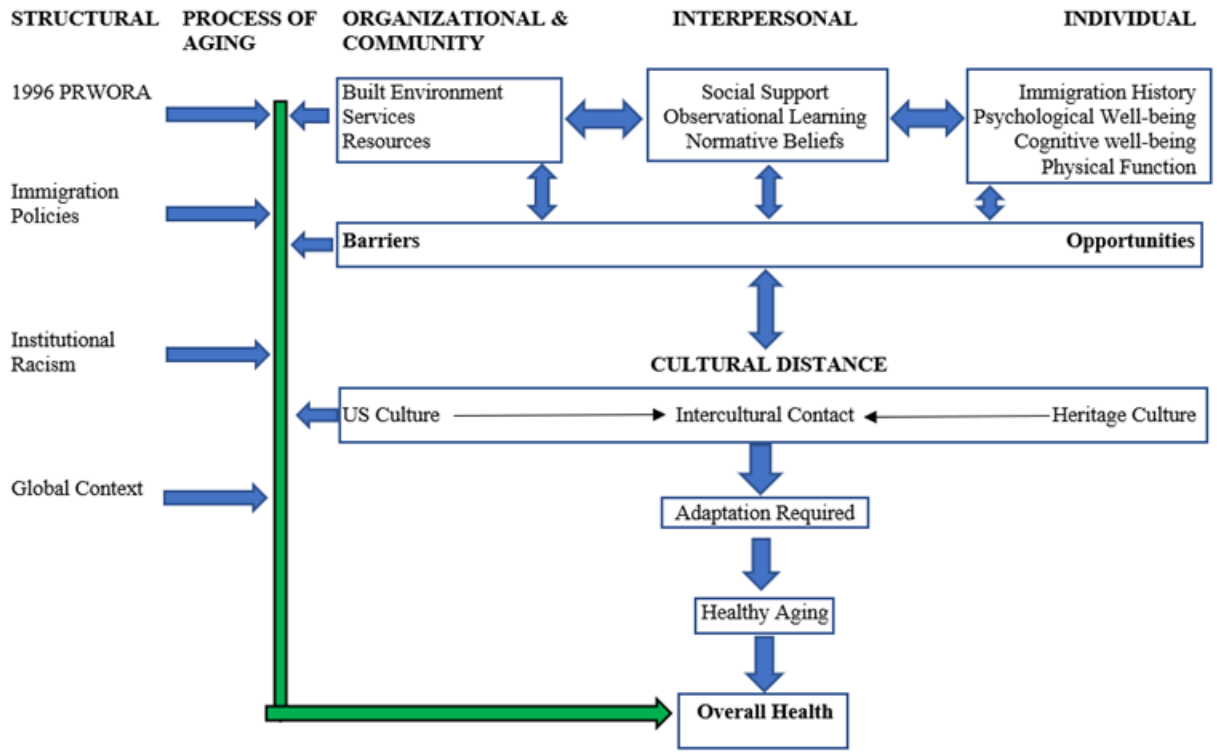
continued engagement with life."(107) A key tenet underlying SAT is that aging is a process(108). Moreover, the four assumptions underlying SAT are: (1) Aging is a process of adaptation that gradually becomes more complicated, (2) the success or lack of success in aging depends on the complexity of adaptation required, for older adult immigrants this requires considerably more adaptation, (3) an individual's choices impact their aging, and (4) aging changes people's beliefs and values(108). Annele et al.(109), operationalized SAT as a multifaceted concept(109). Applied to older adult immigrants, SAT is age-specific to older adults, underscoring age-related physical and psychological challenges. Annele et al.'s model is modified from Fernandez-Ballesteros model(110). While Annelle et al.'s model is comprehensive, it has several limitations which we seek to address in our adapted model. First, it focuses solely on the individual. Second, there is not a relationship between psychosocial factors and biomedical factors, even though these factors influence one another(111). Finally, the very title of the model, 'successful aging', implies that there is a way to unsuccessfully age. Katz and Calasanti note that when older adults are asked about successful aging, "we learn that disability and disease are not necessarily experienced in terms of unsuccessful aging nor is successful aging a precondition of aging well"(112). Hence, while activity, health, and productivity can all be good things for aging older adults, they do not dictate whether one self-assesses themselves as successfully aging. Therefore, in our adapted model, we focus on how multi-level factors interact to impact health, rather than an individual self-perception of aging success.

A Unified Model

In Figure two, we illustrate our unified conceptual model. In addition to combining AT, SCT, and SAT, and addressing the aforementioned limitations, we added several aspects from Table 2. We incorporated elements from Table 2 to enhance the immigrant-specific elements of

this model, and link elements from the literature as there was not a common model used. The unified model is called the Older Adult Immigrant Adapted Model for Health Promotion (OAHM).

Figure 2. The Older Adult Immigrant Adapted Model for Health Promotion (OAHM)



A major benefit of this model, is that it includes concepts of aging, acculturation, immigration, and health, situated within an ecological context. From a public health perspective, this model illustrates how different dimensions interact specific to older adult immigrants, and spheres where prevention and intervention efforts could be targeted.

From a theoretical standpoint, the use of a clear framework, such as OAHM, would enhance studies(47). We should note that we have used the terms model, framework, and theory rather interchangeably due to the number of different frameworks, models, theories, and uses of those terms, by authors in the literature. We recognize that these terms do have different

definitions(113). Thus, the OAHM is best considered a conceptual model. Additionally, when we use the phrase, 'from a theoretical standpoint,' we draw on Jaccard and Jacoby(114), to mean from the standpoint of recognizing the importance of relationships between concepts(114). In essence, we argue that studies are better grounded, more clearly defined, and aid in a clearer understanding of outcomes when there is a 'road-map' of the relationships between concepts.

The three headings on the top-right, individual, interpersonal, and organizational and community, have double-headed arrows because they influence one another. For example, observational learning and normative beliefs impact service use. If service utilization is not acceptable due to observational learning and normative beliefs, then those important services may go unused. Lack of use of preventative care based on observational learning and normative beliefs was found to negatively impact the health of older adult immigrants in several studies(18,94). Individual, interpersonal, and community and organizational factors are directly linked to barriers and opportunities. For instance, a lack of a safe area to walk in or a lack of public transport may limit access to social support as well as contribute to poor physical function while enhanced ELP may provide opportunities for larger social networks and greater access to resources. At the same time, just as individual, interpersonal, and community and organizational factors interact with barriers and opportunities, so does cultural distance.

The interaction between one's heritage culture and US culture, or intercultural contact, can be stress-inducing and requires negotiation and shifts in economic circumstances, languages, cultures, and roles, and influences barriers and opportunities. For example, for older adult immigrants, lack of SES resources due to migration circumstances may be a barrier to seeking adequate medical services. Additionally, while enhanced ELP may facilitate greater social support, both acquiring ELP and maintaining one's native language are important for the health

and well-being of older adult immigrants(61,69,90,115,116). This cultural distance and negotiation influences the amount of adaptation required. Immigrants who migrated at an older age(117,118) may face additional cultural and linguistic adaptation challenges. The amount of adaptation required, particularly if it is perceived as difficult adaptation, affects health aging, which affects overall health.

The last two major sections in Figure 2 are the structural and process of aging categories on the upper left. The reason arrows from the other sections point towards the process of aging section is because aging is a process, that gradually becomes more complicated(108), and it is an interaction between multiple factors that shape health. Moreover, in the process of aging, there is the aspect of time. Older adult immigrants continue to age which gradually creates more challenges. For example, feelings of isolation and depression may put an older adult immigrant at risk for worsened cardiovascular health(111). This isolation may also act as a barrier to accessing health services, which negatively impact healthy aging and one's overall health. Hence, from a public health perspective, promoting healthy aging and overall health requires interventional adaptation as one ages.

Finally, the structural section includes the 1996 PRWORA, immigration policies, institutional racism, and the global context. For example, the restrictions put in place by the 1996 PRWORA restrict a vulnerable population from receiving vital resources. Among older adult immigrants who immigrated after 1996, "Medicaid coverage significantly declined among older noncitizens but increased among older naturalized citizens after Welfare Reform."(119) This lack of insurance, and also under-insurance among older adult immigrants generally(120), is a barrier and leads to a lack of usage of preventative care and costly emergency-room visits later(119). Furthermore, as an example of how immigration policies impact health, the 1990

Immigration Act, “increased the refugee ceiling from 43,000 to 50,000 per year for peoples from the former Soviet Union.”(94) This, in combination with policy shifts in the FSU, allowed more refugees, specifically Jewish refugees, to leave the FSU. However, these policy shifts occurred decades after WWII, the holocaust, and during continued anti-Semitism in the FSU(121). Thus, refugees from the FSU tended to be older and were exposed to negative conditions for a longer period of time before immigrating. Exposure to conditions, which Gubernskaya posits, is linked to worse health outcomes(18). These policies influence the process of aging for older adult immigrants, and from a public health perspective when assessing health-influencing factors, the role of policy at certain points in time and in certain contexts, needs to be included. The OAHM illustrates how different factors interact to influence the health of older adult immigrants.

Recommendations for Future Research

We have several recommendations for future research based on the literature we reviewed, and in the interest of coherence and concision, we provide three main recommendations for future research: Greater emphasis on context, a clear theoretical framework, and more robust and clearly defined measurement of concepts such as acculturation.

First Recommendation

Future research with older adults should clearly explicate the context. Contextual information was missing from many of the studies we reviewed. Many studies we reviewed focused the background section of their study on a health outcome of interest without emphasizing the broader contextual factors influencing that outcome. Regardless of the type of study (qualitative, qualitative, mixed methods), context is crucial in aiding the researcher, readers, and wider audience in understanding the factors impacting that group. Context is crucial because factors affecting the health of older immigrants do not exist in isolation. These factors

include history, policy, built environment, language, and institutional racism. To understand the barriers and facilitators of health among a particular immigrant group context is invaluable to illustrating that health does not exist in a vacuum. If we as public health professionals want to truly commit to increasing health equity, we need to understand the various manners in which different factors influence risk differently among specific older adult immigrant groups. For example, older adult immigrants from the FSU may seldom face discrimination based on race but face added barriers due to language; while older adult Latinx immigrants from Belize (an English-speaking country) may not face as significant language concerns, they may encounter institutional racism in the US. In essence, future studies should emphasize context.

Second Recommendation

Secondly, we recommend that future studies apply a theoretical framework. Out of the 145 studies we reviewed, only 47 explicitly articulated that they used a theoretical framework. Using a clear theoretical framework enhances research(122). Theory aids researchers in understanding the potential pathways and mechanisms potentially impacting the outcomes of interest in a study(47,122). As noted by Brazil et al., atheoretical approaches to research can lead to a "simple input/output" study(122,123). Hence, theory is important to shaping a comprehensive study; it informs the pathways impacting the variables of interest, which in turn may impact the questions asked in the study, study design, and evaluation tools. Future research, regardless of study type, should incorporate theory.

Third Recommendation

Our third recommendation contains two steps. Firstly, most of the literature on older adult immigrants focused on those from South Korea, China, and the FSU. There was little literature on the health of older adult Latinx immigrants or those from the Middle East, and even

less on older adult immigrants from the continent of Africa, or Black older adult immigrants from Latin America. Future research with older adult immigrants should pay greater attention to these groups. Secondly, as noted in the results section, acculturation was inconsistently defined and measured, leading to difficultly in determining to what extent one was able to conclude how the acculturative process impacted the health of older adult immigrants in the US. For example, common measures, such as citizenship status, ELP, and length of stay in the US are proxy measures and are confounded by other factors such as SES(124). Hence, future studies in which the researcher is collecting primary data, should use robust measures of acculturation to truly attempt to capture the phenomenon they are attempting to capture. Such as Mao et al.'s examination of Behavioral Acculturation, Cognitive Acculturation, and Identificational Acculturation(60).

Limitations

The main limitation of this review is that it is very broad. We did not focus on a particular health topic or population but instead the barriers and facilitators of older adult immigrant health in the US as a whole. However, for future studies or reviews, greater specificity is warranted. Moreover, we did not examine state-by-state differences regarding the differential application of the 1996 PWRORA. It is quite possible that, due to the restrictiveness of our search terms, important themes were not reflected in the literature we reviewed. For example, violence and pre-migration and migration experiences are not comprehensively discussed in this review, likely due to our restriction in search terms. Finally, this review does not address provider interactions with older adult immigrants. The most common recommendation in the articles we reviewed was that providers and staff who work with older adult immigrants should be better prepared to work with them. This recommendation, focused on interpersonal

relationships, often lacked any explicit direction on how to integrate it. Only two articles engaged with staff, and Eckemoff found that hospice staff did not feel prepared or equipped to work with the older adult immigrants they were serving(125). Future reviews should take this into account.

Conclusion

Older adult immigrants in the United States are a large group, and unique factors inhibit or facilitate their health and well-being. As the population of immigrants, and older adult immigrants continues to grow in the US, the US medical and public health professionals need to be prepared to work with this large group. Hence, in this integrative review, we conducted a systematic review of 20 years of literature. We found that social support, isolation, mental health, activity participation, health insurance, and service use were the most commonly discussed barriers and facilitators of health. Moreover, a guiding framework was only used in one-third of the studies, and nearly every framework differed. Following our review of the literature, we examined AT, SAT, and SCT, and combined those theories with elements from the findings in the literature, to create the Older Adult Immigrant Adapted Model for Health Promotion (OAHM). Then, we explicated recommendations for future research, such as further illuminating acculturation, examining age-at migration, incorporating theory, understanding context, and conducting more research with Latinx older adult immigrants, and older adult immigrants from the continent of Africa. Public health strives to promote health and prevent adverse health outcomes. This is the first integrative review on the health of older adult immigrants in the US, and we strove to elucidate research recommendations, from a public health perspective, to promote the health of older adult immigrants.

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ARTICLE TWO

The Triality of Roles for the Trilingual Researcher:

Processes from a Community-Engaged Qualitative Cross-Language Health Study

Abstract:

There are numerous ethical and procedural challenges when conducting cross-language research, and there is a need to discuss the role of multilingual researchers, as much of the existing literature focuses on working with third-party interpreters or translators. In this article, we expand the recommendations for cross-language research for trilingual researchers and multi-lingual health studies, through examination of literature and processes from a Community-Engaged Qualitative Photovoice project. We present adapted cross-language research methods for future cross-language research studies. These adapted methods include seven considerations: (1) What and why? Considerations for Study Design, (2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation, (3) Who? The role of the translator/interpreter during the research process, (4) Who again? Translator/interpreter credentials, (5) What are you really saying? Dynamic equivalence, (6) Do your *ears* deceive you? Reflexive reflective reflexivity, and (7) Triality, not just Duality, of the role of the Researcher.

Key words: Cross-language research, trilingual researchers, qualitative research methods, Photovoice, trustworthiness, validity, insider-outsider, immigrant health, older adult immigrants.

Introduction

Thirteen percent of people speak at least three languages (*Multilingual People*, 2018; *Trilingual*, 2022). Yet, a search using the term "trilingual researcher" in Google Scholar, CINAHL, and PubMed, yielded no results pertaining to the trilingual *researcher*, rather the trilingual research. Hence, in this article we expand the recommendations for cross-language research, building upon the literature on the roles of bilingual and trilingual researchers and third-party interpreters or translators. We discuss navigating the role of a trilingual researcher within the context of a Qualitative, Photovoice, Community-Engaged Participatory Research project, and emphasize the experience of the lead author (MMH), a polyglot who conducted research in Spanish and Russian for an English-speaking audience.

To summarize the project, we conducted a Community-Engaged Participatory Qualitative – Narrative Inquiry – Photovoice project with older adult (55+) Spanish and Russian-speaking immigrants in Southeastern Wisconsin, in the United States (US). In this project, we sought to examine the health-impacting experiences of older adult Spanish and Russian-speaking immigrants; specifically, what barriers and facilitators of health they identified, using a broad definition of the term 'health'[2]. In essence, the novel approach – Narrative Inquiry, Community-Engaged, and Photovoice – of this project had the potential to promote health equity among older adult immigrants through centering their stories, perspectives, and images. As listening to the voices of older adult immigrants is critical to ensuring they have the best health and wellbeing possible. Hence, the purpose of this descriptive qualitative study was to better understand the lived realities of older adult Russian and Spanish-speaking immigrants in Southeastern

[2] In this project, we used the term 'health' broadly to mean factors that facilitate or inhibit, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (*World Health Organization*, no date).

Wisconsin in relation to health and wellbeing. Central to this project were cross-language research methods.

Thus, this article is divided into the following sections: (1) Background (2) A Community-Engaged Participatory Research Approach, and (3) Cross-Language Research Methods – More than a Technical Concern.

Background

The Wisconsin Context – Why Russian and Spanish-Speakers?

Southeastern Wisconsin, and specifically Milwaukee County, is home to the largest concentration and population of Russian-speaking and Spanish-speaking immigrants in the state of Wisconsin. Yet, despite the large populations of Spanish and Russian-speaking immigrants, not just in Milwaukee, Wisconsin, or the US as a whole, there is little literature explicating the health challenges faced by *older adult* Spanish and Russian-speaking immigrants.

For example, in our 20-year review of the literature (M. M. Hawkins *et al.*, 2022), only eleven articles focused on barriers and facilitators of health among older adult immigrant Hispanic/Latinx people[3] (Spanish-speaking immigrants). Whereas 19 articles from 2000-2020 focused on the barriers and facilitators of health among immigrants from the Former Soviet Union (FSU) (Russian-speaking immigrants)[4].

Rationale

[3] While the terms 'Hispanic' and 'Latinx' are often used interchangeably there are differences between these two "pan-ethnic terms" (Lopez, Krogstad and Passel, 2021). Hispanic refers to Spanish-speakers from Spain and Latin American while Latinx refers to those from Latin America regardless of language spoken (Lopez, Krogstad and Passel, 2021). For example, those from Mexico, Chile, and El Salvador, are both Latinx and Hispanic, while one from Brazil would be Latinx but not Hispanic.

[4] In our review of the literature on Spanish and Russian-speaking immigrants, for each article that discussed Hispanic/Latinx immigrants and those from the FSU, we examined the article to determine what languages were used on the studies to restrict our evaluation to Spanish and Russian-speakers.

In the US there was a large influx of immigrants from the FSU, primarily Russian-speaking, following changes to US policy in the latter half of the 20th century. After these changes, over 1.6 million people left the FSU (Kobrin and Oppenheim, 2017; *Jewish Museum Milwaukee*, no date). More than 600,000 individuals from the FSU immigrated to the US between 1970-2000 (Mehta and Elo, 2012). In fact, between 1970 and the late 1990s, more than 5,000 Russian-speakers immigrated to Milwaukee (*Jewish Museum Milwaukee*, no date; 'Russians', no date). The Village of Shorewood, located in Milwaukee county, is home to the largest concentration of Russian-speaking immigrants, most of whom are Jewish from the FSU, in Southeastern Wisconsin (Rory Linnane, 2011). Notably, twenty-five percent of Russian-speaking immigrants from the FSU were already considered older adults (over 65) when they immigrated (Basok and Brym, 1991).

Furthermore, in the US, 18.5% of the population (60 million people) is Hispanic/Latinx (US Census Bureau, 2021). Moreover, the median age among Latinx immigrants is 43 (Pew Research Center, 2021). Only 7% of the Latinx population in the US is over the age of 65. Yet, 5% of US-born Latinx people are over age 65, while 12% of Latinx immigrants are over the age of 65 (Pew Research Center, 2021). As of 2008 (the most recent data available according to the WI Department of Health Services), 112,931 Latinx people reside in Milwaukee-county and only 4% were over the age of 65 (*U.S. Census Bureau QuickFacts: Milwaukee city, Wisconsin*, no date). We could not find information on Latinx *immigrants* specifically in Milwaukee. This is not surprising that this data may not be readily available as many Latinx people do not want to make their immigration status know due to fears of deportation.

Thus, in Wisconsin, the Spanish and Russian-speaking populations are large, yet are relatively unknown and understudied. Furthermore, we selected these two groups for several

additional reasons, both groups – compared to English-speaking US-born individuals are, (1) low income (Aroian *et al.*, 2001a; Holmes, Driscoll and Heron, 2015; U.S. Department of Health and Human Services, 2019), (2) have higher rates of hypertension (Casimir *et al.*, 2010; Elfassy *et al.*, 2020), (3) have higher rates of mental health concerns (Miller and Gross, 2004; Casimir *et al.*, 2010; Coyle and Dugan, 2012; Guzman, Woods-Giscombe and Beeber, 2015), (4) use programs such as Medicare, Medicaid, SSI, and SNAP to meet their needs (Aroian *et al.*, 2001a; Gubernskaya, Bean and Van Hook, 2013), and (6) have limited English Language Proficiency (ELP) (Tran *et al.*, 2000; Tran, Sung and Huynh-Hohnbaum, 2008; M. Hawkins *et al.*, 2022). Yet interestingly, the two groups vary in highest level of educational attainment. Older adult Russian-speaking immigrants have higher levels of educational attainment compared to older adult Spanish-speaking immigrants (Smith, 1996; Aroian *et al.*, 2001b; U.S. Department of Health and Human Services, 2019).

Despite the size of these communities, only 30 articles from 2000-2020 addressed barriers and facilitators of health among older adult Russian and Spanish-speaking immigrants. Hence, not only is there a dearth of literature, but institutional mistrust (Berk and Schur, 2001; Leyro and Stageman, 2018; Shapiro, 2021) causes both groups to be difficult to reach, thus a Community-Engaged Approach was critical in this project.

A Community-Engaged Participatory Approach

> *"It is participatory. It is cooperative…It is a co-learning process. It involves systems development and local community capacity building. It is an empowering process through which participants can increase control over their lives. It achieves balance through research and action."* (Israel *et al.*, 2008, p. 9)

Community-Based Participatory Research (CBPR) seeks to promote health equity through community-driven work. CBPR emphasizes community-led collaborative initiatives that encompass the key CBPR principles (Israel *et al.*, 2008).

CBPR often develops over years, and the key CBPR principles are:

Table 1. Community-Based Participatory Research Principles (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date)
"1. recognizes community as a unit of identity; 2. builds on strengths and resources within the community; 3. facilitates collaborative, equitable involvement of all partners in all phases of the research; 4. integrates knowledge and action for mutual benefit of all partners; 5. promotes a co-learning and empowering process that attends to social inequalities; 6. involves a cyclical and iterative process; 7. addresses health from both positive and ecological perspectives; 8. disseminates findings and knowledge gained to all partners; and 9. involves a long-term commitment by all partners." (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date)

Community-Engaged Participatory Research (CEnPR) falls under the umbrella of Community-Based Participatory Research (Balls-Berry and Acosta-Pérez, 2017; Tuttle, 2020). This project encompasses many, but not all CBPR principles, hence this study was a Community-Engaged Participatory Research project and not a full Community-Based Participatory Research project. In essence, CEnPR highlights issues that are important to the community, bi-directional relationships, and some, although not necessarily all CBPR principles (Israel *et al.*, 2008; Balls-Berry and Acosta-Pérez, 2017; Tuttle, 2020). Hence, project development and implementation were grounded in some, but not all CBPR principles.

Regarding principle one, "recognizes community as a unit of identity" (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date), in this project, this involved recognizing social networks among participants, geographic clusters and neighborhood centers where groups of Spanish and Russian-speaking immigrants gather, symbolic systems within the Russian and

Spanish languages, as well as "shared values and norms" (Steuart, 1993; Israel *et al.*, 2005). Thus, we focused on apartment buildings and senior centers with a high number and concentration of Spanish and Russian-speakers, and noted the surrounding area (i.e. parks, immigrant-owned – Russian and Spanish-speaking - grocery stores, traffic, green space). Additionally, we used snow-ball sampling to recruit participants, working within peer networks to reach these groups and address some institutional mistrust (Salazar, Crosby and DiClemente, 2015).

Regarding principle three, "facilitates collaborative, equitable involvement of all partners in all phases of the research" (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date), we co-developed this project over the course of three years with community members, community advisors and non-profit organizations, prior to beginning the project. For example, an interest in using Photovoice in a project related to health developed in the beginning of 2019 during IRB-approved focus groups we conducted with older adult Russian-speaking immigrants and a local non-profit organization.

Regarding principles five and six, "promotes a co-learning and empowering process that attends to social inequalities… involves a cyclical and iterative process" (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date), each step of project development has been iterative and involved co-learning. Much of the project development came through informal conversations when MMH taught English as a Second Language to older adult immigrants from 2018-2021. MMH, along with my community partners, have also implemented various projects from 2018-2022 and learned from the successes and failures of those various projects. For example, cross-cultural and cross-language programming between older adult Russian-speaking women and University of Wisconsin-Milwaukee (UWM) students was a success. However, recruiting UWM

students to assist in shoveling out bus stops for older adults during the winter was a failure due to its total lack of feasibility. Providing COVID-19 education was successful via conference calls, but leading English language classes via conference calls were a failure with older adult Russian-speaking immigrants.

MMH also met quarterly with the members of the Latino Research Action Team to discuss project development, hear their ideas on the direction of the project and merge our various viewpoints. The iterative development with the Latino Research Action team was especially important in terms of evaluating our reflexivity. The two members of the Latino Research Action Team and MMH are all Spanish-speaking Latinos, but we are also all different ages and genders. Moreover, the duration they and MMH's families had been in the US differed greatly, and their families all originated from different regions in Latin America.

Furthermore, in constructing this project, drawing on Vanner, (2015) MMH wrote two separate IRB proposals. The first IRB proposal was to talk with potential participants about their interest in a Photovoice project and learn and implement their feedback on what could be improved. Then in the second IRB proposal MMH incorporated their feedback and requested to begin data collection and conduct the project.

Finally, regarding principle eight, "disseminates findings and knowledge gained to all partners" (Israel *et al.*, 2008; Tuttle, 2020; Hussong-Christian, no date), anecdotal findings have been distributed to partners throughout this multi-year process, and all formal research findings from this study are discussed with participants, and partners. Yet, the entire CEnPR process is compounded by the multiple languages and role of power dynamics.

Central to CBPR and CEnPR and the utilization of CBPR principles is that CBPR is an "instrumental strategy…based in social justice" (Muhammad *et al.*, 2015, p. 2). Thus, Muhammad et al. (2015) highlights the importance of power sharing.

Researchers are in positions of power, which can unintentionally harm communities. Thus, trust, relationships, reflexivity, and historical understanding of power processes are crucial (Muhammad *et al.*, 2015). This necessitates a discussion of power. Feminist theorist Diane Wolf discusses three positions of power that change based on the researchers positionality as an insider, outsider, outsider-within, and insider-outsider, and Muhammad et al. adds a fourth, "epistemology of power" (Wolf, 1996; Muhammad *et al.*, 2015). Hence, these four positions of power are: (1) positionality of the researcher in relation to the community, (2) the research process, meaning who decides on the design, and how much power is shared, (3) "the representation and writing of the findings" (Wolf, 1996; Muhammad *et al.*, 2015, p. 1049), (4) "the epistemology of power – how power is exerted in the construction of knowledge." (Muhammad *et al.*, 2015, p. 1049) Regarding Muhammad et al. and Wolf's third and fourth points, MMH discussed findings with my community advisors and participants throughout the study, as data analysis is an iterative process. This was to help MMH address her own "interpretive authority" (Denzin and Lincoln, 2011, p. 187).

Importantly, addressing these power dynamics is rooted in the cross-language research methods themselves. Hence, this leads directly into the next section of this article: *Cross-Language Research Methods – More than a Technical Concern.*

Cross-Language Research Methods – More than a Technical Concern

"By aiming at pure objectivity and equivalency, researchers tend to reduce the translation process to a technical act instead of regarding it for what it is, that is, a significant

variable in the research process that can influence its content, outcomes, and ethical adequacy."(Shklarov, 2007)

Translation is never neutral.

This project required a tremendous amount of language translation. To clarify, translation involves translating written text, while interpretation deals with interpreting spoken language in real time (*Translation vs. Interpretation | Kent State University MCLS*, no date). As all interviews were conducted in Russian or Spanish, no interpretation was required. However, there was a significant amount of translation at every stage of this project. Hence, we used a multi-step process in the design, interview, and results process, to ensure "cross-language trustworthiness." (Squires, 2009).

Squires (2009) notes in their review of 40 cross-language qualitative studies that only 6 of the 40 studies "met all the criteria recommended by the cross-language methods literature."(Squires, 2009) Then, in their updated 2020 review, they reviewed 73 articles (Squires, Sadarangani and Jones, 2020). However, the goal of their 2020 article differed from their 2009 article. Rather than finding articles that fit the criteria, they used the articles to create more robust recommendations for cross-language research (Squires, Sadarangani and Jones, 2020). Our cross-language methods differ and build upon the existing literature because our team includes several bilingual and trilingual researchers themselves. Presently, much of the current literature on cross-language methods is written by monoglots and focuses on working with third-party interpreters or translators.

Thus, to synthesize, update, and adapt, our cross-language methods, first we examined Squires four areas of consideration in cross-language research: methods, conceptual equivalence, translator credentials, articulating the role of the translator in the research process (Squires,

2009), and their updated recommendations (Squires, Sadarangani and Jones, 2020). Second, we evaluated a critique of Squires recommendations (Croot, Lees and Grant, 2011), and also included Croot et al.'s recommendations for translation, "methods of data collection, incorporating reflection on the role of the interpreter" (Croot, Lees and Grant, 2011). Third, we examined the article, "Now I see it, now I don't: researcher's position and reflexivity in qualitative research" on reflexivity in qualitative research (Berger, 2015). We also examined numerous other articles in addition to the aforementioned seminal articles. In essence, we examined seminal literature spanning over 10 years to synthesize, adapt, and refine our cross-language research methods in this study.

We also sought to address the main limitations of the existing literature in our adapted recommendations. For example, in Squires et al. updated 2020 literature review on cross-language research, much of the literature on study design in cross-language qualitative research pertains to working with interpreters. In their 17-year review of the literature, Squires et al., (Squires, Sadarangani and Jones, 2020) discuss the role of interpreters *as reflected* in 17-years of literature. In the literature, there is mention of the "dual-role interpreter" (i.e. someone with language and healthcare training) yet the dual-role interpreter is not discussed as being part of the research team (Squires, Sadarangani and Jones, 2020). Rather, the dual-role interpreter "should be factored into study design and discussed in the limitations." (Squires, Sadarangani and Jones, 2020). Hence, the articles they reviewed neglect the role of bilingual, or trilingual, researchers themselves.

Thus, we sought to adapt, synthesize, and update cross-language recommendations. Table two provides a synthesis of our adapted cross-language methods:

Table 2: Adapted Cross-Language Methods

1. What and why? Considerations for Study Design
2. When do we translate, and how many times? Question development, pilot testing, transcription, and translation
3. Who? The role of the translator/interpreter during the research process
4. Who again? Translator/interpreter credentials and positionality
5. What are you really saying? Dynamic equivalence
6. Do your *ears* deceive you? Reflexive reflective reflexivity
7. Triality, not just Duality, of the role of the Researcher

(1) What and why? Considerations for Study Design

Narrative inquiry is a utilized and recommended approach in cross-language research (Squires, 2009; Bergen, 2018). This is because Narrative Inquiry, or Narrative Analysis, emphasizes narrative and stories, rather than how a participant uses exact language (Squires, 2009). Here we discuss why Photovoice *and* Narrative Inquiry were util approaches in this cross-language research project.

Photovoice

Regarding the utility and novelty of this study, Photovoice revealed the images and stories important to participants, moreover Photovoice aided in building rapport with participants, stimulating discussion, and leading to a smoother transition into other interview questions. Hence, not only are the photos a finding in and of themselves, but they also aid with 'breaking the ice' for the interview.

Wang and Burris in their seminal 1997 text, "Photovoice: Concept, methodology, and use for participatory needs assessment" note the many reasons for employing photovoice methodology. First and foremost, imagery is powerful (Wang and Burris, 1997). They note that photovoice can act as a challenge to dominant linguistic powers as one does not need to speak English or know how to write in order to take part in it (Wang and Burris, 1997). For older adult Russian-speaking and Spanish-speaking immigrants in Milwaukee who do not speak English, photovoice was a tool not only for participants to take part in research but to also challenge the

English-speaking hegemonic traditional research structures. Moreover, photovoice is about participants producing knowledge and highlighting aspects of their lives that they find important (Wang and Burris, 1997). It allows the audience to have a better understanding of the participants viewpoint (*who* finds *what* important), affirmation of the community, exploration of ideas, and the depiction of assets (Wang and Burris, 1997).

In our project, incorporating photovoice methodology helped center participant voices, depict participants viewpoints, what participants find important, and allow space for non-English speakers to participate in research. Photovoice methodology also helped to address our research questions because it emphasizes *assets* not just deficits, experiences of living in Wisconsin, and visual images encompassing those lived experiences.

Narrative Inquiry

Narrative Inquiry was our qualitative analytic perspective. Narrative inquiry begins with data collection that encourages storytelling. This perspective allowed for not only centering the voices of older adult immigrants, but it allowed participants to *lead* the discussion, spending time on what they view as important (Chase, 2018; Penninah Kako, 2020). In essence, participants can tell a story, "in their own way."(Penninah Kako, 2020) Additionally, narrative inquiry provides information on context of the story, *how* the participant is telling the story, content of the story, and the form of the story (Chase, 2018). Narrative Inquiry and Photovoice methodology are advantageous to combine because of the emphasis on an elicitation of stories, in this case through photos. Participants can not only describe their lives, but they can also *show* their lives.

Narrative inquiry emphasizes stories (Chase, 2018; Penninah Kako, 2020), and while the definition of Narrative Inquiry has grown, "an expanded definition embraced oral and written

narratives ranging from short topical stories about particular events…to entire life stories." (Chase, 2018, p. 547) Narrative inquiry fits particularly well with Photovoice methodology because photos elicit stories, either directly through capturing an event, or indirectly through reminding the photographer of something of import. Furthermore, Narrative Inquiry allows for not only centering the voices of older adult immigrants, but it allows participants to lead the discussion and places value on the spoken story in addition to the subsequent transcripts (Penninah Kako, 2020). Thus, Narrative Inquiry is a valuable approach because it fits well with Photovoice Methodology in emphasizing the participants depicting their own viewpoints and what they view as important, and also because it stresses *how* things were said, *what* was emphasized, and *what stories* they chose to tell. Finally, Narrative Inquiry was beneficial in addressing our research aims because it stresses an elucidation of lived experiences, lived experiences and health, assets, challenges, how knowledge is developed about how things are done, and how the individual approaches health-related concerns.

(2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation

Prior to Beginning the Study

Scientific integrity involves transparency and expertise at each step of the process. This includes processes of translation and interpretation (Squires, 2009).

Hence, when developing, validating, and translating the questions from English to Spanish and Russian, MMH worked with two Russian-speaking community advisors (CAs) (two older adult women from the FSU), and two Spanish-speaking community advisors (two Spanish speaking middle-aged adults, one male, and one female) – the Latino Research Action Team.

Question development, validation, and translation took place over 11 months (October 2020-September 2021).

To develop questions during the aforementioned 11-month period, MMH drew from several sources, and question development was an iterative and collaborative process. (1) MMH drew upon the 2019 focus groups with older adult Russian-speakers to begin to develop the initial topics for questions. (2) MMH met with two Russian-speaking and Spanish-speaking CAs several quarterly to further discuss what topics and questions they viewed as important for their communities. (3) MMH then wrote preliminary questions in English and translated them into Spanish and Russian. (4) MMH met with the Russian-speaking CAs weekly for four weeks to discuss, refine, correct, and pilot test the questions (*Social Research Glossary*, no date), and forms in Russian. (5) MMH met with my Spanish-speaking CAs twice to discuss, refine, and correct the questions, and forms (i.e. camera usage directions, IRB form, recruitment script) in Spanish. (6) MMH wrote a two-part IRB (Vanner, 2015), in order to discuss the project with potential participants prior to starting the project in order to receive feedback on the content and questions and make changes before submitting part-two of the IRB to begin the study. (7) In addition to our community advisors, MMH also worked with Dr. Joe Peschio, the bilingual chair of the Russian Department at the University of Wisconsin-Milwaukee, to refine the translations prior to beginning the study.

There was only one instrument that required translation, which was the Mini-Cog. The Mini-Cog is "a 3-minute instrument that can increase detection of cognitive impairment in older adults." (*Mini-Cog*© , no date) A lack of cognitive impairment was part of the inclusion criteria for this project, hence a screening was necessary. The Mini-Cog had already been translated into

Spanish and English, and other Slavic languages, such as Croatian. Russian is a part of the same language branch as Croatian (*UCLA*, no date).

MMH reviewed both the English and Croatian versions of the Mini-Cog when translating the Mini-Cog into Russian. For the translated instrument see appendix one. The translation was reviewed by three bilingual, Russian-language professors, with formal training in translation: Dr. Joe Peschio, Dr. Nina Familiant, and Professor Olga Ogurtsova. It was also reviewed and piloted by two Russian-speaking CAs.

In essence, for the Spanish translations *prior to begin the study*, there were three checks on the translations. That of MMH, and that of two bilingual community advisors who comprise the Latino Research Action Team, and with years of experience evaluating and validating translations from English to Spanish. For the Russian translations *prior to begin the study* we had four checks on my translations. That of MMH, that of two Russian-speaking Community Advisors, and a bilingual professor of Russian. Notably, the instrument translation had more checks.

During the Interviews

No translation or interpretation took place during the interviews. However, there was language validation that took place during the interviews. During two interviews at the beginning of the study, a trilingual (English, Russian, and Spanish) student (NMV) trained in human subject research protocol, observed the interviews to provide another layer of linguistic validation. She observed the interviews to double-check MMH's understanding of participants. Her observation also provided verification that MMH was properly following all protocol. In essence, NMV's presence aided in maximizing trustworthiness in the interview process (Squires,

Sadarangani and Jones, 2020), as she was able to verify that MMH was appropriately following protocol and procedures, and responding to participants in the appropriate language.

After the Interviews

The interviews were recorded via recording device, and then de-identified in Presonus software (*Studio One | PreSonus*, no date). Then, the interview was uploaded to Google Speech-to-Text for initial transcription. We selected Google Speech-to-Text because it had transcription options for multiple languages, including regional options for Spanish (ex: Puerto Rican Spanish, Mexican Spanish, etc.). While the use of Google software is relatively uncommon in research due to the use of the Cloud, however after consulting with both the UWM IRB and UWM Information Security, an exception was made in this case because there was a lack of a viable alternative for transcription software. Immediately after Google Speech-to-Text transcribed the interview, the transcription was moved to a Word Document, and the transcription and audio file were deleted from Google Cloud.

After initial transcription, the transcript was then reviewed, verified, and validated by a trilingual student (NMV), and then was reviewed, verified, and validated by MMH. In order to maximize dialectical understanding, for each interview MMH collected data on participants region of origin and she asked about additional clarifying questions of participants on their language usage (i.e. *guagua* for bus/transport in Puerto Rico, versus *wawa* to mean baby in Ecuador) (Squires, 2009). All data analysis was conducted in Russian and Spanish. Quotes were translated into English as late as possible.

For the Russian translations, they were reviewed by a bilingual professor and native speaker of Russian, not involved in the initial study development (Dr. Nina Familiant). The translation was then back-translated into Russian and the translation and back translation were

reviewed with the two Russian-speaking community advisors. The back translation was also reviewed with participants. For Spanish, the translation was review by a bilingual native-Spanish-speaking professor (Dr. Esmeralda Santa Cruz Sala), not involved in the study development. It was also reviewed by two bilingual community advisors. Then MMH back translated into Spanish and reviewed the translation with participants.

From beginning to end there were multiple checks on every aspect of language translation and validation. Yet, the reason there were additional meetings and points of validation for the Russian-language material is because MMH's Spanish is better than her Russian, which we will further explicate in the credential section. Hence, we needed to ensure that the Russian-language was at the same standard as the Spanish-language.

(3) Who? The role of the translator/interpreter during the research process

To reiterate: translation is never neutral and is far more than a technical concern. Cross-language research and translation begs the question, *whose epistemology is it anyway?* By this we mean, without clear explication of the role of language and translation, the philosophical and cultural underpinnings of "the process of knowledge production" (Temple and Young, 2004, p. 164), go unspoken. These colonial and neo-colonial underpinnings, drawing from Postcolonial Feminism, then thus require challenging underpinned Ethnocentric "essentialized knowledge" (Wesp *et al.*, 2018).

Hence, in examining the role of the translator or interpreter, much of the extant literature unconsciously creates separation between the translator or interpreter and the research team overseeing the study, thereby unconsciously reinforcing power differentials. For example, in their review examining 17-years of cross-language research, Squires et al., discuss the types of research roles interpreters can have (2020). None of the roles include a bilingual member of the

research team (Squires, Sadarangani and Jones, 2020). In the articles reviewed, the interpreter or translator served in an external role. This both negates the role of the interpreter or translator on "the process of knowledge production" (Temple and Young, 2004, p. 164), but it also potentially reinforces existing neocolonial power structures between researchers and members of the community they work with.

Therefore, regarding the role of the translator or interpreter, we recommend not only including bilingual and trilingual research team members, but also recognizing that language is culturally, contextually, and temporally bound. It is also situated within the neo-colonial structures that influence approaches to research purporting objectivity with an Ethnocentric-Eurocentric framework. This needs to be explicated in order to challenge dominant epistemological structures so that voices from minoritized non-English-speaking communities can be heard *from their viewpoint*. Hence, the role of the translator or interpreter is never neutral, rather that individual, or individuals, is working in hegemonic academic discourse, situated in a neo-colonial context, translating language that is culturally, contextually, and temporally bound. Therefore, the role of the translator or interpreter in the entire research process requires thorough explication, which leads directly into the next sections.

(4) Who again? Translator/interpreter credentials and positionality

A critical part of cross-language research is trustworthiness, credibility, and dependability of the research conducted in the languages of interest (Squires, 2009). This requires examining the credentials of the translator or interpreter as well as their positionality.

In blunt terms, the translator or interpreter should, "demonstrate the ability to communicate between languages using complex sentence structures, a high level of vocabulary, and the ability to describe concepts or words when they do not know the actual word or phrase"

(Savignon, 1976; Danesi, 1996; Squires, 2009, p. 4). While originally Squires (2009) recommended that translators and interpreters should hold formal credentials, this was revised in their 2020 review to instead include that language ability should be "independently" evaluated (Hull, 2016; Squires, Sadarangani and Jones, 2020). Presently, we will discuss the lead author's (MMH) credentials and positionality. MMH is from Milwaukee, Wisconsin.

Spanish

MMH began formal study of the Spanish language in an instructional setting at four-years-old. MMH has had formal Spanish-language instruction through kindergarten, elementary school, middle school, high school, college, and graduate school. MMH has had her Spanish-language skills evaluated in middle school, high school, college, graduate school, and by my community advisors.

Concurrent to her middle school studies, MMH began receiving Spanish language instruction at the University of Wisconsin-Milwaukee in the 8th grade during the evenings. Additionally, MMH is Latina (Mexican), and her family traveled to Latin America nearly every summer growing up. While in Mexico, MMH was enrolled in Spanish-language classes. MMH also participated in three summer study abroad trips to Guatemala. Finally, MMH began volunteering and later working as a Spanish-English interpreter for a local social service agency in college. Her Spanish was evaluated via a summer-long independent study when she transitioned from volunteer to full-time intern.

Dialect training

In addition to exposure to different dialects while traveling, MMH has received formal training in different Spanish dialects. While in high school, MMH took a year-long Spanish film course. The course was designed to introduce students to different topics and areas of the

Spanish-speaking world, also emphasized dialectical differences in the Spanish-speaking world. In college, MMH took a semester-long course specifically on Puerto Rican Spanish. In graduate school, during the three months MMH spent in Ecuador, MMH received formal instruction on how indigenous languages, specifically Kichwa, impacted Spanish in Ecuador.

Health training

MMH has not only received formal Spanish-training for health-specific vocabulary, MMH also developed and led the "Spanish tables for Health Students" to assist in introducing students to health-specific vocabulary in Spanish. MMH received health-specific Spanish-language training beginning in middle school, as the Spanish lessons were housed in the UWM College of Nursing, and then again in graduate school when taking a nursing course in Ecuador.

Russian

MMH began informal study of the Russian language at 10-months old, as a close family member only spoke Russian when she arrived from the Former Soviet Union in 1991. MMH learned brief phrases and the names of animals. MMH did not begin formal study of the Russian language until college. MMH majored in Russian as an undergraduate and took 13 Russian language courses, in addition to history and culture courses focused on the Russian Empire and the Former Soviet Union. MMH also participated in a 4-month-long study abroad to Moscow, Russia, where her Russian was formally evaluated. In graduate school, MMH added a Doctoral Minor, to include the formal study of Russian and Kichwa. MMH completed four additional Russian language courses at UWM, and two grammar certificate programs through the NovaMova school in Kyiv, Ukraine, where her Russian was again evaluated. MMH has had her Russian language skills evaluated in college, graduate school, and by my community advisors.

Dialect training

There are far fewer dialectical and regional differences in Russian, compared to Spanish. This is due to the "top-down language standardization process of the Soviet era" (Grenoble and Bulatova, 2017, p. 118). While the process of language standardization across the FSU had extremely deleterious effects on regional, endangered languages, the result was far greater standardization of the language throughout the FSU. While Russian is far more standardized, MMH still received exposure to regional differences through travel in Belarus, Ukraine, and throughout the Russian Federation – from St. Petersburg to Siberia.

Health training

MMH received formal training in Russian health-specific language through her doctoral minor. One course in the doctoral minor focused on how depression and cardiovascular disease impact the Russian-speaking population utilizing a public health perspective. The second course examined the COVID-19 Sputnik V vaccine.

(5) What are you really saying? Dynamic equivalence

To define dynamic equivalence, we must first examine conceptual equivalence. Conceptual equivalence is about ensuring the concepts composing a word or phrase are the same, or as similar as possible, among different languages. However, there is some debate regarding the utility of equivalence, as "absolute equivalence" is impossible (Baker, 2011; Sutrisno, Nguyen and Tangen, 2014, p. 1338). Yet, conceptual equivalence is important as literal translations are not always possible and thus demonstrating comparability of concepts is crucial to the translation (Squires, 2009). Moreover, literal translations may actually lose nuance of meaning if the research lacks a depth of sociocultural competence in that language (Squires, 2009).

Hence, dynamic equivalence, focuses on, "reproducing the message from the source language to the target language in the most natural manner" (Sutrisno, Nguyen and Tangen, 2014, p. 1339). While there are pros and cons to both conceptual and dynamic equivalence, we selected dynamic equivalence in this study as a goal of dynamic equivalence is a clear understanding of the message by those in the "target language" (Sutrisno, Nguyen and Tangen, 2014, p. 1340). We also needed to ensure dynamic equivalence between *Spanish and Russian*. To ensure dynamic equivalence, in our translations, we worked with a trilingual student (NMV), two additional bilingual Spanish-speaking community advisors; two Russian-speaking community advisors, two trained bilingual (Russian and English – Dr. Familiant; Spanish and English – Dr. Santacruz Salas) faculty members not involved in study design, project conception, or data collection. Finally, we reviewed back-translations with participants. The multiple stages of translation and back-translation in this project aided in ensuring trustworthiness, transparency, reducing bias, and creating a smooth and clear translation (Sutrisno, Nguyen and Tangen, 2014). See table three for an example of dynamic equivalence:

Table 3. Example of Dynamic Equivalence

English: *This study is also to show the strengths of the Russian and Spanish-speaking communities, as many people in Wisconsin are unfamiliar with the Russian and Spanish-speaking communities.* Spanish: *Esta investigación pretende además mostrar la fuerza que tienen las comunidades Ruso-hablante e Hispanohablante. Mucha gente desconoce que existen comunidades de Ruso-hablantes e Hispano-hablantes en Wisconsin.* Russian:	Rationale Where the translation differs from being a literal translation is in regard to the word and concept of *community*. In the English and Spanish versions, I use the word 'community' and 'comunidad.' As both share a similar meaning. However, this is different in Russian. In a Russian-English dictionary the word for community comes up as об*ѝ*ина (obshina). However, it "has a very different connotation" (Shklarov, 2007, p. 531) than it does in English and Spanish. Hence, in the Russian translation the word community is completely removed. Instead of the word 'community' it

Это исследование также призвано показать сильные стороны…русскоговорящей поскольку многие жители в Висконсин не знакомы с русскоговорящими и испаноязычными людьми.	is written as *Russian-speakers* (*русскоговорящей)* and with *Russian-speaking people* (*русскоговорящими людьми)* in Wisconsin, to achieve dynamic equivalence.

(6) Do your ears deceive you? Reflexive reflective reflexivity

Our understanding of language is culturally, contextually, and temporally bound. Berger writes, "interpretation of findings is always done through the eyes and cultural standards of the researcher." (2015, p. 221) In essence, our experiences, perceptions, and reactions during an interview can lead to "unconscious editing" in our analyses (Berger, 2015, p. 221). Our ears can deceive us. Hence, reflexive reflective reflexivity is paramount to minimize this source of bias.

We have used numerous tools to minimize bias in this project and enhance reflexivity. As this is a CEnPR project we have engaged in extended interaction with participants (Berger, 2015). In addition to the years spent building relationships prior to beginning the study, one participant called MMH months after her interview to ask if MMH could help her find to state-specific quarters for a Christmas gift for her granddaughter. Another participant asked MMH to take her to the grocery store, since her son was not available, MMH translated labels, and she and a participant had an exchange about types of sour cream. Still another participant, a recent immigrant to the US, was struggling with understanding the social services available to her and she was feeling very isolated. MMH was able to connect her with a social worker and the participant said it was immensely helpful.

We have also engaged in member checking, triangulation, keeping a detailed audit trail, and peer review (Denzin and Lincoln, 2011; Berger, 2015). To further promote reflective reflexivity, MMH maintained extensive field notes. MMH used a structured field note guide, and

for each interview MMH kept note of 29 different areas of interaction. This included notes, including but not limited to, the timing of the interview, the participants demeanor, why the participant participated, concurrent activities in the area, my own emotional reactions and thoughts before, during, and after the interview, and power dynamics.

Keeping detailed field notes was extremely helpful. For example, in interviews where less privacy was available (during four interviews, a room was not available to conduct the interview in a private and quiet space), due to the participants behest, the interviews were conducted in semi-public spaces where there were interruptions. In interviews where less privacy was available, there were difficulties soliciting a great depth of information. Moreover, regarding recruitment, we used snow-ball sampling in this project, hence participants were key in recruiting other participants. One participant noted, after she agreed to participate: *I'll see if I like it, then I'll let others know*. After she participated, she was enthusiastic to recruit others.

MMH's own positionality also affected the interviews in several ways. She is a white, female, Latina, Russian and Spanish-speaking, 20-something researcher. MMH conducted research with older adult (55+) Spanish and Russian-speaking individuals in Wisconsin. There was a generational gap between MMH and the participants, even though MMH grew up around older adult Russian-speakers, and older adult Latino family members (who refused to speak Spanish as they viewed it negatively). MMH also worked closely with older adult undocumented Latina women as an adult. However, the immigration experience, the older adult experience, and not speaking English as her first language, are not her personal experiences.

Yet, participants were generally curious as to why MMH spoke Spanish and Russian, and was interested in working with them. Participants were excited, that even though MMH was not of the same generation, MMH had some understanding of their experiences already, and they

were very excited that MMH spoke Spanish and Russian. In essence, MMH had an insider-outsider position and was a linguistic insider (Cormier, 2018). However, MMH did not automatically disclose her background to participants, as MMH did not want to shift attention from what they were discussing, and MMH struggled with how much to disclose. Berger (2015) notes that the question of disclosure is not an easily solved question.

Thus, for these interviews, MMH and NMV re-listened to them multiple times to ensure MMH's reactions to the information did not influence participant response. Hence, while MMH's experiences, and disclosure does offer some "familiarity" and "potentially deeper understanding of the phenomenon" (Berger, 2015, p. 224), reflective reflexivity was important for not allowing previous knowledge to skew our understanding of participant responses and thereby interpretation of findings.

There was also a language gap between MMH and participants. While MMH speaks Russian and Spanish, only one of the participants spoke English completely fluently, and she still preferred to conduct the interview in Russian. None of the other participants spoke English at an advanced level. Hence, this put MMH in a position of power as a gatekeeper to the English-speaking community. A result of this was that some participants were eager to demonstrate their English-language ability, no matter the level, and some detail was lost as the participant did not have the words in English. In these cases, MMH tried to nudge the participant towards speaking in the language they were fluent in (Spanish or Russian), but was not always successful.

Finally, we speculate that MMH's gender impacted participant recruitment. In our study design we had planned to recruit both female and male identifying individuals. In the end, the only people who participated in this project were women. No men participated in this study.

MMH did attempt to recruit men, and even some of the female participants attempted to recruit their male counterparts, to no avail.

(7) Triality, not just Duality, of the role of the Researcher

> *"Seeing two parallel cultural meanings or realities, and hearing two or more conceptual understandings might be challenging, but if not obscured, it might meaningfully enrich the in-depth perception of the context area and contribute tremendously to the ethical sensitivity and the quality of research."(Shklarov, 2007)*

In conclusion, if "a bilingual researcher assumes a double role" (Shklarov, 2007), *then a trilingual researcher assumes a triality of roles*. The role of the trilingual researcher includes language broker, cultural broker, academic broker, and research broker, to name a few. This is done across three systems, not only two language systems, but three, in which there is quite a degree of variation. Populations are not homogeneous (Shklarov, 2007). The peoples who speak Spanish and Russian are not homogeneous, hence it is not trilingual and tricultural, but *trilingual* and *multi-cultural*. Moreover, one is interpreting someone else's words in a specific context, time, place, and for a specific audience (Oittinen, 2014). Shklarov argues that if one is in a duality of roles, or in the case triality of roles, to accept it (2007). In this way, the multi-lingual researcher may have "a unique asset and a significant advantage." (Shklarov, 2007) Embrace the tension so that one can honestly engage with the ethical quandaries of this role to conduct a sensitive, nuanced, and complex project.

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ARTICLE THREE

"Your soul will rest in the fresh air"

Health-Influencing Experiences of Older Adult Russian and Spanish-Speaking Immigrants in Southeastern, Wisconsin, United States

Abstract

Older adult immigrants experience unique factors that influence their health within the context of the place. In this Community-Engaged Participatory Narrative Inquiry Photovoice project, we examined factors impacting the health and wellbeing of older adult Russian and Spanish-speaking immigrants in Wisconsin. Through iterative narrative analysis of individual interviews, examining of photos from participants, and input from community advisors we developed participants meta story illustrated in three major themes: (1) *The Environment - Rest your soul in the fresh air*, and (2) *Social Support - You think you are by yourself but you're not alon*e, and (3) *Outsiderness – We're human.*

Keywords: Photovoice, Older Adult Immigrant Health, Qualitative Research, Narrative Inquiry, Acculturation, Place

Highlights

- Older adult immigrants have unique and poorly understood health-related needs.
- The place of residence, in this case Southeastern Wisconsin, among older adult immigrants impacts their health and well-being.
- Access to the natural environment and social support positively impacted older adult immigrants' health and well-being.
- Feelings of Outsiderness were summarized as feeling like permanent guests in their homes.

Funding: This work was supported by the University of Wisconsin – Milwaukee Chancellor's Graduate Student Award.

1. Introduction

Over 7.3 million older adult immigrants reside in the United States (US).[1] That number is only expected to increase.[1] While most older adult immigrants in the US are from Mexico, there is a large number of Russian-speaking immigrants.[2] That number is anticipated to increase due to the current war in Ukraine. Many of those fleeing the war speaking Russian and Ukrainian.[3,4] Thus, there is an urgent need to better understand the needs and experiences of older adult Russian and Spanish-speakers. Yet, despite the large and growing populations of older adult Russian and Spanish-speaking immigrants in the US, the literature is sparce and dated regarding their health needs, and the place-specific context impacting their health and wellbeing.

Hence, in this Community-Engaged Participatory Qualitative Photovoice project, we used the Older Adult Immigrant Adapted Model for Health Promotion[5] as our guiding model, to gain a better understanding of the factors impacting the health and wellbeing of older adult Russian and Spanish-speaking immigrants in Wisconsin, in the United States (US).

Given the Community-Engaged Participatory approach of this project, the aims and research questions were developed over an iterative multi-year process with community stakeholders and advisors. Based on this multi-year development, two of my research questions were: (1) What (meta) stories are important to older adult Spanish and Russian-speaking immigrants? And (2) what do older adult immigrants view as the advantages and disadvantages of living in Wisconsin in relation to health?

This innovative project combines methodologies not previously utilized or combined with older adult Russian and Spanish-speaking immigrants to promote health equity by better understanding the factors that influence their health. These methodologies are also advantageous

in exploring the place-based factors that influence the health of older adult Russian and Spanish-speakers in Southeastern Wisconsin. Moreover, this project underscores the utility of these approaches with non-English-speaking older adult immigrant groups in the US to highlight their experience and showcase their own perspectives through the use of photos.

In this article, we will first describe the place – Southeastern Wisconsin. Second, we will describe the materials and methods in my Community-Engaged Participatory[6] qualitative - Narrative Inquiry - Photovoice project. Third, the results will explicate the meta story, integrated in three key findings: (1) *The Environment – Your soul can rest in the fresh air*, and (2) *Social Support - You think you are by yourself but you're not alon*e, and (3) *Outsiderness – We're human.* Finally, we discuss the implication of the findings within the Older Adult Immigrant Adapted Model for Health Promotion[5] and the acculturation components of the model.

1.1 The Place: Wisconsin, The United States

Southeastern Wisconsin is home to many Russian and Spanish-speaking immigrants. Between 1970 and the late 1990s, more than 5,000 Russian-speakers immigrated to Milwaukee County.[7,8] Moreover, as of 2008 (the most recent data available according to the WI Department of Health Services), 112,931 Latinx folxs reside in Milwaukee-county, but the number of Latinx immigrants was not available.[9] There were several additional reasons we worked with older adult Russian and Spanish-speakers: (1) Long-term relationships we developed with the Russian and Spanish-speaking communities in Southeastern Wisconsin, (2) interest from members of the communities in the project and project development, and (3) similarities between the two groups – both groups tend to be low income,[2,10] and have higher rates of health concerns compared to their English-speaking non-immigrant counterparts, such as hypertension,[11,12] and mental health concerns.[12–14]

Geography, and spatial location within that geography, impact health.[15] In essence, place, and neighborhood, influences health in a nuanced and multifaceted manner. Furthermore, neighborhood effects on health include, but are not limited to air quality, water quality, food, shelter, safety, education, work, transport, relationships, and play.[16] A key attribute of understanding neighborhood effects on health is understanding environmental factors, such as parks, and green space, as well as assessments of those spaces.[16,17] The specific location of Southeastern, Wisconsin, in the upper Midwest of the United States (US), was described by participants as positively affecting their health, yet the relationship was highly nuanced. As I will demonstrate in the results section, parks, green space, and relationships with close friends and family within the geography of Southeastern Wisconsin positively impact participants health, while other aspects of spatial location, such as strained relationships with non-English-speakers in Southeastern Wisconsin, were a source of stress.

Milwaukee County, the primary place of residence among participants, borders Lake Michigan, and has "140 miles of trails, [and] 169 parks and parkways".[18] Yet, Milwaukee County is among the most segregated in the country.[19] Segregation, discrimination, and the accompanying history of redlining and racially restrictive covenants,[19] in Milwaukee have impacted the built environment. Hence, Figure 1 depicts the racial and ethnic composition of Milwaukee County. Next, Figure 2 shows parks and trails.[20] Figure 3 notes the recruitment locations via blue circles for all but one participant (who was from Southeastern Wisconsin, but not Milwaukee County). Finally, Figure 4 shows a map of Milwaukee parks and trails with the recruitment locations overlayed on it.

Figure 1[21]	**Figure 2**[22]

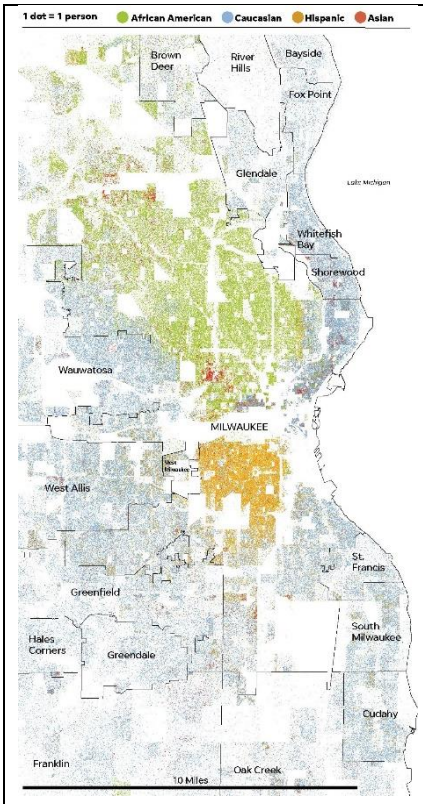
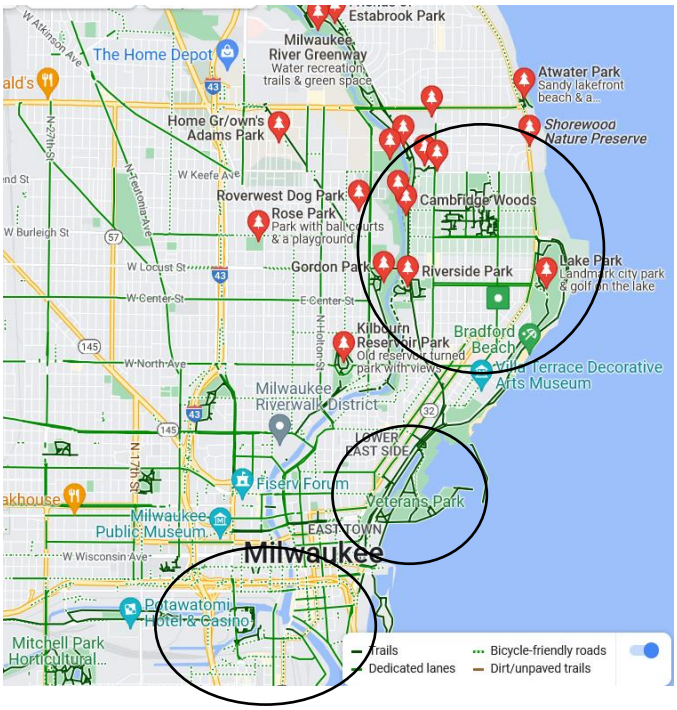
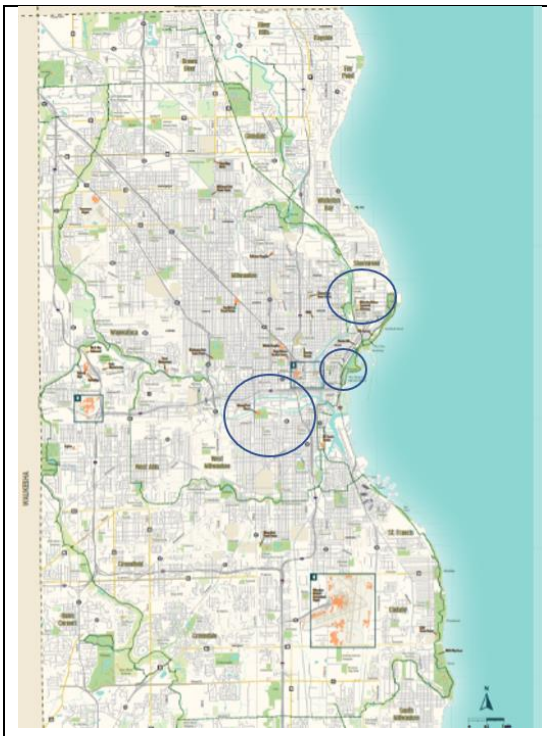


Figure 3[23]

Figure 4[20]

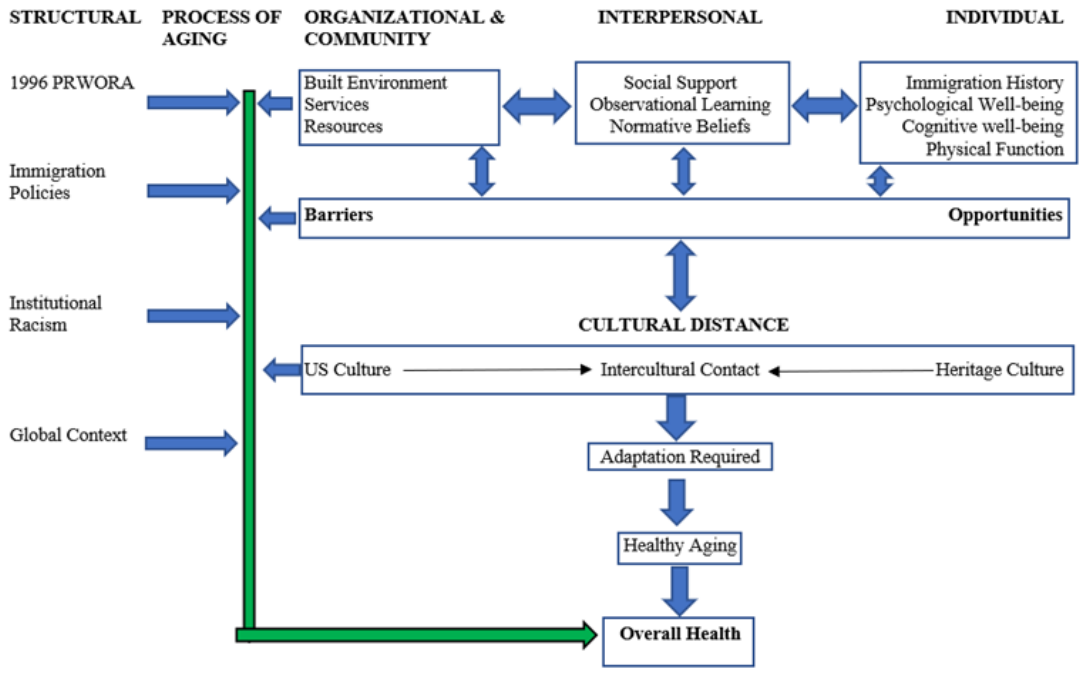




In essence, recruitment locations demonstrate better access to green space than in other parts of the city. However, we are not inadvertently purporting an ecological fallacy,[12] rather the maps demonstrate the geographic and spatial context, reinforced by participants own discussion of their easy access to positive spaces in their environment. It is also important to note, that not every participant lived in the recruitment bubbles. Some participants lived further away but attended a senior center in the recruitment areas, others were recruited through snow-ball sampling. Yet they still had access to green spaces.

Furthermore, to better understand the geographic and spatial relations to health among participants, we use the Older Adult Immigrant Adapted Model for Health Promotion.[5]

1.2 The Older Adult Immigrant Adapted Model for Health Promotion (OAHM)[5]



The Older Adult Immigrant Adapted Model for Health Promotion combines elements of Successful Aging Theory, Social Cognitive Theory, and Acculturation Theory, situated in an ecological context.[5] The model, in addition to being specific to older adult immigrants, highlights the relationships between concepts such as individual psychological well-being, social support, observational learning, the built environment, and barriers and opportunities. For example, if an older adult immigrant does not speak English, this may limit the availability of social support. This interacts with the built environment in that if an individual is not confident in their English language abilities, they may not feel comfortable accessing services such as a public bus, thereby impacting their relationship with the built environment. In essence, a lack of English language proficiency acts as a barrier to fully accessing their built environment. It can also act as a barrier to more robust social support, which in turn affects psychological well-being.[5,24–26]

Notably, acculturation is not explicitly present in the model. This is because acculturation is not defined consistently in the literature.[5,27,28] Common acculturative models include the

Bidimensional Acculturation Model,[29–31] the Acculturation Model,[32,33] and the Ecological Acculturative Framework.[5,34,35] In this article, we define acculturation as "it denotes a multidirectional process of integration, negotiation, and potentially biculturalism."[5,36–39] Hence, while "acculturation" is lacking in the model, it is present in the model, in sections such as cultural distance, observational learning, normative beliefs, and the adaptation required.

1.3 Who is an immigrant?

Merriam-Webster notes that an immigrant, is, "a person who comes to a country to take up permanent residence."[40] We use the term 'immigrant' very broadly, this is because we did not ask questions about documentation or immigration status in the interviews. Thus, we relied on participants self-selection to participate after they heard the recruitment script. Therefore, we included Puerto Ricans under the umbrella of *immigrant* or rather *migrant, "*a person who moves from one place to another."[41] While this is debatable because Puerto Rico is a territory of the US, the inclusion of Puerto Ricans in literature examining the experiences of immigrants and migrants is common in the literature.[42,43]

2. Materials and Methods

Data collection for this Community-Engaged[6] qualitative Photovoice project took place from October of 2021 to April of 2022. The part of the study described here is one part of the larger project. As this was a Community-Engaged Participatory project,[6] project development was a multi-year iterative process with community members and several non-profit organizations. One of the aims of this qualitative arts-based project was to better understand the factors impacting the health and well-being of older adult Russian and Spanish-speaking

immigrants in relation to their place of residence – Wisconsin. This research was approved by the University of Wisconsin-Milwaukee's Institutional Review Board (UWM IRB).

2.1 *Data Collection*

To meet the inclusion criteria as an older adult, participants needed to be at least 55 years old. Data were collected via photos and in-depth interviews using an interview guide. All interviews were conducted in Spanish or Russian (by MMH). Drawing on the Community-Engaged Participatory approach[6] of this project, community members and advisors aided introductions, building upon multi-year relationships with different sites, as well as analysis. Hence, we used a form of convenience sampling – purposeful snowballing sampling[44] to recruit participants. Snowball sampling and a Community-Engaged approach, building upon existing relationships, were ideal in this project because they aided in recruiting participants who would have otherwise been very difficult to reach.[44]

During recruitment, each participant was read the recruitment script, and then was provided the consent form (in either Spanish, Russian, or English – the one participant who spoke fluent English used the English consent form). For participants who had poor eyesight, the consent form was read out-loud. This protocol was written into, and approved, by the UWM IRB. Prior to the interview, participants were asked to select or take at least 10 photos. For participants who choose to take photos, a camera was provided. The photos were then discussed in the interviews. We selected Photovoice as a methodology due to the community-engaged grounding of this project. Community advisors and members and the research team had discussed Photovoice for several years before this project began. Furthermore, Photovoice is especially advantageous, as imagery is powerful.[45] Wang and Burris in their seminal work on Photovoice note that photovoice can act as a challenge to dominant linguistic powers as one does

not need to speak English or know how to write in order to take part in it.[45] Photovoice also provides affirmation of the community, exploration of ideas, and the depiction of assets.[45]

The in-depth semi-structured interviews lasted on average an hour. The interview guide consisted of 32 questions, with demographic questions asked last, to reduce the potential for response bias.[46,47] Given the Narrative Inquiry methodology of the project, questions were structured to elicit stories.[48] Hence, each interview began with discussion of the photos the participant had taken, and what the photos were about. Interviews were recorded using a recording devise. Then, after I deidentified the interviews in Presonus Software[49], I received approval to use Google Speech-to-Text Transcription Software to do the initial transcription of the interviews. Transcripts were then validated and verified by a trilingual student (NMV) and MMH, to ensure accuracy and validity.

2.1.1 *Cross-Language Methods*

As this entire project was conducted in Spanish and Russian, robust cross-language research methods were pivotal to maximizing the trustworthiness of this project and its results. We sought to meet seven different criteria for robust cross-language research[50]: (1) What and why? Considerations for Study Design, (2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation, (3) Who? The role of the translator/interpreter during the research process, (4) Who again? Translator/interpreter credentials, (5) What are you really saying? Dynamic equivalence, (6) Do your *ears* deceive you? Reflexive reflective reflexivity, and (7) Triality, not just Duality, of the role of the Researcher.[50] Hence, at each point of the study, from its inception to its completion, we sought to ensure reflexivity as to why certain decisions were made, iterative and continuous input from the community advisors, multiple checks on the translations and back-translations,[50] and participants

feedback throughout. For example, each translation was checked by five people, and Participants had the "last word"[51(p5)] on the results and how their voices and photos were used.

2.1.2 *Mini-Cog Screening*

In this project, while we were working with older adults, we were not measuring cognitive decline. Thus, inclusion criteria to participant in the study included a lack of significant cognitive decline; this was done using the Mini-Cog screening. The Mini-Cog screening, "is a 3-minute instrument that can increase detection of cognitive impairment in older adults."[52] Notably, the Mini-Cog is not a diagnostic instrument.[52]

2.2 *Data Analysis*

All data analysis was conducted in the languages spoken by participants, Russian and Spanish. We conducted two complementary forms of analysis in this qualitative Photovoice project, we used a Narrative Inquiry approach[48,53] and Barone and Eisner's[54] criteria for arts-based work for the photos. Combining these methods, which incorporate photos, stories, and targeted questions from a semi-structured interview guide, led "to a fuller picture"[55(p456)] and is a form of triangulation.[55] We used triangulation as combining multiple methods, to "produce knowledge on different levels, which means they go beyond the knowledge made possible by one approach".[56(p41)] We also worked with two additional researchers (NMV and KB) to aid with the verifiability and dependability of the findings.[57,58] Working with NMV and KB aided to "offset the subjective bias of any one researcher" [58(p213)] improving dependability. We also engaged in member checking, consultations with community advisors, peer review, and keeping a detailed audit trail.[59] These steps were pivotal as they aided in challenging my "interpretive

authority".[59(p187)] The combination of photos, targeted questions, and stories not only illustrates feelings but grounds itself in explicating the phenomena of interest.

2.2.1 *Narrative Inquiry*

Narrative inquiry is focused on stories,[48] and how narratives, "attend to layers of meaning".[48,60] Hence, given the Narrative Inquiry approach of this project, the questions, and photos were designed to elicit examples and stories.[48,53] Through an iterative process of re-reading and re-listening, we identified the "metastory",[53] the structure of the stories, common and significant phrases, figures of speech, and major themes both within-case and across-cases, conceptualizing the results.[53] In summary, MMH listened and re-listened to interviews, while NMV did the same. Through the listening and re-listening process MMH and NMV independently noted major themes and metastories within and between cases. After listening and relistening independently MMH and NMV, through careful collaboration, elucidated the overarching results. MMH then conducted preliminary translations. The results, original language (in Russian and Spanish), and translations were concurrently assessed by the four community advisors (two Spanish-speaking and two Russian-speaking). After this portion, MMH finalized the results in English. Translation occurred as late as possible. Peer review was conducted by two experts in Qualitative Research, both of whom work with immigrants. KB, then evaluated the findings and provided feedback on areas of the results that lacked clarity. Moreover, MMH kept a detailed audit trail of decision making regarding the results. Finally, and importantly, using a synthesized member checking approach[61,62], participants were able to review the entire set of results including the written descriptions and discussion by the authors, which MMH back-translated into Russian and Spanish. Participants provided direct feedback on the "resonance"[62] of results, asked for changes and additions to be made, and verified the validity

of results. Participants were especially excited to hear what speakers of the other language had said (i.e. Russian speakers were curious about what the Spanish-speakers had said and visa-versa), commenting, and in some cases crying, that their voices were heard and that the other group had similar experiences.

2.2.2. *Arts-Based Research*

Drawing upon Barone and Eisner's[54] criteria for judging arts-based research (Incisiveness, concision, coherence, generativity, social significance, and evocation and illumination[81]) in essence, the photos and identified arcs and themes, get "to the heart of a social issue." [54(p148)] In terms of concision, the photos, should succinctly portray the issue. Both incisiveness and concision are strongly linked to overall coherence, which determines whether the piece fits together.[54] The first four criterion, incisiveness, concision, coherence, and generativity should naturally lead to social significance; however, "significance doesn't speak for itself. It requires an interpretive or thematic frame."[54(p153)] In our study, we used OAHM.

Incisiveness, concision, and coherence were achieved by first sorting the photos into rough common stories (i.e. the importance of parks). Then, once organized in rough themes, MMH listened, and re-listened to the corresponding interviews with the photos to conduct a within-interview and between interview analysis. Then, the metastory was refined, and the number of photos representing each story reduced. We selected the photos that were the clearest and brightest (in terms of photo quality) to aid concision and coherence. Then, MMH and NVM reviewed the coherence of the photos with the corresponding story and selected quotes. Finally, participants were shown the selected photos and quotes, as well as reminded of their own photos to view overlap in stories. Participants found the selected photos generative of the metastory.

3. Results

3.1 *Participants*

While this study was strictly qualitative, we did calculate several descriptive statistics using Stata version 17,[63] to create a picture of participants. All participants (N=23) identified as female and were between the ages of 60-98. The average (mean) age of participants was 76 years old. The average age of Russian-speakers was 78 (min-68, max-91), and for Spanish-speakers it was 75 (min-60, max-98). Participants had lived in Wisconsin an average of 22 years (1950-2021). Participants identified as Ukrainian (n=1), Russian (n=5), Azerbaijani (n=1), Jewish (n=1), Colombian (n=1), El Salvadorean (n=1), Mexican (n=5), and Puerto Rican (n=8). Participants took an average (mean) of 10 pictures (min-3, max-25). The average (mean) Mini-Cog score was 4.42 (min-3, max-5). A Mini-Cog score of 3 was the threshold for inclusion.[52] Regarding education, 35% (n=8) had an elementary school level of education or less, 9% (n=2) has some secondary school, 17% (n=4) had completed secondary school, 35% (n=9) had post-secondary education (technical, bachelors, or masters), and 4% (n=1) had a PhD. Finally, participants spoke an average of 1.9 languages (min-1, max-5). Languages spoken included, English, Spanish, Russian, Ukrainian, Turkish, Azerbaijani, Yiddish, Hebrew, and French.

There was a slight difference between Spanish and Russian-speakers on the Mini-Cog score (4.23 for Spanish-speakers, and 4.75 for Russian-speakers). However, there was a significant difference in level of education. Among Russian-speakers, 100% had a post-secondary education of higher, and among Spanish-speakers, 53% had an elementary school-level of education or less, and overall, 93% had a secondary-school level of education or less. Only one Spanish-speaking participant had a post-secondary-level of education. Russian-speakers were also slightly older on average than Spanish-speakers. Participants talked about

their level of education in the context of their place of migration. For example, Mexican and Puerto Rican participants discussed that education was not valued both in that time period and because they were needed on *"the ranch"* – Participant 16, and it was not viewed as important especially *"for the women"* – Participant 19.

3.2 ***The Environment – Your soul can rest in the fresh air***

When asked the question "why did you take this photo?" participants noted that they wanted to show what they liked in their environment. Moreover, in a subsequent question, "tell me what you like about Milwaukee and Wisconsin" the most common answer was the natural environment, specifically their neighborhoods, parks, and lakes: *"First and foremost – (Lake) Michigan"* – Participant 4 (88 years old). She then sang a short song about Lake Michigan.

michigan song.mp3

Photos one and two – taken by participants one and two. The photos capture a park on the shores of Lake Michigan.

"It is good because there is the lake. There is somewhere to go and look at the lake." - *Participant 1 (81 years old)*

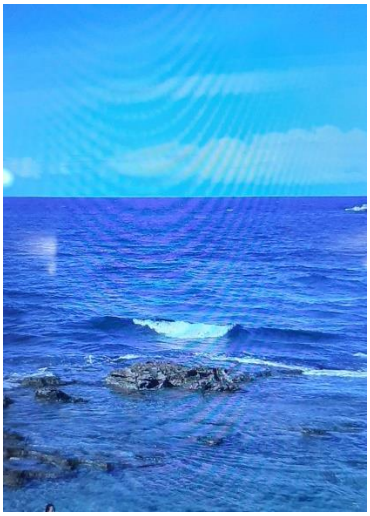
"It is a good place…I feel invigorated here, you can go nearby and rest, your eyes will rest, and your soul will rest in the fresh air." – Participant 2 (75 years old).

Photos three and four were taken by participant 8 (71 years old). She reiterated her love of the lake and parks particularly her daily walks in those parks, as well as her enjoyment of the animals. Participants discussed their love of both wild animals in parks and their own pets as positive experiences in their lives. Animals, both wild and domestic, provided a sense of both enjoyment and comfort to participants.

"I really like this beauty…When I'm going home [to my apartment], this is [the beauty] I see [showing the photos]… I love them (the birds), I don't know why… Once I'm back home, I'll show my neighbors."– Participant 8 (71 years old).

Participant 8 also noted that seeing the animals reminded her of home: *"here there are plenty (of animals), there (in Azerbaijan) there are a lot (of animals)."*– Participant 8

Additional participants noted how the lakes and parks reminded them of home, their place of origin. Participant 15 (61 years old) said: *"I love the beach…I am from Puerto Rico, surrounded by water…I love the water. Here I love to go to the water, the water by Downtown."* Participant 15 selected a picture of the beach in Puerto Rico (photo five).



Participant 21 (80 years old) took photo six: *"I like where we live. Because it's very tranquil, very beautiful. Not many cars pass by, it's good, good, very beautiful."* As you can see in her photo, there a few cars, ample walking area, and plenty of green (in the summer, the photo was taken in February).

In essence, the geographic and spatial location of parks, lakes, and green spaces, were perceived by participants as positive. However, participants noted that outside of the parks, lakes, and their own neighborhood, there was a problem with littering (especially off the freeways), which they disliked. Yet, overall their self-assessments[16] of their environments illustrate that living in Southeastern Wisconsin is an *advantage.* Participants loved the *"quiet city" (тихий город)* – Participant 2, and the green spaces: *"Especially in the summer, when it's green and the sky is blue, the beautiful light-blue lake is like art."*– Participant 3 (80 years old).

Easy access to parks, walking paths, green spaces, and the lakes were described as advantages, and linked to *social support*, because participants would often walk with their friends in these places. This physical and social activity was positively associated with improved health and wellbeing.

3.3 ***Social Support - You think you're by yourself but you're not alone***

Participants took photos of their friends and family to demonstrate their appreciation of their companions, and the photos elicited stories and specific details about their relationships, and how they benefitted them.

Photo seven was taken by participant 11. She took a photo of her close friends, and described how she had been helped by companionship:

"Coming here has helped me a lot, because, look (pointed at photo), this is (person in purple), she taught me how to make creative crafts, to do this… embroidering, and I am sewing a dress (for someone)…And these three, and without these three friends that I have, I would have none." – Participant 11 (60 years old).

Many participants established their primary social groups, through apartment buildings in which there were many speakers of the same language (ethnic clusters), through religious services, and services specifically for seniors. Participant 16 described how she made friends at a senior center, and how her depression had been relieved:

"You think you're by yourself but you're not alone. Here you make friends. Here your depression is relieved…There are a lot of things you can do here, and it's really good here (in the senior center)…Before, I was very depressed (she began to cry)… I spent my time crying, I had no one to talk to, no one, but here (at the center)… I am relieved… It (the center) helped me,

helped me a lot…(stopped crying) I come here to pass the time. You enjoy yourself here, and you are bettered here." – Participant 16 (76 years old)

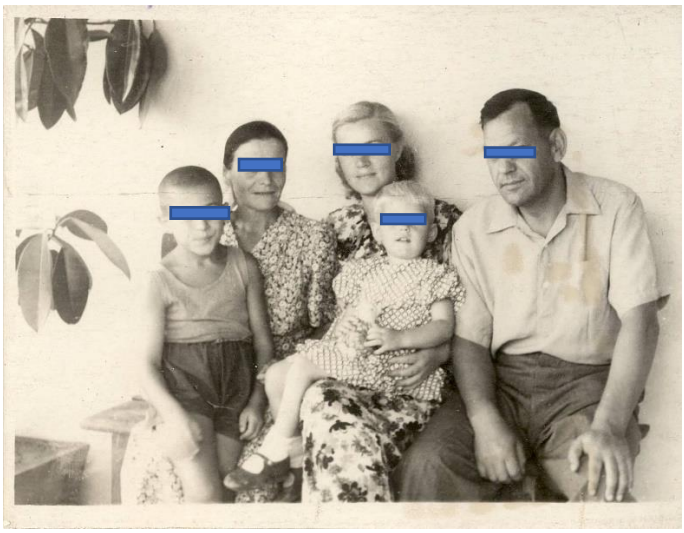
Social support was also linked to participant assessments of the physical environment. Specifically, participants would go walking with their friends on sidewalks and through parks. In this way participants had physical and social benefits, even as they experienced age-related decline (photo one shows participant sitting on her walker after walking to the park.):

"Now our difficulties are all connected with our health, we are already attached to out walkers. When I arrived 10 years ago, I didn't have a walker, and I walked by foot…45 minutes by foot, and we had the company of three people from our home (building) and we would walk (by foot)…(Now) we have fun with the walker, walking somewhere around the house (building)." – Participant 2 (75 years old)

Photo eight. Taken by participant 2 of participant 4, who walked every day.

Social support, or feelings of not being alone, were not only linked to current friendships, but also family both living and deceased. Feeling connected to relatives who were living as well as deceased fostered a sense of both pride and link to a larger history.

Photo nine was taken by participant 24. She selected this picture because it was the beginning of her memories, “from this moment on I remember myself” – Participant 24 (68 years old) The picture was significant for participant 24 as it reminded her of memories of herself and her family during that time.



Participant 21 (80 years old) summarized: *“My family, I love them so much.” (Mi familia, la amo tanto)*

We should note that there were two counter. These two participants, who were surrounded by people via their daily interactions at a senior center, still reported feeling isolated, primarily due to separation from their families. While this finding was not reflected among the rest of participants, it is notable because it suggests further nuance to the relationship between social support and wellbeing.

Overall, social support through multiple avenues was an advantage for participants, especially as it was linked to positive physical interactions with the environment, such as increased exercise. Yet, despite the described advantages of social support and a positive physical environment, participants struggled with feelings of Outsiderness in Wisconsin.

3.4 ***Outsiderness – We're human***

Participant 11 (60 years old) said, "we're human" (cried). She and other participants described discrimination based on several aspects including language and race. By Outsiderness, participants meant that despite living in Wisconsin for decades, they still faced discrimination and felt like *guests*. Therefore, the plea "we're human" was to say that participants should be treated as such.

The last question we asked before the demographic questions was, "what do you think Milwaukeans/Wisconsinites should know about Russian-speakers and Spanish-speakers in Milwaukee/Wisconsin?" With the follow-up inquiry, "how are you treated here?"

Participant 11's subsequent description of discrimination outside of their social support circles was echoed by additional participants. Participant 21 (80 years old) said:

"Understand each other, how traditions differ [between peoples]…So that they [people in the community] understand it, so that, they don't discriminate against people, right…That is what I hope for…I see a little bad, right, from those who discriminate…They don't understand your way of being, how you live is different…The ones who lives here also have to understand how to live here. You have to understand people, behave well, don't discriminate, be humble, patient."

Hence, in an effort to show themselves, many participants chose to take photos of themselves, or ask others to take photos of them, showing themselves with things they had made, or while doing activities. Participant 12 asked her friend to take a photo (photo 10) of her weaving a cross, which she then gifted to her friend (photo 11), Participant 14 (68 years old), who also asked that a photo be taken of her, to demonstrate her pride in this work and relationship.

Photo 10

Photo 11

Given the feeling of Outsiderness, participants stressed that relations between communities in Southeastern Wisconsin needed to improve. When answering the aforementioned questions, Participant 12 (98 years old) said that the relationship between the Spanish-speaking and non-Spanish-speaking communities needed to improve, through, "more understanding, more communication, if there is no communication, there is nothing." This was echoed by sentiments of a lack of community cohesion, which contributed to feelings of Outsiderness. Participant 10 (76 years old) said that she would have more support in a more united community, "with a united community, yes, but here no, I don't see that…I don't know, everyone is doing their own things, I don't know, this union, no (isn't there)."

Feelings of Outsiderness were also linked to English Language Proficiency, or rather a lack thereof. Participant one summarized the tension between pride in their own identities as Russian and Spanish-speakers and English Language Proficiency (ELP) as feeling like permanent "guests" despite having lived in Wisconsin for decades.

"I think that they (Wisconsinites) should know that we're good. They should know that Russian-speakers would never do anything bad, that Russian-speakers understand that they're not the

masters here and that they're guests here and they behave quite modestly… This is what English-speaking Americans should understand…They're not evil people, they're good people… They would, with pleasure, come to the aid of Americans if needed." – Participant 1 (81 years old)

The impact of lack of ELP was further explicated by Participant 8: "It's bad that I don't know that language." (*вот плохо то что я языка не знаю*) The lack of ELP increased feelings of isolation, "I am alone" (*я одна*) – Participant 8. Yet, for participants who had learned English, not at an advanced level, but at a level which allowed them more freedom, they expressed increased comfort going out-and-about, using public transport, and engaging with others. In essence, enhanced ELP decreased feelings of being an outsider.

"Therefore, I now feel like a fish in water, that is to say, I can (go to) any building… All I have to do is ask for help… Before I was afraid to speak [English]…Now, I feel great in any place, on a bus, in a store, in a hospital." – Participant 3 (80 years old)

Other participants echoed this sentiment of enhanced ELP facilitating a greater sense of ability to navigate transport, appointments, and other outings. Participant 1 took a picture of a bus to demonstrate her appreciation of public transport, and Participant 16 expressed that ELP enhanced her confidence when working with her physician. Finally, despite feelings of separation with the non-English-speaking community, participants described a sense of pride in their own communities that they thought Wisconsinites should be aware of: "We're hard workers, and *very intelligent*…We're humble people." – Participant 17 (80 years old)

Photo 12

4.0 Discussion

Notably, while Russian and Spanish-speakers are two distinct groups, here we do not disaggregate the results by group. This is because both groups described nearly identical experiences regarding the role of location on their health. For participants, there was a nuanced relationship between the factors impacting their health.

4.1 *The Impact of the Built Environment Impact on Physical and Mental Health*

Drawing on OAHM, examining the socioenvironmental influences[64,65] in the model, participants clearly described how both the physical and social environment influenced their health, and their health-facilitating behaviors. For example, participants described the built environment as an advantage, specifically lakes, parks, green spaces, and the availability of senior centers. Engaging with local parks and lakes allowed participants to relax. Moreover, their physical environment was linked with their social environment, through group walks. Thus, participants reported positive psychological benefits, prolonged physical function, and normative beliefs that reflected the importance of regular exercise. Moreover, as aging "is a process of adaptation that gradually becomes more complicated"[5,66] the normative belief of participating in regular exercise facilitated greater physical function for a longer period of time and reduced the

physical adaptation required. This is especially important as poor physical health negatively impacts older adult immigrants.[25,67–69]

The built environment, for many participants a senior center, was an advantage as it led to greater social support. That social support, through the service and resource of a senior center, led to decreased reported depression among participants, improved psychological wellbeing, and overall fewer barriers to receiving support. Factors that decreased depression are especially pertinent among older adult immigrants as depression is a major contributor to poor health among older adult immigrants.[12,25,67–75] In essence, observational learning and normative beliefs, through participants descriptions of learning new skills via activity participation at the senior center also gave participants a sense of pride, continued learning, and opportunities to "safely engage in"[65] activities that positively influenced their psychological, cognitive, and physical well-being. Overall, the physical and social environment promoted healthy aging and supported their overall health.

Gao et al.[76], and Rote and Markides[77] also found the built environment and neighborhood cohesiveness was facilitated by the health of older adult immigrants. Moreover, social support is supported by the literature as being extremely important for older adult immigrants.[5,24,25,67,68,70,76–87,87–93,93–99] Additional studies have examined the role of activities (ranging from ex: social, cognitive, spiritual/religious, and physical) as facilitators of health among older adult immigrants.[5,77,78,80,90,92,95,97,100,100–106] This study adds to the existing body of literature as it articulates the relationship between the built environment, activities *facilitated by* the built environment, *and* social support.

4.2 ***The Impact of Acculturation***

Furthermore, acculturation is not explicit yet it is present in the model[5] used to guide this study and was present in participant descriptions. To reiterate, acculturation is a "multidirectional process of integration, negotiation, and potentially biculturalism."[5,36,38,107] Negotiation and integration included not only ELP, which was a major stressor for some participants, but also navigation of place-specific tasks such as navigating the local public transport system. In essence, acculturation was linked to access to resources. For example, participant 3 described how improved ELP facilitated comfortable access to transport, medical visits, and simply going from place to place. While for participant 8, severe acculturative stress, exacerbated by a lack of ELP, contributed to isolation and even wanting to leave the US, through stressful enhanced cultural distance. In essence, lack of ELP was a disadvantage, acted as a barrier to fully integrating in the environment, and exacerbated the cultural distance.

The existing body of literature supports the importance of ELP in the health of older adult immigrants.[5,69,70,84,89,108–113] This study adds to the existing body of literature as it further articulates the role between acculturative factors, such as ELP, and place-specific tasks and access to resources, as the linkage between language and access to transport is not presently well documented in the literature about older adult immigrants.

4.3 ***The Impact of Discrimination***

Moreover, discrimination and feelings of Outsiderness was a factor that negatively affected participants. Discrimination is a documented barrier for older adult immigrants in relation to their health.[5,27,28,78,108,114–117] Emphasized in the model under the 'Structural' column, participants discussed that the relationship between the English-speaking and non-English-speaking populations in Wisconsin needed to be improved, through improved understanding of each other, improved communication, and understanding the strengths, or assets[6], of their

respective communities. Such improved understanding would contribute to reduced cultural distance, and improved well-being among non-English-speaking populations.

5.0 Conclusion

Older adult immigrants contend with place-specific factors that impact their health. Among older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin, access to parks, green space, and transport facilitated feelings of relaxing and enjoyment. Access to green spaces was linked to social support as participants and their friends would take walks together through the parks. Social support was also bolstered through intentional services such as senior centers. Yet, despite strong relationships with older Russian and Spanish-speakers, relationships with English-speaking Wisconsinites were strained and contributed to feelings of Outsiderness, described as feeling like permanent "guests" in the community. OAHM was helpful in conceptualizing the pathways between relationships to demonstrate how factors such as social support were linked both to individual psychological well-being and the built environment. In essence, the use of photos and in-depth interviews allowed participants to *show* what was important to them and drive the narrative.

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ARTICLE FOUR

"You Die or You Get Better"

Conceptualizations of Health-Seeking Behavior and Health Care Encounters among Older Adult (Im)migrants in Wisconsin, the United States

Abstract (350 words)

Older adult immigrants are a large and growing population in the United States. While most older adult immigrants come from Mexico and are Spanish-speakers, there are also hundreds of thousands of older adult Russian-speaking immigrants who immigrated after the dissolvement of the Soviet Union. The current war in Ukraine is fueling an additional wave of migration of Russian and Ukrainian-speakers. In this study we sought to gain an enhanced and more nuanced understanding of the experiences of older adult Russian and Spanish-speaking immigrants regarding their health, health-seeking behavior, health care expectations, and encounters with the healthcare system. Utilizing a Community Engaged and Participatory Research approach, this project was developed through multiyear relationships with non-profit organizations, community advisors, and community stakeholders. Through this multiyear development using a Community Engaged and Participatory Approach, we conducted a Qualitative – Narrative Inquiry – Photovoice project, employing the Older Adult Immigrant Adapted Model for Health Promotion as our guiding framework, with older adult Spanish and Russian-speaking immigrants in Southeastern, Wisconsin, located in the upper Midwest in the United States. The key findings were: (1) "Whom can I trust if not my son?" (From whom do participants trust to get information), (2) "You're already old, you're already sick" (When and why participants seek out medical care), and (3) "You die or you get better" (Issues of access to the healthcare system). The findings illustrate challenges accessing the healthcare system as a whole, but also differing expectations of medical care. Improved training on health communication and sensitively working with different groups is of utmost import for public health and health care professionals. These findings have implications for the training of future health professionals and structuring of healthcare systems, in the global context in which they are situated.

Key words: Photovoice, Narrative Inquiry, Global Health, Older Adult Immigrants, Qualitative Research, Community Engaged, Health Research, Health Communication, Promoting Health Equity.

Background

There are over 7.3 million older adult[5] immigrants in the United States (US)(1). By 2060, that number is expected to increase to over 22 million (1). Most older adult immigrants in the US come from Mexico (1). The current war in Ukraine is fueling mass emigration, thereby increasing the number of refugees. As of April 28th, 2022, more than 5 million Ukrainians have fled their homes (2). As men ages 18-60 are prohibited from leaving the country, those fleeing the country are primarily women, children, and older adults (3). Due to the crisis, the US has pledged to welcome up to 100,000 Ukrainian refugees (4), many of whom speak Russian as their first-language (5). It is within this context, as well as the continued COVID-19 pandemic, that we conducted this study with older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin, in the US.

We worked specifically with older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin for several reasons (1) long term relationships with both the Russian and Spanish-speaking communities in Southeastern Wisconsin, (2) community organizations, community advisors, and community stakeholders were interested in the project and co-developed it, (3) similarities between both groups, as the two tend to have low incomes and live below the poverty line (6,7), and both groups have higher rates of specific health concerns including hypertension (8,9) and mental health concerns (9–11), compared to their White US-born counterparts.

In working with older adult Russian and Spanish-speaking immigrants in Southeastern Wisconsin (WI) we aimed to: (1) gain a better understanding of personal experiences that related to, or influenced, their health; (2) assess their needs and views in relation to health and

[5] Defined as age 65 and older by the American Community Survey.(1)

wellbeing, and (3) evaluate the factors that impacted their health and wellbeing. We sought to address these aims through a Community-Engaged Qualitative – Narrative Inquiry – Photovoice project that applied the Older Adult Immigrant Adapted Model for Health Promotion (12).

Our three key findings elucidated these aims. These findings were: (1) "Whom can I trust if not my son?" (From whom do participants trust to get information): Participants primarily trusted their children and those within their social networks rather than their health care providers, (2) "You're already old, you're already sick" (When and why did participants seek medical care): Participants principally sought medical care with the expectation for curative care, and (3) "You die or you get better" (Difficulties with the healthcare system): Participants cited interpretation issues and long wait times the healthcare system was semi-inaccessible. The results of this study are crucial to improving health communication and understanding of health behavior, and ultimately promoting health equity. Central to situating these results is articulating the global context.

The Global Context

Discussing the global context in this project with the lens of both public health and global health, necessitates articulating the fundamental link to *global impact* (13). Emigration and subsequent immigration have a global impact – geographically, economically, culturally, linguistically, and politically, particularly when we also explore the reasons for migration. Understanding the global context is key to promoting health equity, because to attain one's "full health potential"(14), the historical and present conditions perpetuating health inequalities must be understood (14).

Following elucidation of key terms, we briefly explicate the history of Spanish and Russian-speaking immigrants in the US; focusing on Mexican and Puerto Rican (im)migrants as

the two largest Latinx groups in the study, and immigrants from countries of the Former Soviet Union.

Migrant, Immigrant, Refugee

Broadly defined, a migrant is *"*a person who moves from one place to another."(15) An immigrant is "a person who comes to a country to take up permanent residence."(16) While a refugee is "fleeing armed conflict or persecution."(17) Notably, in this study, we use the term *immigrant*, or *(im)migrant*, broadly because several Puerto Ricans self-selected into this study. Participants all heard the recruitment script, and then self-selected to participate based off the script. Since we asked no direct questions about immigration status, they were able to participate. The inclusion of Puerto Ricans in studies of migrant and immigrant experiences is supported in the literature (18–20).

Despite our broad usage of the term immigrant, these terms (*refugee, immigrant, migrant*) are neither completely interchangeable nor *cut-and-dry* in difference, due to the sociopolitical landscape at the time of migration (12,21,22). For example, due to the older age of participants, several Puerto Ricans in this study were born shortly after Puerto Rico became a territory of the US (23). Moreover, according to the US Immigration and Nationality Act (101(a)(42), a refugee is, "unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."(24) This broad definition excludes those migrating due to climate-change related disasters (25). It also excludes most of our participants, who migrated due to forced migration(26) but did not meet the definition of a refugee. Most of our participants expressed that they had no choice but to migrate to the US, describing it as "required" to escape violence,

discrimination, and poor economic conditions. For others, they were forced to migrate due to the needs of their children, describing the move as "with pain in my heart, I came (to the US)." (Participant 22) Despite the forced migration nearly all the participants faced, only one met the US's definition of a refugee and came as a refugee.

Spanish-speaking Latinx[6] *(Im)migrants*

In the US, 18.5% of the population, or 60 million people, are Latinx (28). Latinx is an ethnicity, not a racial group, and Latinx includes those from Latin America (29). Among Latinx people, Mexicans and Puerto Ricans are the largest subgroups in the US (1,29). Latinx immigrants have a median age of 43 (28), while the median age for non-Hispanic White people is 41 (30). Five-percent of US-born Latinx people are over age 65, while 12% of Latinx immigrants are over the age of 65 (28). As of 2008 (the most recent data available according to the WI Department of Health Services), 112,931 Latinx people reside in Milwaukee-county and only 4% were over the age of 65 (31). We could not find information on Latino *immigrants* specifically in Milwaukee.

Mexico

The history of Latinx migration to the US is steeped in colonization, war, treaties, and border shifts. As expressed in the documentary, *Mountains, Mist and Mexico*, Mexicans - "we've always been here."(32) Mexico used to encompass much of the southern and western US, including present-day Texas, Arizona, New Mexico, and California (33). The US annexed Texas in 1845 (33), and the present boundary between the US and Mexico was established in 1848 following the US-Mexico war, when Mexico was forced to relinquish one-third of its former

[6] Latinx and Hispanic are frequently used interchangeably, and we do so in this article. However, they do refer to two different "pan-ethnic terms" that refer to two different, although often overlapping groups (Hispanic – Spanish-speaking origin, Latinx – Latin American origin regardless of language spoken) (27). In this study the Latinx immigrants all spoke Spanish as their first language, and identified as Latina.

territory (34). Between 75,000-100,000 Mexicans remained north of the border following the war and were naturalized as US citizens (34).

Following the war, minimal migration from Mexico occurred until the 1880s when, due to increasingly restrictive laws against immigrants from Asia (35), employers facing a labor shortage began to "look to Mexico"(32,34) to meet their labor demands. Due to the Mexican Revolution in the early 20th century, and economic opportunities in the US, Mexicans continued to emigrate (32). During World War II and also as a result of fluid migration at the border, when the US Government had friendlier policies towards Mexico, the Mexican population in the US ebbed and flowed (34). As of 2021, 62% of Latinx immigrants are Mexican (28,36). Yet, Latinx people, particularly Mexicans, continue to be scapegoated and face discrimination as more restrictive policies were enacted and as immigration became more politicized (37).

Puerto Rico

Puerto Rico "is one of the world's oldest colonies, having been under some form of military occupation or protectorate status since 1508."(38) Over 30,000 Taíno lived in Puerto Rico (Borikén), prior to Spanish colonization in the late 1400s and early 1500s (38). By 1530, due to forced labor and disease, only 1148 Taíno remained in Puerto Rico (38). Slavery was not abolished in Puerto Rico until 1873 (38). In 1898, during the Spanish-American war, the US annexed Puerto Rico (39). In 1917, via passage of the Jones-Shafroth Act, Puerto Rico became a US territory, granting Puerto Ricans citizenship (39). Following the Jones-Shafroth Act, a Selective Service Act was passed, meaning, Puerto Ricans could be, and were drafted to fight in US wars, but did not and do not have representation in congress, until Puerto Rico became a commonwealth in 1952 and was granted a "non-voting representative" (39,40). In the 1950s-1970s, due to changes in industry on the island, there occurred *La Gran Migración* from Puerto

Rico, when 25% left Puerto Rico and settled in various cities in the 50 US states, primarily to states such as California and New York (39). In Southeastern Wisconsin, specifically Milwaukee and Waukesha counties, there are approximately 36,000 Puerto Rican individuals (41).

Despite this history, half of Americans do not know that Puerto Rico is a US territory, and that Puerto Ricans are US citizens (42). This lack of understanding fuels isolationist sentiments. For example, following Hurricane Maria, among US people who knew that Puerto Rico was part of the US, 80% supported sending aid, while among those who thought Puerto Rico was not part of the US, only 40% supported sending aid (42). Moreover, Puerto Ricans also face discrimination across all 50 US states, even from other Latinx people (43). Latinx people born in Puerto Rico or another Latin American country faced greater discrimination that Latinx people who were born in the 50 US states (43).

Systemic discrimination impacts health among Latinx people via multiple avenues, including through the Social Determinants of Health (SDOH) (44). The SDOH include: Economic stability, education access and quality, healthcare access and quality, the neighborhood and the built environment, and the community and social context (44). Seventeen-point-two percent of Latinx immigrants live below the poverty line compared to 9% of non-Hispanic White people (29), and 70.5% have a high school diploma compared to 93.3% of non-Hispanic White people (29). According to 2014 and 2017 National Health Interview Survey data, 52% of Latinx non-citizen immigrants (this includes undocumented people, as well as green card and other visa holders) had no health insurance compared to 16% of US-born Latinx people (45). Thirty-five percent of Latinx non-citizen immigrants had no usual place of health care compared to 20% of US-born Latinx people (45).

English language acquisition also impacts Latinxs people; 71.1% of Latinxs people do not speak English at home (29), and 42% of Latinx immigrants do not speak English well, compared to just 1% of US-born Latinx people (45). This is important because English language proficiency has implications for healthcare access. Finally, while Latinx people actually have higher life expectancies versus non-Hispanic White people (82.1 vs. 80.6) (29), an examination of the Hispanic Health Paradox (46) is outside of the scope of this article.

Russian-speaking Immigrants from Countries of the Former Soviet Union

Countries of the Former Soviet Union (FSU), or the Union of Soviet Socialist Republics, included: Russia, Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan (47). Following changes to US policy in the latter half of the 20th century and the dissolving of the FSU from 1988-1992 (47,48), more than 600,000 individuals from the FSU immigrated to the US between 1970-2000 (49). Between 1970 and the late 1990s, more than 5,000 Russian-speakers immigrated to Milwaukee, in Southeastern Wisconsin (50,51). Many immigrants were Jewish, and other religious minorities who also left the FSU (50,52).

We specify *Russian-speakers*, because while over 130 languages were spoken in the FSU (53), Russian was the lingua franca (54), and leaders of the FSU directed significant resources to improving literacy (only 28.4% of the population was literate in 1917 (55)), language standardization, and "Russification"(55), despite official state support of multilingualism (55). For example, schooling in the indigenous languages of the FSU was replaced by Russian-language education (55). Thus, while many (129) other languages were present in the FSU, immigrants from the FSU who immigrated in the latter half of the 20th century and early 21st

century (which includes the participants in this study), primarily spoke Russian as either their first or second language.

Notably, twenty-five percent of Russian-speaking immigrants from the FSU were already considered older adults (over 65) when they immigrated (56). Before we continue, it should be noted that much of the literature in this section is dated, as much research was done with immigrants from the FSU shortly after the dissolvement of the FSU but tapered off. Hence, this article is also crucial as it provides updated information about a large aging population.

Regarding the SDOH, during the peak wave of immigration from the FSU to the US in the 1990s (1990-1999), 65% of immigrants had a bachelor's degree or higher (57)[7], compared to 23% of US-born individuals during the same time period (58). Yet, despite this high level of education, older adult immigrants from the FSU tend to be low-income and rely on government assistance (i.e. Medicaid, SSI, SNAP), with one study finding that 100% of participants (76.5% had a college degree or higher) received government assistance (59,60). Older adult Russian-speaking immigrants from the FSU tend to overutilize services (61), yet have worse health outcomes compared to non-Hispanic White US-born individuals (9). Regarding language, most older adult immigrants from the FSU struggle with English, and have limited English Language Proficiency (62,63). Finally, we could not find data on the life expectancy of Russian-speaking immigrants from the FSU to the US; however, we were able to find data on their life expectancies in Israel (most immigrants from the FSU migrated to either the US or Israel), which was 64 years (64).

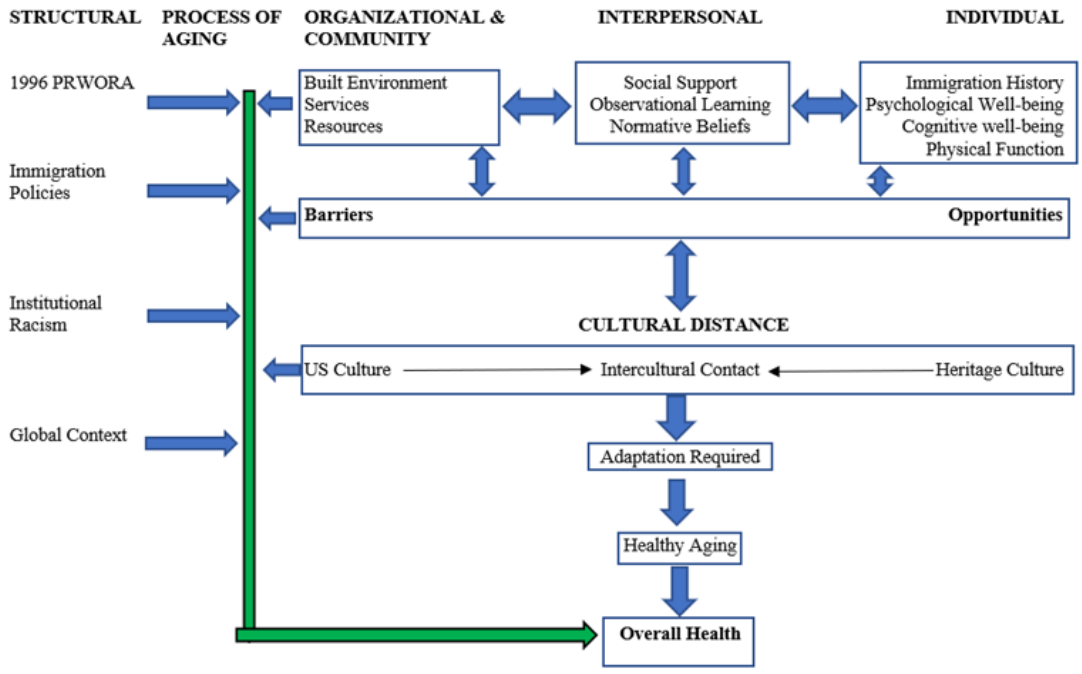
Historically, many emigrated from the FSU due to antisemitism, which involved cultural, political, and economic discrimination (48,65,66). Presently, due to Putin's invasion of, and war

[7] More updated information could not be found.

in Ukraine, Russian-speaking immigrants in the US are reporting increased discrimination and hostility (67,68). As a result, some Ukrainian refugees, many of whom speak Russian as their first language, are rejecting the Russian language, preferring Ukrainian as a form of resistance (5). While many refugees will speak Ukrainian, the need for both Ukrainian-speaking and Russian-speaking providers working with recent immigrants will be of utmost importance as the war continues.

The history of the global context is foundational to understanding some of the barriers to promoting health equity. The subsequent explication of the Older Adult Immigrant Adapted Model for Health Promotion illustrates the manner in which pathways interact to promote or impede health among older adult immigrants in the US.

Theoretical Framework – The Older Adult Immigrant Adapted Model for Health Promotion (OAHM)(12)



We used the OAHM model to frame our study and results. OAHM combines elements of Successful Aging Theory (69–71), Social Cognitive Theory (72,73), and Acculturation (74–77),

in the context of the Social Ecological Model (78). OAHM isa conceptual model (12) that broadly demonstrates that pathways by which factors may interact among older adult immigrants, specifically highlighting that aging is a process (12,69).

OAHM illustrates the ways in which factors can potentially interact. For example, is an older adult immigrant is limited in physical function, but their peers go on walks together every day, thereby reinforcing normative beliefs and observational learning, the older adult may still go on the walks, thereby aiding their overall health. However, in order to go on the walks, the built environment also needs to be conducive to walking (i.e. safe and available sidewalks or parks). In this way the built environment, normative beliefs, and physical function all interact to affect one's overall health. These are also forms of barriers and opportunities. The availability of sidewalks and parks in the built environment act as opportunities to engage in health-promoting behavior. Without such factors in the built environment, even with normative beliefs that support physical activity, this would be a barrier to promoting healthy activity.

In the context of this article, which emphasizes the healthcare experience, we will explicate additional aspects of the model, as well as discuss the role of health communication. According to the Society for Health Communication (79), health communication is defined as, "the science and art of using communication to advance the health and well-being of people and populations."(79) In essence, what are the tensions in values, attitudes, behaviors, and identities (74), between older adult immigrants and the US healthcare system? And how do public health campaigns, provider interactions, or even working with health care staff to make appointments bridge or exacerbate that cultural distance during intercultural contact? In the discussion section, we explicate the results within the context of the model, OAHM, and provide implications for health communication.

Methods

We conducted a Community-Engaged Participatory Qualitative Photovoice project with older adult immigrants in the US. The study was approved by the University of Wisconsin-Milwaukee Institutional Review Board. All participants provided informed (written) consent to participate in this study.

Community-Engaged and Participatory Research (CEnPR)

Community-Engaged and Participatory Research (CEnPR) falls under the umbrella of Community-Based Participatory Research (CBPR) (80); however, CEnPR is not CBPR because CEnPR does not include *all* CBPR principles. The key principles of CBPR are: "It is participatory. It is cooperative…It is a co-learning process. It involves systems development and local community capacity building. It is an empowering process through which participants can increase control over their lives. It achieves balance through research and action."(80)
In essence, CEnPR highlights issues that are important to the community, bi-directional relationships, and some, although not necessarily all CBPR principles (80–82). Central to CEnPR and CBPR are community advisors or community advisory boards (80). In our study, we had two community advisors in the Russian-speaking community, and two community advisors in the Spanish-speaking community. We worked together on each step of the project, from project development, to question refinement, facilitating introductions with potential participants, and assessing the results.

Moreover, central to CBPR and the utilization of CBPR principles is that CBPR is an "instrumental strategy"(83). Researchers are in positions of power, which can unintentionally harm communities; thus trust, relationships, reflexivity, and historical understanding of power

processes are crucial (83). We explicate here a brief summary of the four-year development of this project.

In 2018, the lead author (MMH) began volunteering with two local non-profit organizations in Southeastern Wisconsin. With one organization MMH worked with older adult Russian-speaking immigrants teaching English as a Second Language (ESL). The second organization serves primarily with Latinx population in Southeastern Wisconsin, and MMH volunteered in the Advancement Department. The shift towards research and action(80) began in the spring of 2019 with both organizations. When teaching ESL roughly 50% of each session was spent discussing issues the participants faced, including their health, access to healthcare, or access to transport. In the spring of 2019, MMH received approval from the University of Wisconsin-Milwaukee Institutional Review Board to conduct focus groups with her ESL class to assess the strengths of their communities, challenges that faced, and potential solutions. Below is an excerpt from the focus group interviews:

Table One: Excerpts from the 2019 Focus Groups
Question: How would you describe the community of [the building] to someone unfamiliar with it? *"Here at [our building] it is very clean, and everything is in order, and every person has to go through an interview to live here."* *"[The community] is a very well-educated community, full of good people, with no alcoholics or hooligans"* *"We are an active community, we go into the city, on picnics."*
Question: What type of health program would you like to see here? *"Our biggest issue is transport, we would like to see better transport, because we have to wait for people to pick us up and it can take a long time."* *"It is very hard in the winter, one slip and that's it, I'm done."*
One woman elaborated on why the ESL classes were important to her, *"There are 23 theaters in Milwaukee, and I can't go to any. I can only go to the music ones, because music is a universal language. But I want to learn English to I can go to the other theaters."* This individual passed away two months after the focus groups.

It was from these focus groups that interest in a Photovoice project developed, with one participant saying: *"I will take pictures of everything! To show what it is like for us."*

From 2019 until the beginning of the COVID-19 pandemic, MMH worked with residents and the local non-profit to facilitate more activities to accommodate Russian-speaking residents needs; however, this became more difficult with the COVID-19 pandemic, and during that time the non-profit organization sold that building. This was a source of stress for residents as the selling of the building meant that there were no longer any Russian-speaking staff on site. The new management made changes without consulting the residents, such as disposing of the entire Russian-language library in the community room that residents themselves had paid for. There are also continued cultural tensions in communication between the new management and Russian-speaking residents. MMH has tried to work to alleviate some of the cultural tensions between new staff and residents. At the same time, MMH continued to work with Latinx serving organizations as a volunteer. MMH assisted with events related to Latinx health and grant writing, for example.

From 2018 onward through such projects, MMH strove to center community advisor and participant voices and balance research and action. For example, the 2019 focus groups led to an increase in planned activities, such as cross-cultural nights with a university club and older adult Russian-speakers. A collaboration with Fight Asthma Milwaukee led to a collaborative publication on asthma rates among different Latinx groups (20). In another collaboration, MMH worked on a quantitative analysis of National Health Interview Survey Data, in which we examined heart attack symptom literacy among Latinx people (45). In 2020, MMH also collaborated with the Jewish Museum Milwaukee (JMM) during a class on Eastern European Jewish history to conduct archival research. In that project, MMH examined why so many Russian-speaking people immigrated to Southeastern Wisconsin. That paper is now housed at JMM and available upon request.

Moreover, in line with the CEnPR approach, when designing this study MMH wrote a two IRB proposals, following recommendations from Vanner, a scholar who focuses on participatory methods (84). First, MMH went to potential recruitment sites and met with potential future participants about what they thought about the study, changes they would like made, and its potential contributions. Then, MMH incorporated their feedback and wrote a second IRB proposal to conduct the project. Furthermore, during the data collection process, MMH did not only go to the recruitment sites when MMH was conducting an interview. MMH also went just to get to know people better, conducting over 125 site visits between all three locations. Sometimes MMH was offered food, *cambas* (crafts) other times participants called about recommendations for gifts for their grandchildren, and MMH attended a graduation ceremony for a group of older adults who had participated in a fall-prevention program. The CEnPR approach of this project was vital to establishing trust, designing a project of import and interest to non-profits, community advisors, and participants, and ensuring that participants had the "last word"(84) on the study.

Narrative Inquiry

We used Narrative Inquiry as our qualitative approach. Narrative inquiry emphasizes stories (85,86), with the definition encompassing, "an expanded definition embraced oral and written narratives ranging from short topical stories about particular events…to entire life stories."(86) Combining Narrative Inquiry and Photovoice with older adult Russian and Spanish-speakers was especially advantageous as not only did the photos elicit stories, but participants were able to show their own viewpoints in the photos and lead the discussion (85). Moreover, Narrative Inquiry places emphasis on *how* things were said, *what* the participant chose to focus on, meaning, *what* stories the participant *chose* to tell. Narrative inquiry and Photovoice were

also important to combine with participants, most of whom did not speak English, as they synergistically act to challenge dominant sociolinguistic structures and elevate their voices (87).

Photovoice

Broadly speaking, Photovoice involves the use of photos in research. Photovoice is also participatory (87). Wang and Burris in their seminal 1997 text, "Photovoice: Concept, methodology, and use for participatory needs assessment" that, imagery is powerful (87), and that photovoice allows participants to take part in research that they may have traditionally been excluded from, and also challenge the English-speaking hegemonic traditional research structures. Moreover, photovoice is about participants producing knowledge and highlighting aspects of their lives that they find important (87). It allows the audience to have a better understanding of the participants viewpoint (*who* finds *what* important), affirmation of the community, exploration of ideas, and the depiction of assets (87,88).

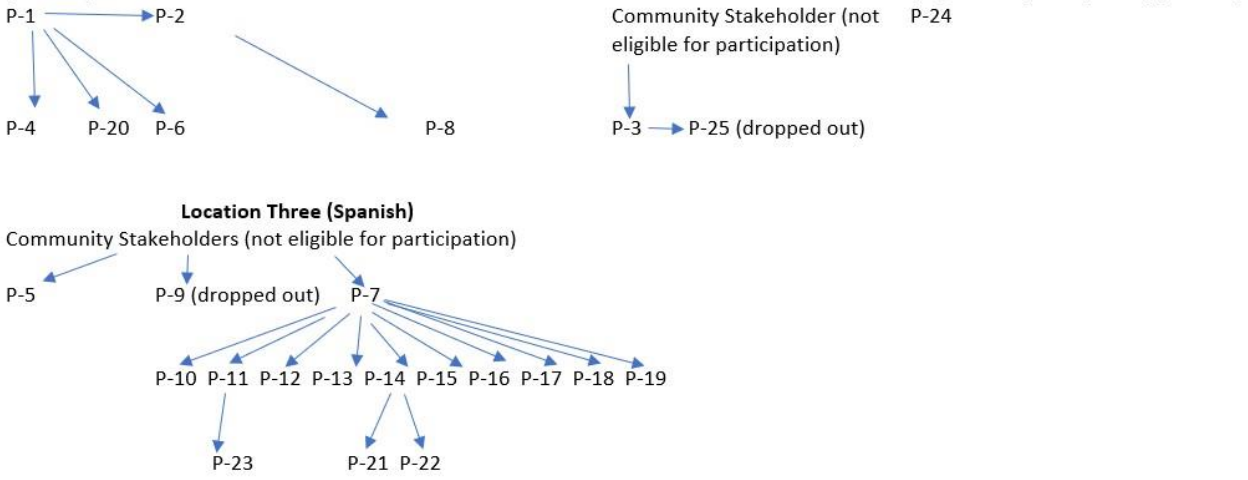
There is also support in the literature for using a Photovoice approach with older adults (89). As, older adults are generally "under-represented in research studies and sometimes occupy marginalized positions in society"(89), including older adults is not only important but research using a Photovoice approach can also benefit participants (89). For example, a Photovoice study with older adults in Canada illustrated that the use of photos allowed participants to *show* what made their communities age-friendly or not (90). Additionally, the process of taking photos itself was therapeutic, facilitated more robust data, and allowed for sharing experiences (89). Hence, for older adults, particularly older adult non-English-speaking immigrants, who are under-represented, and yet comprise millions of people in the US alone, Photovoice is an advantageous approach.

In essence, the complementary CEnPR, Photovoice, and Narrative Inquiry approach, allowing participants to highlight what was important to them, not only in the photos, but beginning with project development and culminating with their edits and approval of the results.

Data Collection

Data collection took place between October of 2021 and April of 2022. To recruit participants, we employed a purposeful snow-ball sampling approach (91,92). See Figure One for the recruitment illustration.

Figure One. Study Recruitment



In total, we recruited 25 female participants, two of whom dropped out due to COVID-19, thus the final number of participants was 23. Participants needed to be at least 55 or older to participate (12,93). As there was no upper limit in age, MMH, who conducted each interview, used the Mini-Cog screening to assess cognitive impairment (94). The Mini-Cog screening, is a brief screening of cognitive decline and is scored between 0-5 (0 meaning significant impairment, and 5 meaning no notable impairment) (94). Using the recommended threshold from Mini-Cog, participants needed to score a 3 or higher to participate in the study (94).

We collected data through photos and recorded interviews with participants. For each interview, MMH also recorded field notes, using a 29-point field guide, which included power dynamics, the setting, number of interruptions, and gestures. The recruitment script, camera usage directions, consent form, and interviews were supplied and conducted in the participants language of choice (Spanish or Russian) by MMH. We used seven recommendations[8] for cross-language research in this project to maximize linguistic rigor and trustworthiness (93). Interviews lasted an average of an hour. After the interview, MMH used Google Speech-to-Text software to do the initial transcription. The use of Google Speech-to-Text was approved by the UWM IRB. Then, a trained trilingual student NMV verified and validated the transcription and thereafter MMH reviewed, verified, and validated the transcriptions, meaning MMH carefully re-listened to each other interview first creating a second transcript of that interview, then comparing that transcript to the one created by NVM, and listening and resolving discrepancies. If any areas of the transcript were still unclear, MMH consulted with NF, ESS, and participants themselves to reach clarity.

Notably, our study involved in-person interviews and technology (the cameras) with older adults during the COVID-19 pandemic, hence, there were numerous interruptions to the study and adjustments needed to be made during recruitment and data collection. The COVID-19 pandemic had three major impacts on our project: the recruitment locations, timeline, and the technology used in the project. One of the original sites we had planned for recruitment did not back up due to the on-going pandemic. Another site reduced their hours and were only open half

[8] (1) What and why? Considerations for Study Design, (2) When do we translate, and how many times? Question development, pilot testing, transcription, and translation, (3) Who? The role of the translator/interpreter during the research process, (4) Who again? Translator/interpreter credentials, (5) What are you really saying? Dynamic equivalence, (6) Do your *ears* deceive you? Reflexive reflective reflexivity, and (7) Triality, not just Duality, of the role of the Researcher(93).

time (9am-12:30pm). Moreover, due to the Omicron surge in the winter of 2021-2022, we ceased recruitment and interviewing for a full four weeks. We also had two participants drop out due to COVID-19. Regarding technology, we contended with major supply chain issues that affected the availability of disposable cameras for participants. Originally, we had planned to use only one type of disposable camera for consistency in image quality. However, due to supply chain issues, that became impossible. We worked with DLJ (student and Photojournalist), who went directly to the suppliers, to no avail. Hence, we amended the original IRB proposal to include multiple types of cameras, including a range of instant-print polaroid-like cameras. The impact of COVID-19 on the supply chain, from the availability of disposable cameras, to delay in film development, drastically increased the cost of the study. Our hope is that future studies can learn from the challenges we faced conducting in-person research during a pandemic.

Data Analysis

We (MMH & NMV) conducted data analysis in the languages of the participants (Russian or Spanish). A third trained student researcher (KB) provided a third set of validation and verification of findings. Data analysis was also multi-faceted as a form of triangulation (95), meaning, we used interview data (both the participants stories and their direct answers to interview guide questions), photo data, and OAHM provided additional theoretical triangulation. Data analysis was an iterative process of listening and re-listening to interviews, assessing the within-interview and between-interview themes (85,86), understanding the stories and overall metastory (85,86), photo organization to promote concision, coherence, generativity, significance, and evocation (96), and keeping an audit trail as well as working with community advisors, peer reviewers, and participants to assess and refine the findings (97,98). Finally, we used Stata version 17 to calculate the descriptive statistics.

Results

The results are described here and in tables 2-5 with corresponding explication of the metastory. The story is centered in three key pieces (1) "Whom can I trust, if not my son" Whom do participants trust to get information, (2) "You're already old, you're already sick" When and why did participants seek out medical care, and (3) "You Die or You Get Better" Difficulties with the Healthcare System. Each aspect of the results is designed to lead into the other. For example, whom participants trusted to obtain information affected their ideas of when health care should be sought, and when they sought health care and their expectations with health care impacted their experiences with the system. Markedly, while we worked with two groups (older adult Russian and Spanish-speakers), in the results we do not differentiate by group. This is because regarding themes around healthcare systems and experiences accessing health care, the stories were nearly identical. This is particularly compelling given the differing levels of education between groups (see table two). For only two individuals did education seem to impact their health care expectations. These two individuals (both Russian-speakers) had a PhD and were PhD (ABD). Hence, given the nearly identical experiences, the results are not disaggregated by group.

Table Two. Demographic Results
N – Number of participants
(%) - Percentage
M **-** Mean

	Spanish-Speakers 15(65%)	Russian Speakers 8(35%)
Ethnicity	Mexican 5(33%) Puerto Rican 8(53%) Colombian 1(7%) El Salvadorean 1(7%)	Russian 5(62.5%) Ukrainian 1(12.5%) Azerbaijani 1(12.5%) Jewish 1(12.5%)
Age	60-69 5(33%) 70-79 5(33%) 80-89 4(27%) 90-99 1(7%)	60-69 1(12.5%) 70-79 3(37.5%) 80-89 3(37.5%) 90-99 1(12.5%)
Gender	Female 15(100%)	Female 8(100%)

Education	Less than primary school 8(53%) Some secondary school 2(13%) Completion of secondary school 4(27%) Post-secondary* 1(7%)	Post-secondary 7(87.5) PhD 1(12.5)
Mini-Cog Score	*4.23***	*4.75*
Number of Photos taken	*9.87*	*11.87*
Number of Years in Wisconsin	*26*	*19*
Number of languages spoken	*1.5*	*2.6*
*Post-secondary refers to technical college, a bachelor's degree or a master's degree. **A Mini-Cog score of 3 or more was the threshold for inclusion. No one had less than a Mini-cog score of 3 and 5 was the maximum score.		

"Whom can I trust, if not my son?" From whom do participants trust to get information.

Participants primarily relied on their social networks to get information about how certain things are done, or to answer questions specific to their health. These networks included who they asked about how to make a doctor's appointment and who they asked to find out more information about COVID-19?

There was a slight difference between participants who had family in the area, versus those who did not. For participants whose family still primarily lived in their countries of origin, they more heavily relied on social service organizations and friends. While participants who had family in the area relied more on them for information, explicitly saying that they trusted in their English Language Proficiency. Even for participants who said they primarily trusted their medical providers for health information, they still relied on their children to translate and work with the provider, and trusted their provider if their children trusted the provider. However,

participants did not necessarily blindly trust their children. For example, participant 3 trusted her son, not because he spoke fluent English but because he was a medical doctor.

The two photos below, taken by participants 19 and 4, show people important to them, people whom they trust, in general and to obtain information. The photo on the left is of a staff member at a senior center and on the right is a photo of participant 4 and her granddaughter. The selected quotes demonstrate the story regarding trust and information among participants. In essence, participants trust their children, but not solely due to their relationship or English Language Proficiency, but also due to their medical credentials. Outside of their children, participants trusted staff at social service organizations. Some participants emphasized that they trusted the staff at social service organizations more than their own children. Lastly, participants trusted medical professionals themselves.

Table Three. ***"Whom can I trust, if not my son" From whom do participants trust to get information.***

Participant 19 took this photo of senior center staff. Participant 4 selected this photo of family.

"(I trust) Only my son…Yes, he knows English well, thank God (laughed)…Whom can I trust, if not my son…He is the closest person, whom I trust." - Participant 1 (81 years old)
"He (my son) is a doctor…I have no one else I trust here." - Participant 3 (80 years old)

"It's really good here (at the senior center)…If I need help, I ask (the staff here)." - Participant 16 (76 years old)
"(I trust) The doctor, I have been with him for many years …He only speaks a little Spanish, but he calls on me at home…If I need medication, my son talks to him, my son speaks English, and my son translates." – Participant 7 (73 years old)

"You're already old, you're already sick" When and why did participants seek out medical care

Participants recognized their age and its impact on their increased need for medical services. Participants also saw not only their primary care physician but also various specialists as they were able. Many participants said that they tried to see their doctor as needed (when they were sick) every three to six months; however, as detailed in part three of the results, this was not always possible.

Regarding when and why participants sought out medical care, participants primarily said that they sought care, *when they were sick*. They also recognized that due to their age, they may need more specialized care. Yet, the main sentiment explained was that they sought out *curative care*, meaning, participants accessed care expecting to be cured by the medical professional, or if not cured, sustained through medical care. There was only one participant who said that they did not like going to the doctor and went once a year. However, as detailed in part three of the results, part of her reticence to see a medical professional was due to negative experiences with the US healthcare system. There were two negative cases (participant 1 and 24), who described the importance of preventative health care.

In essence, participants sought out curative health care as needed or recommended by their provider when they *trusted* their provider and expected that care to be curative or maintain their quality of life. Participant 12 (98 years old) took a picture of masks to conceptualize health and the pandemic. She described the pandemic as increasing the need for health care services, but also called the masks a "curiosity (laughed)…For two years." (*curiosidad (laughed)…Por dos años*), underscoring an emphasis on *treatment* rather than *prevention*. The quotes illuminate the story of when and why participants sought out medical care.

Table four. ***"You're already old, you're already sick" When and why did participants seek out medical care***

Participant 12.

"I like my doctor…(I trust in him) Because he has cured me…He gives me medication for 15 minutes, and I feel okay. That's why I like my doctor…He cures me." - Participant 16 (76 years old)

"Regarding my challenges, I am very weak…My son already tells me 'mami prepare yourself, you're already old, you're already sick.' And I know that, but don't tell me that…I have like five specialists, who all help my control (my ailments)." – Participant 5 (72 years old)
"I call on the doctor when I get sick. (I go to the doctor) When it is necessary. In general, the doctor schedules a follow-up appointment three months later. The decent doctors will tell you to come in when you need to, those are also the doctors who are not overloaded with patients. My endocrinologist, I felt that he wasn't overloaded (with patients)." – Participant 2 (75 years old)

"You Die or You Get Better" Difficulties with the Healthcare System

In her quote, "you die or you get better" participant 5 was referring specifically to the long wait times to make an appointment. However, the story begins before the long wait time to have an appointment. The issues begin with making an appointment. Participants needed to wait for an adult child to call to make the appointment, or they needed to wait for an interpretation service, such as a telephone interpreter or social worker to aid in the phone call. Once they were able to make the call, they contended with long wait times for an available appointment, which ranged from weeks to months, often for crucial specialists such as pulmonary specialists or cardiologists. Then, once they finally had the appointment, interpreters were not always called for the appointment.

If interpreters were called for the appointment, some participants were very happy with them, but others felt that the interpreters were not accurately or fully interpreting what they were saying. While only one of the participants in this study spoke fluent English, participants had been in the United States, specifically Wisconsin, for an average of 20 years, and thus while they

could not speak fluent English, they could understand a fair amount. Participants therefore perceived that they understood enough English to understand that the interpreters were not interpreting what they said. Some participants expressed that the interpreters seemed to have a dominant language that they were more comfortable with, and others expressed that, interpreters who spoke both languages fluently lacked sufficient medical terminology to do the interpretation.

Moreover, participants noted issues with providers themselves in providing the care they needed. For example, one participant noted that she needed a procedure for her pregnancy; however, the physician refused to perform the procedure and she changed physicians as a result. It was unclear where communication disintegrated between the participant and her physician, but the end result was a change in physician shortly before giving birth.

Finally, there was the wait time to receive results, and hence referrals based on those results. Some participants described waiting months to receive incredibly important results (such as finding out whether they had a heart attack). The wait times throughout the process created a sense of frustration and helplessness, which is best described by participant 5, saying "you die or you get better." In essence, it takes so long to get an appointment that by the time you have the appointment, you are already either dead or better. This sentiment was expressed by both Russian and Spanish-speaking participants.

Notably, there were several negative cases, meaning, there were several instances in which participants were extremely happy with their experiences with the healthcare system. These instances were specific and existed when the following combination of factors was present: (1) Providers who either spoke the language of participants, or if they did not speak the language, had a high level of cultural competency. (2) Health care centers were spatially located

in the community with *many* bilingual staff and a high degree of cultural competence *engrained* in the health care center. Finally (3) ease of making the appointment. If participants could call, speak to staff who spoke the same language as them, and have the appointment within a week or two, they were extremely happy.

Participant 23 took the following photo at her local health center in the dialysis treatment area. Participants had many comorbidities, thus being able to reliably access the healthcare system is of vital importance. The photo also reflects an understanding of the increased complications associated with age.

Table five. ***"You Die or You Get Better" Difficulties with the Healthcare System***

Photo taken by Participant 23 at a medical center.

"You die or you get better…I die or I get better, that's it…When you're waiting for such a long time (for an appointment), a week, three weeks, a month, *then what happens?*...(to meet with the lung specialist) I spent four months waiting…And with my situation (health concerns) I couldn't do that." – Participant 5 (72 years old)
"When you go to the doctor, and with the translator, I realized that the translator, they don't always understand what they're translating, and they translate badly and not (what I

said)…Several times, I noticed that I don't know exactly how they've translated, do you understand? Then, there have been several instances when I was at the doctors, when I then understood, based on the phrases she used, that she (the translator) was not completely translating to the doctor what I had wanted to say. It could be that she didn't know English well enough, or that she's didn't know medical terms very well." - Participant 1 (81 years old)
"I looked for another doctor, because the doctor that I had, he worked in a catholic hospital, and before they were not permitted to do certain things*…So, then I changed doctors (because the other doctor couldn't perform the surgery needed)." - Participant 22 (85 years old)
"Occasionally it is a problem, because they (health care staff) don't quickly tell you the results (of your medical tests). For example, I have been waiting on the results of an EKG for almost two months, and tomorrow I will have a stress test…It could be that I had a heart attack, it could be, it could be, and they don't know….But, but *it's been two months* (emphasized). Because sometimes, I can't understand why (it takes so long), and *it was me* (emphasized), who asked to have the EKG (that would show a potential heart attack), because my husband died (of a heart attack). *I asked for it (the EKG).* And if I had not asked for it, I wouldn't know, if I had a heart attack." – Participant 24 (68 years old)
*It is important to note that participant 22 is NOT meaning abortion. She is talking about a different life-saving procedure that she required.

Discussion

The discussion is organized into two sections: Implications situated within OAHM, and implications regarding health communication.

The results and OAHM

Intercultural contact with health care and the healthcare system was stressful for participants. This intercultural contact included strained direct communication with providers, but also difficulties accessing the system at all due to barriers in making the appointment, long wait times to have the appointment, and long wait times to receive the results. The strained intercultural contact also necessitated more adaptation on the part of participants, which impacted their overall health by elevating their stress levels. In essence, the difficult intercultural contact between participants and the healthcare system acted as a barrier to them being able to access services and resources accordingly. Barriers to accessing services, specifically health care, negatively affects the health of older adult immigrants (12,99–102).

Conversely, trust in the provider and treatment (12,103–107), and culturally sensitive and competent care (12,104,108–110), are pivotal for facilitating health among older adult immigrants in the US. For the few participants (the negative cases from section three of the results) who had consistently good experiences with the healthcare system and their providers, the providers and medical center was culturally sensitive, competent, and participants *trusted* the facilities. Sixteenth Street Community Health Centers(111) located in Southeastern Wisconsin, is an excellent example, and a specific example given by participants, of a health care center(s) that takes a holistic approach to health and was loved by participants. What was unique about Sixteenth Street was that: Providers spoke the language of participants, or if they did not speak the language, had a high level of cultural competency, the health centers were located in the community with *many* bilingual staff and a high degree of cultural competence *engrained* in the health care center, and participants were able to easily make an appointment. Provider preparation, specifically on cultural sensitivity and competency, has facilitated improved results

among patients (105). Hence, future studies should not only examine those receiving health services but also those providing services. Moreover, training for those providing services (nurses, physicians, public health educators, social workers) should include topics such as cultural humility, cultural safety, and cultural competency (112–115).

Regarding where participants obtained information, the barriers to accessing services and resources in the healthcare system was a likely reason that participants described receiving most information about how things are done in the US from their social support networks. These networks primarily included a reliance on children, to make health care appointments, accompany them during appointments, or to explain how to do things in the US. This change in role, from caretaker to dependent can be a source of stress (59,116,117). For participants without children in the area, social support networks where participants obtained information also included friends and staff through senior centers and social service agencies. Social support networks made health care accessible (i.e. family members interpreting, culturally competent social workers), thereby removing some of the barriers to health care. However, the barrier was only removed to make health care *not completely inaccessible*. Participants still experienced significant stress and distress around accessing health care.

The findings also reflect that aging is a process that becomes more complicated (12). The need for more frequent care and appointments with more specialists was expressed by participants. Aging as a process and increases in health care support required clashed with the intercultural contact barriers participants faced when trying to access health care. Availability and accessibility care is a main driver of older adult immigrant health (99,105,108,118–122), either as a facilitator or barrier. Participants knew they were older and knew they needed more care but were frustrated when the care they needed was semi-accessible due to barriers making the

appointment, long wait times to have the appointment, and long wait times to get the results of important tests.

Long-wait times and communication issues with providers have also led to a trend amongst Latinx immigrants of seeking out traditional healers or herbal medicine (123). As participant five noted succinctly, accessing the health care she needed took so long but the time she got it she was either 'dead or better.' These wait times are indicative of a system-level issue. Wait times for health care in the US are long (124), and differ between primary care, specialist care, and emergency care (124). Waiting times impede access to health care and are also indicative that the healthcare system is under strain (125). Hence future studies, and policies, should target the strains on the healthcare system, which has only been severely worsened by COVID-19 (126).

The results and Health Communication

A key stressor regarding the intercultural contact between participants and the health care system was the expectation of medical care as *curative*. Regarding the expectation of medicine as curative, this is reflected in the literature. Arioan et al.(59) explains that cultural practices, carried over from migrants from the FSU, contribute to the high usage of health and social services and perceptions of medicine in the US as curative. At the same time, there is an *underutilization* of preventative services among those from the FSU (104). Moreover, self-administration of herbal medicine is common amongst both Russian and Spanish-speaking immigrants (104,127,128), which can lead to unintended medication interactions or side effects (12,104). These ideas of US-medicine as curative and the use of herbal medicine underscore the need for vastly improved health communication.

Health communication includes verbal communication, written communication, electronic communication, and pictographic communication (128). This can include, but is not limited to, articles, brochures, billboards, meetings, and social media campaigns (129). Written health materials that are culturally relevant and tailored, are effective at promoting health among older adult immigrants (12,116,130–134). Additionally, health education, provided verbally through formats such as health care meeting, or via members of one's social network (family, social workers), also promotes health among older adult immigrants (12,101,135,136). A key point of both translated written materials and verbal health communication is that it needs to be culturally appropriate for the population, which includes translation or interpretation in the language and culturally relevant examples. To provide culturally appropriate material and care, health professionals need to be trained on these topics.

Presently only 10 states mandate CLAS training (137). CLAS, or the National Standards for Culturally and Linguistically Appropriate Services, part of the US Department of Health and Human Services (138), "are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations"(139). Universal adoption of CLAS standards would be an important step towards improving care for cultural and linguistic minorities nationwide. Improved training could aid in *clarifying health care expectations*; for example, communicating the importance of preventative health care, or the importance of disclosing herbal medicine. Greater competency amongst health professionals, such as public health and medical professionals, may also help reduce some of the burden on immigrant's children, and facilitate greater trust in the healthcare system.

Finally, improved health communication, through national prevention campaigns, or interpersonal relationships (where most of our participants obtained their health information),

would facilitate improved health among older adult immigrants, reduced stress among providers, and would aid in alleviating the present condition (culturally incompetent campaigns and health advice) driving health inequalities among older adult immigrants.

Conclusion

Promoting health equity among older adult immigrants, a large and growing population, is vital for reducing the conditions driving poor health outcomes. In our study, we examined the experiences of 23 older adult Russian and Spanish-speaking female immigrants in Southeastern, Wisconsin. Using a Community Engaged and Participatory Approach, through this Qualitative – Narrative Inquiry – Photovoice project, we learned who participants trusted, where they obtained the majority of their health information, and why they generally had poor experiences with the US healthcare system. These findings have implications for public health and health care professionals. We recommend nationwide adoption of CLAS standards and strategies to improve health communication through improved training on cultural humility and competency. This study also has implications for conducting research during COVID-19, and in the midst of Vladimir Putin's invasion of Ukraine.

Declarations

- The study was approved by the University of Wisconsin-Milwaukee Institutional Review Board.
- We had obtained consent for publication
- Data and materials are confidential and not publicly available.
- We have no competing interests to declare.
- This study was funded by the University of Wisconsin – Milwaukee Chancellor's Graduate Student Award.

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CONCLUSION

First, to my reader, thank you for reading this far! Second, I will now briefly and concisely summarize how the results are connected to the specific aims and research questions.

Older adult Russian and Spanish-speaking immigrants in Southeastern, Wisconsin, contend with unique circumstances and challenges that impact their health in nuanced ways. Using complementary frameworks, a Community-Engaged Participatory approach, and the Older Adult Immigrant Adapted Model for Health Promotion, this descriptive qualitative study explored their lived realities and emphasized their perspectives through words, photos, and a robust translation process. This project also elicited clear explication of the specific aims and research questions. As a reminder, this project had the following specific aims and research questions:

Specific Aims

1. Gain a better understanding of the experiences (examples from one's life) in relation to health of Russian-speaking and Spanish-speaking older adult immigrants through a Community-Engaged and Photovoice approach.
2. Assess the health and wellbeing needs and views of Russian-speaking and Spanish-speaking immigrants through Narrative Inquiry, emphasizing storytelling in interviews when discussing the photos.
3. Gain a better understanding of the factors impacting the health and wellbeing of Russian-speaking and Spanish-speaking immigrants through the application of Older Adult Immigrant Adapted Model for Health Promotion.

Research Questions:

(1) What are the lived experiences in relation to health and wellbeing of older adult Russian and Spanish-speaking immigrants in Southeastern, WI? And, (2) how do those lived experiences influence health outcomes? To explore these overarching questions, we had additional questions:

e. What stories are important to older adult Spanish and Russian-speaking immigrants?
f. What do these older adult immigrants view as the advantages and disadvantages of living in Southeastern Wisconsin in relation to health?
g. Where do these older adult immigrants get most of their health-related information regarding how things are done? (ex: scheduling a doctor's appointment)
h. Who do these older adult immigrants trust to get most of their information from?

In this project, participants talked specifically about how the built environment – specifically in Southeastern Wisconsin - and social support positively affected their physical and mental health. Participants described that not only did social support in their daily lives positively impact their mental health, but maintaining ties to their families and cultures of origin was also important. Conversely, instances of discrimination negatively impacted their physical and mental health.

Moreover, given the older ages of participants, they had complex health needs that only increased with age. Hence, participants needed robust health care but it was semi-inaccessible due to several factors: (1) difficulty making an appointment, (2) issues with interpreters, (3) long wait times for an appointment, and (4) long wait times for results. Thus, while social support and the built environment positively impacted the physical and mental health of participants, actual

interactions with the health care environment and healthcare system negatively impacted their health and wellbeing.

However, it was not only that the healthcare system was semi-inaccessible, but that differing expectations of health care caused tension between participants and health care staff. For example, 21 of 23 participants had the expectation of health care as curative, or at the very least to maintain their livelihoods. Furthermore, most participants did not trust health care staff, such as doctors, to provide information. Rather, for questions of health, and also general questions of daily function, participants primarily trusted their children and staff at social service organizations. While participants also trusted their peers for information, it was never explicitly stated that participants trusted their peers for information related to their health, which could be due to personal sensitivity around health issues.

The findings from this project have implications for public health, health care, and social work practice, such as the potential importance of implementing CLAS standards at a national level. The findings also support their importance of the built environment on health, as well as other SDOH, such as the social and community context. Moreover, these findings have methodological implications for future cross-language research, and Photovoice and Narrative Inquiry research with older adults.

Recommendations

For future research

There is a dearth of research with older adult immigrants in the US. This dearth of literature means that there are insufficient recommendations for working with older adult immigrants. Furthermore, my research highlights some of the challenges working with older

adult immigrants, particularly regarding the role of institutional mistrust on research participation. Hence, I have several recommendations for future research.

First, I recommend research to further articulate the origins of institutional mistrust among older adult Russian and Spanish-speaking immigrants. While I am able to theorize, drawing extensively on the sociohistorical context, why this institutional mistrust exists, further research addressing this mistrust specifically could illuminate the specific pathways of this mistrust. For example, many older adult Russian-speaking immigrants are also holocaust survivors who were quite literally "experimented on".[1] Fears of being "experimented on"[2] impact Latinx peoples participation in research. In fact, a grounded theory[3–5] approach may be particularly advantageous, as it would aid in developing specific theory regarding reticence in research participation among older adult Russian and Spanish-speaking immigrants.

Second, this research supports the use of non-experimental designs with older adult Russian and Spanish-speaking immigrants. The use of non-experimental designs intersects with the origins of institutional mistrust and historical trauma among older adult Russian and Spanish-speaking immigrants. Non-experimental designs, particularly those that draw on a CEnPR or CBPR approach, may facilitate community-driven research thereby synergistically increasing both research participation and a sense of ownership among participants about the research, and thus increasing the volume of research with older adult Russian and Spanish-speaking immigrants and thus appropriate recommendations.

For health policy

This research also has implications for health policy. For instance, given that most participants identified family members, friends, and staff at social service agencies, as those from

whom they trusted to receive information, adopting a program such as Village Health Teams could be advantageous. Village Health Teams, comprised of Community Health Workers, were introduced in Uganda in 2001 to provide both health education, and at time primary health care.[6] Village Health Teams (VHTs) are composed of individuals from the communities they serve.[6] A 2019 study in Uganda revealed that VHTs, "leveraged existing community structures to educate clients in familiar settings".[6] While VHTs face challenges regarding pressure to share personal resources and role confusion,[6,7] overall VHTs have been successful in reducing barriers to health service access and also improving health outcomes among community members.[6]

VHTs would be advantageous in supporting the health of older adult immigrants because they operate within existing social support systems. As the older adult Russian and Spanish-speaking immigrants in this study primarily trusted those within their social support networks, creating VHTs may help reduce barriers to health care access, clarify healthcare expectations, provide accurate health information, and thus improve health outcomes. Hence, health policy ought to support the creation of VHTs and implementation, monitoring, and evaluation should measure the success of the program.

For health literacy

According to the Centers for Disease Control and Prevention (CDC), there is personal health literacy and organizational health literacy. Personal health literacy is defined as, "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."[8] Key to this definition of health literacy is being able to *use* or *act on* information, and make decisions that are "well-informed"[8] not simply informed. Health literacy challenges were present among participants in this study, which impacted their ability to make informed decisions.

Health literacy challenges were exacerbated by health care providers who lacked the cultural and linguistic understanding to understand that misunderstanding for taking place. For example, one participant said, "I like my doctor…(I trust him) Because he has cured me…He gave me medication for 15 minutes, and I feel okay. That's why I like my doctor…He cures me." (Participant 15). Participant 15 was referring to her asthma, a chronic incurable condition.[9] The communication was worsened because her doctor, who she really liked, did not call interpreters during her visits. While the participant assured me that the lack of interpreter was not a problem, that was clearly not the case as the participant did not understand that she was not cured of a chronic condition.

Furthermore, health literacy challenges were present in the conception of health care as *curative* rather than preventative. The expectation informed health care actions, such as when to seek care, which was often after a problem had become apparent. Lack of preventative healthcare engagement is common not only in the participants in this study, but among older adult immigrants from the FSU across the US, Germany, and Isreal.[10] While health literacy screening tools in primary care settings could be beneficial for identifying literacy challenges,[11] this does not include those who, "don't make it to the clinic door".[11] Therefore, as mentioned in the health policy section, VHTs, drawing on existing social support networks, could be advantageous in addressing health literacy challenges. For instance, a primary function of VHTs is to provide health education. This health education from the VHTs could address health literacy concerns and at the very least help get patients to the clinic door.

For culturally specific considerations - Religion

Older adult Spanish and Russian-speaking immigrants are two distinct groups. Yet, the results presented in this dissertation are not disaggregated by group. However, I do not want to

neglect culturally specific considerations. One of the sub-themes that emerged from the interviews – but only among Spanish-speakers – was the theme of religion, and the importance of religion in their lives. Participants described that religion brought them comfort and daily prayer served as a coping skill with daily stressors. Cobb et al.[12] found that religion, specifically prayer and meditation, were a common coping practice among undocumented Hispanic immigrants. Yet, interestingly they found a *positive* relationship between problem focused coping (prayer and meditation) and depression.[12] While the literature on religion and religious practices among Spanish-speaking (Hispanic) immigrants as related to health, well-being, and coping, is relatively sparse, it warrants consideration in future studies.

Conversely, even among older adult Russian-speaking immigrants who were religious (emigrants from the FSU cite religious discrimination are a major impetus for leaving[13]), participants did not discuss religion in the interviews. It was unclear whether this was because religion was not important in their lives, or because trepidation from the religiously-punitive Soviet structure persisted. Regardless, improved understanding of the role of importance of religion on the health of older adult Russian and Spanish-speaking immigrants in necessary.

…

Finally, I hope you enjoyed this dissertation, and that you were relieved to read that I did in fact keep the conclusion brief and concise. Hence, I would like to end on one of my favorite Chinese expressions, which roughly translates to *if you start something, finish it*, or *give up, or see it through to the end*.

一不做，二不休

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APPENDICES

Appendix A: Mini-Cog Translation into Russian

Инструкции по администрированию и ранжированию

Тест на когнитивные нарушения

Первый этап: запомните три слова

Выберите одно из списков слов

Скажите тестируемому “Слушайте внимательно. Я произнесу три слова. Повторите их эти слова и запомните.” Если человек не может повторить слова после трех попыток, перейдите к этапу №2 (см. рисунок).

Списки слов были использованы в одном или нескольких клинических исследованиях. Для многократного тестирования рекомендуется использовать разные списки слов.

Список 1	**Список 2**	**Список 3**	**Список 4**	**Список 5**	**Список 6**
Банан	Лидер	Деревня	Река	Офицер	Дочь
Рассвет	Сезон	Кухня	Страна	Сад	Ра*й*
Стул	Стол	Ребенок	Палец	Картина	Гора

Второй этап: *нарисуй***те часы**

Скажите "Нарисуйте часы. Сначала напишите цифры на циферблате. А потом нарисуйте стрелки часов на десять минут двенадцатого.”

Используйте распечатку. По необходимости повторите инструкции. Перейдите к третьему этапу, если тестируемый не закончил рисунок за три минуты.

Третий этап: вспомните три слова

Попросите тестируемого вспомнить три слова, которые Вы сказали ему на этапе №1. Скажите "Какие три слова я просил Вас запомнить?"

Укажите номер списка и запишите ответы тестируемого ниже:

Word List Version: _____ Person’s Answers: _____ ____

Appendix B: Interview Guide

Questions:

1. What is this picture? |
2. Tell me about this photo. |
3. Why did you take this photo? |
4. Why was this image important to you? |
5. Can you tell me if this photo was about a specific event? If so, can you tell me more about it? |
6. Tell me about what you like about this photo. |
7. Tell me about what you like about Milwaukee/Wisconsin. |
8. Why did you move here? |
9. When did you move here?
10. How did you feel about moving here?
11. What do you like most about living here? |
12. What are the greatest difficulties you face living here? | In relation to your health?
13. What services do you seek out for your health?
14. How did you find those services?
15. Where do you get most health information about how things are done? (i.e. making a doctor's appointment) |
16. Who do you trust to get information from? |
17. Why do you trust them? |
18. Who do you talk to when you have a question? Do you have friends or family who live in Milwaukee/Wisconsin? If you do, can they help you with your questions? |

19. Do you ever have trouble making a doctor's appointment when you need one? |
20. When do you make a doctor's appointment? |
21. Do you like the neighborhood you live in?
22. What do you like about it?
23. Does your neighborhood support or inhibit your health?
24. What do you think Milwaukeans/Wisconsinites should know about Russian-speaking/Spanish-speaking Milwaukeans/Wisconsinites? |

Demographic

25. How old are you? |
26. How long have you lived in Milwaukee/Wisconsin? |
27. When did you immigrate? |
28. How much education do you have? |
29. Where does your family live? |
30. How many languages to you speak? |
31. How do you identify your gender? |
32. How do you identify your race and ethnicity? |

Appendix C: Additional Background Information - Migration of Jews to Milwaukee from the Former Soviet Union Examining the Arc of Migration with an emphasis on 1970 to the Present

Citation: Hawkins, M. (2021). Migration of Jews to Milwaukee from the Former Soviet Union: Examining the Arc of Migration with an emphasis on 1970 to the Present. *Jewish Museum Milwaukee*.

Migration of Jews to Milwaukee from the Former Soviet Union

Examining the Arc of Migration with an emphasis on 1970 to the Present

Introduction

Historically, Milwaukee, Wisconsin (WI), has had a large Jewish population, particularly a large Jewish immigrant population, and Jewish people in Milwaukee are typically of German and Eastern European descent.[9] At the turn of the 20th century, Milwaukee was home to the 9th largest Jewish population in the United States (US).[10] In terms of its large Jewish immigrant population, in 1990, over 10% of Milwaukee's Jewish population was comprised of recent immigrants from the Former Soviet Union (FSU).[11] Furthermore, at the turn of the 21st century, Milwaukee was home to the 10th largest Jewish population in the US.[12] As of 2015, Milwaukee is among the top 20 cities with the largest Jewish populations in the US, at over 35,400 people,[13]

[9] Cohen, *Jews in Wisconsin*.
[10] Cohen.
[11] "Remarks and Greetings on Behalf of the Milwaukee Jewish Federation."
[12] Cohen & Wiatrak, "Jews from Former Soviet Union Share Struggles and Joys."
[13] "Berman Jewish DataBank"; "Largest Jewish Populated Metropolitan Areas in the United States."

including roughly 5,000 immigrants from the FSU.[14] Despite the size of this population and the unique historical circumstances precipitating migration, such as the fall of the Soviet Union, Jewish migration to Milwaukee from the FSU, particularly after 1970 is not well detailed.

As a public health doctoral student writing this history paper, I have been asked two questions: *why does this matter*? And, *why does this matter in public health?* Better elucidating the arc of Jewish migration from the Russian Empire and particularly the FSU to Milwaukee is of import, as it is a significant part of Milwaukee's history, and as preeminent historian Emanuel Ringelblum noted, history helps us to better understand our relationship to one another and to see ourselves in a broader narrative.[15] In regards to the relevance of history in public health, this is a population with unique health needs. Notably, 25% of immigrants from the FSU were over the age of 65 at the time of migration, [16] and older age brings about unique challenges of its own without the added stress of migration.[17] Additionally, older adult immigrants from the FSU have greater difficulty learning English than younger individuals, which is key to integration and reducing acculturative stress.[18] Furthermore, the need to understand this history in Milwaukee is important for better understanding what services were provided and how they were provided, in order to continue to provide appropriate and sensitive services for this group of immigrants today. Hence, I have no specific hypothesis for this work, rather, this is an exploration and explication of this period of history in Milwaukee.

[14] "Russians."
[15] Kassow, "POLITICS AND HISTORY:"
[16] Aroian et al., "Health and Social Service Utilization Among Elderly Immigrants from the Former Soviet Union"; Smith, "New Russian Immigrants."
[17] Aroian et al., "Health and Social Service Utilization Among Elderly Immigrants from the Former Soviet Union"; Smith, "New Russian Immigrants."
[18] Tran, Sung, and Huynh-Hohnbaum, "A Measure of English Acculturation Stress and Its Relationships with Psychological and Physical Health Status in a Sample of Elderly Russian Immigrants."

In order to explore this period of history in Milwaukee, this paper will be organized in the following manner: First, I will explain my methods, meaning, what data sources I sought out and how I sought those sources out. Second, I will examine Jewish migration to Milwaukee, focusing on the years 1840-1970. I divided up my paper into pre-1970 and post-1970 because Jewish immigration to Milwaukee took place in two major waves, the first from 1840-1920, and the second from 1970 to the late 1990s.[19] Hence, the second section of this paper will focus on 1970 to the present, emphasizing 1970-1999. Under the umbrella of focusing on the years 1970 to 1999 with added discussion on 2000 to the present, there will be four subsections. The four subsections are: (1) The policy changes that facilitated the second wave of immigration. (2) Elucidating why people immigrated. (3) Discussing why so many Jewish immigrants from the FSU ended up in Milwaukee. Finally, (4) examining the role of organizations serving immigrants from the FSU in Milwaukee. Thus, I will explicate challenges that arose and how organizations sought to alleviate these challenges for recent immigrants, what services these organizations offered, and other meaningful information about how these services developed from 1970 onward. As a final note, I will use the term "immigrants from the FSU" throughout this paper to refer to this predominately Russian-speaking Jewish group of immigrants from the FSU.

Methods

I used multiple methods of identifying sources for this paper. First, I drew upon our class readings. Second, I drew upon Google Scholar, particularly an earlier Google Scholar search I conducted using the search terms, "Jewish Migration", "Jewish Migration" AND "20th Century" AND "United States", "USSR" AND "Migrants" AND "U.S.", and "Pogroms." Third, I did multiple Google searches, in English and Russian. Fourth, I used the book, "Jews in Wisconsin"

[19] Rory Linnane, "Tracking the History of Russian-Speaking Families in Shorewood."

by Sheila Cohen, which I purchased from the Jewish Museum of Milwaukee (JMM). Fifth, I reached out to Dr. Anne Dressel of the UWM College of Nursing because I recalled that she did work with immigrants from the FSU in Milwaukee in the 1990s. She provided me with an unpublished paper with compiled interviews from two Russian-speaking female Jewish immigrants to Milwaukee. Sixth, I got access to the Jewish Museum of Milwaukee (JMM) archives. JMM had three boxes devoted to 1974 to 1999; unfortunately, I was only able to go through a box and a half before the archives were closed due to COVID-19. However, the archivist at JMM, Jay Hyland, noted that the box and a half I did go through was most relevant to my research question.

In essence, I used mainly primary sources for this paper: interviews, meeting notes, newspaper articles, museum resources, and other archival materials. This was in addition to using peer-reviewed articles, books, and well-known websites such as YIVO and HISTORY.

1840-1970

Beginning in 1840 and tapering off in the 1880s, five million Germans, including over 200,000 German Jews came to the US, and many came to Milwaukee, WI.[20] As the 1800s continued, some German Jews moved to other areas of the state such as Appleton and Madison,[21] and Jews from the Russian Empire began to arrive in Milwaukee.[22] The first large influx of Jews from the Russian Empire occurred in 1882, when 218 Russian Jewish refugees arrived in Milwaukee.[23] There were differences between the German Jews and Jews from the Russian

[20] Cohen, *Jews in Wisconsin*.
[21] Cohen.
[22] Cohen.
[23] Cohen.

Empire.[24] Most German Jews were of the Reform Judaism tradition, and Jews from the Russian Empire were predominantly Orthodox Jewish, they spoke different languages, had different cultural practices, and had immigrated for different reasons.[25] Many German Jews immigrated due to war, and Jews from the Russian Empire immigrated largely due to anti-Semitism in the 1800s.[26]

Prior to the 19th century, the situation for Jews in Eastern Europe was precarious, but still considered less bad than other places. Notably, the situation for Jews was better in the Polish-Lithuanian Commonwealth than the Russian Empire. [27] (Although there is debate as to whether the treatment of Jews in the Russian Empire was motivated by anti-Semitism or system incompetence, in all likelihood it was both.[28]) Between the 13th and 18th centuries in Eastern Europe, Jews experienced many shifts in their rights, and various atrocities. For example, Jews had been subject to blood libel accusations, both fueling and fueled by anti-Semitism.[29] In 1648, 20,000 of 40,000 Jews in several communities were murdered.[30] Regarding shifts in rights between the 13th and 18th centuries, there were shifts between gaining and then loosing rights such as owning land, trading domestically, being able to access education opportunities, and being able to live outside of cities.[31] However, the Russian Empire's expansion in the 1700s and

[24] I use the phrasing 'Jews from the Russian Empire' instead of 'Russian Jews' because Jews from the Russian empire were not one homogenous ethnic group.
[25] Cohen, *Jews in Wisconsin*.
[26] Cohen.
[27] Rosman, "CATEGORICALLY JEWISH, DISTINCTLY POLISH: THE MUSEUM OF THE HISTORY OF POLISH JEWS AND THE NEW POLISH-JEWISH METAHISTORY"; Michał Rożek and Henryk Halkowski, *The Jews in Cracow : A 700-Year History*; "YIVO | Russia: Russian Empire."
[28] "YIVO | Russia: Russian Empire."
[29] (אמצע מאות ט" ז-י" ז) "עלילות דם בפולין הישנה", וג'זניק/BLOOD LIBEL ACCUSATIONS IN OLD POLAND (MID-16th—MID-17th Centuries)"; Cohen, *Jews in Wisconsin*.
[30] Stampfer, "What Actually Happened to the Jews of Ukraine in 1648?"
[31] Cohen, *Jews in Wisconsin*; Jacek Wijaczka, "The Role and Significance of the Jews in the Economy of the Polish–Lithuanian Commonwealth: The State of Research and Research Directions"; וג'זניק, "עלילות דם בפולין הישנה (אמצע מאות ט" ז-י" ז)/BLOOD LIBEL ACCUSATIONS IN OLD POLAND (MID-16th—MID-17th Centuries)."

1800s, which included its annexation of much of the former Polish-Lithuanian Commonwealth,[32] coincided with a deteriorating situation for Jews.

In 1791, Catherine the Great of the Russian Empire created and forcibly moved Jews to the Pale of Settlement, in what is present-day Belarus, Lithuania, and Moldova, and parts of Ukraine, Poland, Latvia and Russia.[33] Then, from 1825-1855 under Czar Nicholas I, Jewish boys were kidnapped and forcibly conscripted in the Russian military at 12, although children as young as 8 were also conscripted; many died from the conditions.[34] Many of the kidnapped children were also placed in Christian homes, forbidden from speaking Yiddish, and forcibly Baptized into the Russian Orthodox Church.[35] While circumstances for Jews in the Russian Empire briefly improved under Czar Alexander II, following his assassination, Alexander III, who ruled from 1881-1894,[36] enacted the May Laws and began state-sponsored pogroms against Jews.[37] The May Laws prohibited Jews from living outside of towns, owning or leasing land and estates, and operating businesses on Sundays and Christian holidays.[38] As a result of these conditions, 2.5 million Jews left the Russian Empire between 1882-1914.[39] In total by 1920, 3.4 million Jews, most Russian, were living in the US, and Milwaukee had the 9th largest Jewish population in the country.[40]

[32] "YIVO | Russia: Russian Empire."
[33] "YIVO | Maps"; MacKinnon et al., "Improving Detection of Work-Related Asthma"; Cohen, *Jews in Wisconsin*.
[34] Ofek, "Cantonists."
[35] Ofek; Cohen, *Jews in Wisconsin*.
[36] "Alexander III | Emperor of Russia."
[37] Cohen, *Jews in Wisconsin*.
[38] "May Laws Are Instituted in Russia."
[39] "May Laws Are Instituted in Russia."
[40] Cohen, *Jews in Wisconsin*.

In Milwaukee by 1910, 15,000 people reported that they had immigrated from the Russian Empire.[41] By the 1920s over 22,000 Jewish people lived in Milwaukee.[42] The 1920s was also when Jewish Milwaukeans began moving from the west side of Milwaukee to the north-east side, specifically to Shorewood and Whitefish Bay.[43] However, immigration from many places, including the Russian Empire was greatly reduced by 1917. The Immigration Act of 1917, which added a literacy test,[44] and the Johnson Reed Immigration Act of 1924, essentially ended immigration of Jews, because under the 1924 law, quotas on immigrant groups were imposed.[45] The 1924 law, "quota provided immigration visas to two percent of the total number of people of each nationality in the United States as of the 1890 national census. It completely excluded immigrants from Asia."[46] Because the total Jewish population in the US was comparatively small, this meant very few Jews could immigrate to the US[47]

The goal of the 1924 act was discriminatory, and "was a legislative expression of… xenophobia, particularly towards eastern and southern European immigrants."[48] Yet, the quotas were based on the 1890 census, and while information was supposed to be recorded about nationality, race, and country of origin, record-keeping during that time was inconsistent and unstandardized.[49] Thus, the numbers of each ethnic group are not cut-and-dry and should be viewed within having a margin of error due to record-keeping issues at the time.

[41] "Russians."
[42] "Milwaukee Jewish Timeline | Jewish Museum Milwaukee."
[43] "Milwaukee Jewish Timeline | Jewish Museum Milwaukee."
[44] "Milestones: 1921–1936 - Office of the Historian."
[45] Cohen, *Jews in Wisconsin*; "Milestones: 1921–1936 - Office of the Historian."
[46] "Milestones: 1921–1936 - Office of the Historian."
[47] Cohen, *Jews in Wisconsin*.
[48] "The Immigration Act of 1924 | US House of Representatives."
[49] "Immigration Records."

Despite the curtailing of immigration and increased anti-Semitism in the US, particularly in the inter-war period,[50] Jewish life, and the Jewish population in Milwaukee continued to be vibrant and stayed around 20,000-25,000 for the next 60 years.[51] Jewish schools and community centers were established,[52] and a Hebrew Studies program was created at the University of Wisconsin Milwaukee (UWM) in 1961.[53] In fact, Israel's fourth prime minister and first female prime minister, Golda Meir, born in 1898 in present-day Ukraine, lived in Milwaukee from 1906-1921.[54]

The end of the first wave of Jewish migration to the US and specifically to Milwaukee is easy to identify due to the Johnson Reed Immigration Act of 1924. However, there is contestation about selecting a date for the beginning of the second large wave of Jewish migration to the US and Milwaukee in particular. Some historians argue that there are in fact three waves of Jewish migration to the US prior to WWII, or rather that the second wave of migration was in the 1930s and 1940s.[55] Although, according to other scholars who study Jewish immigration from the FSU to the US, they note the 1970s, and the Soviet *Aliyah*, as the starting point of this second wave.[56] There is even debate on this among scholars of Jewish migration to Milwaukee. Focusing specifically on Milwaukee and immigrants from the FSU, according to the JMM archives, their notes on accommodating a second wave begin in 1974 and emphasize the

[50] "The American Jewish Experience in the Twentieth Century: Antisemitism and Assimilation, The Twentieth Century, Divining America: Religion in American History, TeacherServe, National Humanities Center."
[51] "Milwaukee Jewish Timeline | Jewish Museum Milwaukee."
[52] "Milwaukee Jewish Timeline | Jewish Museum Milwaukee."
[53] Armas, "New Online Program Offers Convenient Way to Study Jewish Culture and History and Hebrew."
[54] "Golda Meir | Wisconsin Historical Society."
[55] "Jewish Immigration to America"; Glazer, "The Second Wave and the American-Jewish Community."
[56] L.arissa, "The Two Waves of Russian-Jewish Migration from the USSR/FSU to Israel"; "1970s Soviet Union Aliyah."

largest influx in the 1990s. Although, according to Cohen, the 1980s represent the beginning of the second wave to Milwaukee.[57] For this paper, I have selected 1970 as the starting point.

1970 – The Present

Policy

During the second large wave of emigration, which slowly began in the 1970s and reached its peak in the 1990s, about 1.5 million Jews left the FSU,[58] over 400,000 came to the US,[59] and more than 5,000 people immigrated to Milwaukee.[60] This second-wave of migration was due to changes in US immigration policy, Soviet *Aliyah*,[61] and continued anti-Semitism in the FSU prompting individuals to apply to leave.[62]

Notably, in 1965 President Johnson signed the Immigration and Nationality Act, which removed the quotas based on place of origin from the Johnson Reed Immigration Act of 1924.[63] Then, the Refugee Act of 1980 was enacted.[64] This act detailed the steps for how refugees could come to the US and how the US would fulfill its obligation to the United Nations Refugee Protocol.[65] Finally, the Immigration Act of 1990 created, "Temporary Protected Status (TPS) and the diversity visa program."[66] The act also increased the ceiling, or the highest number of refugees from a region or country, and it "increased the refugee ceiling from 43,000 to 50,000

[57] Cohen, *Jews in Wisconsin*.
[58] Smith, "New Russian Immigrants"; L.arissa, "The Two Waves of Russian-Jewish Migration from the USSR/FSU to Israel."
[59] Smith, "New Russian Immigrants"; Rosenberg, "Refugee Status for Soviet Jewish Immigrants to the United States."
[60] "Russians."
[61] "Aliya from the USSR."
[62] Salitan, "Domestic Pressures and the Politics of Exit."
[63] "United States Immigration and Refugee Law, 1921-1980."
[64] "United States Immigration and Refugee Law, 1921-1980."
[65] "United States Immigration and Refugee Law, 1921-1980."
[66] Yale-Loehr, "The Immigration Act of 1990."

per year for peoples from the former Soviet Union."[67] In addition to changes to US immigration policy allowing for more immigrants and refugees, the FSU also changed its emigration policies.

In 1971, the FSU removed its ban on migration to Israel, prompting *Aliyah*, the mass exodus of Jews from the FSU to Israel,[68] although many used the ability to leave for Israel, and subsequent Italy and Austria 'pipe-line' to go to the US and Canada instead.[69] Then, under Mikhail Gorbachev, who in response to domestic pressure from Jews citing discrimination, allowed more Soviet Jews to leave during 1980s.[70] As a result of multinational immigration policy changes, 1.5 million Jews from the FSU left after 1970.[71]

Reasons for Migration

Anti-Semitism continued to be a significant reason that Jews from the FSU left.[72] Anti-Semitist-based discrimination caused many problems for Jews in the FSU. Cultural, political, and economic discrimination were all cited as reasons for emigration from the FSU.[73] Family reunification was an additional significant reason for emigration.[74] While the reasons for migration among Jews from the FSU during this period are known, I think there is a need to center the voices of some of these immigrants during this period, to better elucidate their lived realities. Thus, for this section I will draw upon interviews from 1997 conducted by Dr. Anne Dressel of the UWM College of Nursing. Her paper, "In Their Own Words, The Jewish Women

[67] Ivanov and Buck, "Health Care Utilization Patterns of Russian-Speaking Immigrant Women Across Age Groups."p. 17
[68] "Aliya from the USSR"; Gitelman, "Exiting from the Soviet Union: Emigrés or Refugees?"
[69] Veksler, "Images of Transit"; Stola, "Jewish Emigration from Communist Poland."
[70] Salitan, "Domestic Pressures and the Politics of Exit."
[71] Smith, "New Russian Immigrants"; L.arissa, "The Two Waves of Russian-Jewish Migration from the USSR/FSU to Israel."
[72] Cohen, *Jews in Wisconsin*; Salitan, "Domestic Pressures and the Politics of Exit."
[73] Salitan, "Domestic Pressures and the Politics of Exit."
[74] Salitan.

of Byelorussia" has not been published and I was given permission to use quotes and materials from this paper.

In 1997, Dr. Dressel conducted in-depth interviews with two Jewish immigrant women from the FSU who had resettled in Milwaukee, WI. Both women were originally from Belarus, but this was spelled Byelorussia in her paper to be consistent with its usage during the time period of interest.[75] One of these immigrant women immigrated in 1980, who will be referred to by her initials as Y.D., and the other in 1991, who will be referred to by her initials M.G. Both women described anti-Semitism, but also resiliency and a hesitancy to leave despite concerns. Y.D. emigrated due to political reasons and discrimination, and M.G. emigrated to be closer to family. Y.D. began her interview by describing the educational and economic discrimination she faced and witnessed. She said:

> *"There were two or three brilliant Jewish men in my class, but they were not allowed to work. They were not allowed to pursue Ph.D. degrees, nor were they given any placement in research institutes. So these Jewish men ended up somewhere, in the post office, I think."*[76] *-YD*

Y.D. herself was at the top of her class in physics at Minsk University, however she was given no opportunities to continue her education or get a job relevant to her expertise. Instead, at first she was to be sent far away to teach, although she did not want to teach, then because she got married she received a "free distribution" meaning she did not have to be sent away for a job. However, even with free distribution, she and her husband, who was also Jewish, had great difficulty finding work:

[75] Anne Dressel, "In Their Own Words, The Jewish Women of Byelorussia."
[76] Anne Dressel.

"Then I had to find a place to work…For months, we drove from one plant to another. We drive and my uncle used his connections to try and find us work. Whenever we would come, prospective employers would say, 'we need people life you.' But when we would have to show our passports, which disclosed our Jewish identity, we were told, 'I'm very sorry, but things have changed."[77] *-YD*

Eventually, her husband found a job teaching at an elementary school and she found a job as a teacher's assistant for a third-grade class. Several years later, Y.D. finally found a job teaching physics, as she, her husband, daughter, brother, mother-in-law, and sister-in-law shared one apartment in Minsk.

Y.D. also noted that she never practiced Judaism in the FSU, she did not know if there were any synagogues in Belarus, and had no interest in practicing Judaism as she was "raised in Soviet times"[78], although she did learn of some Jewish holidays from her mother. It was only her passport, which said that she was Jewish. When asked by Dr. Dressel, "so what does it mean to you to be Jewish?"[79] Y.D.'s husband actually responded, saying, "Nothing! It means nothing special."[80] Y.D. did add, "I feel good to belong to such a people."[81]

Despite knowing very little about Judaism and having no interest in practicing Judaism, greater knowledge of external political events and anti-Semitism did eventually prompt her and her husband's immigration to Milwaukee. She said:

[77] Anne Dressel.
[78] Anne Dressel.
[79] Anne Dressel.
[80] Anne Dressel.
[81] Anne Dressel.

"A very major reason why we immigrated to the United States in 1980 was because my husband listened to foreign news…It became obvious to him that if we could immigrate, we should do so."[82] *-YD*

"[T]here were some circumstances which showed you that Jews are not the same. There was a fire at a radio factory in Minsk in 1978 or 1979…There was a big explosion at the factory in which hundreds of people were killed. They [party leaders] were instructed to quell rumors that Jews had caused the explosion. Jews feared a new era of pogroms would be instituted…It was 1978! And Jews still feared the pogroms… The teachers were to tell their students that this [Jews starting the fire] was not true…As she talked about this, I saw several teachers exchanging knowing glances…I was so shocked that these teachers, who would influence future generations, believed the rumors. It became obvious to me then, that we had to leave Byelorussia if it were possible."[83] *-YD*

Y.D. and her husband immigrated in 1980 and came to Milwaukee. M.G.'s story differed from Y.D. in many ways, although the arc remained the same. Unlike Y.D. who survived WWII by making it east with her mother, M.G., who immigrated in 1991, spent all of WWII in the Minsk ghetto, and was frank about the discrimination faced by Jews in the FSU. Yet, M.G. only eventually immigrated to the US to be closer to her daughter and her family. Regarding WWII and discrimination, M.G. said:

"[During WWII] Many Jews were sent to concentration camps. My second husband, Matvey, was sent to a concentration camp. Many other Jews were sent to the ghetto in

[82] Anne Dressel.
[83] Anne Dressel.

Minsk. My family was sent to a ghetto and all my aunts, uncles, and cousins died in the Minsk ghetto."[84] *-MG*

"In work, in the university, discrimination existed. The discrimination started with the government. There were many problems for Jews and a lot of questions. It was very difficult for Jews to be accepted into the university or a college."[85] *-MG*

M.G. was able to find work after she graduated from Minsk University, however her situation changed drastically after her first husband died in 1973.

"I worked in the Palace of Young Pioneers, where I taught music methods…I worked three hours every day until my husband died at the age of 36. After that, I worked full-time and a second half-time job. At that time in Byelorussia, most women worked because they needed the money. I also think that most women should work and not sit at home in the kitchen,"[86] *-MG*

Dr. Dressel noted that M.G. was laughing when she expressed her feelings about women working. Despite the challenges, M.G. and her family lived comfortably in the FSU, and she did remarry in 1978. M.G. and her family never experienced food shortages, and always had heat, water, and electricity. They owned a car, and she was proud of the traveling she had done, even taking planes to get there, such as to the Baltic Sea, Latvia, Estonia, the Crimean Sea, the Black Sea, and the Caspian Sea. In her interview, M.G. also expressed wanting to continue traveling.

Like Y.G., M.G. was relatively unfamiliar with Judaism prior to immigrating. M.G. knew no Yiddish, or any Jewish customs or holidays prior to immigrating, and learned them only after immigrating. However, unlike Y.G., M.G. did not emigrate due to anti-Semitic discrimination.

[84] Anne Dressel.
[85] Anne Dressel.
[86] Anne Dressel.

Several years prior to 1991, M.G.'s daughter and her family, a husband and two sons, left the FSU as refugees, going through the Vienna-Rome pipeline, and eventually ending up in their intended location of Canada. M.G. with her husband so that he could be closer to his child, and ended up in Milwaukee. She said:

> *"In 1991, my husband and I immigrated to the United States. Our children were here, so we came too. I think in the future, I would like to visit Israel."*[87] *– MG*

M.G. did eventually visit Israel in the mid-2000s.

Why Milwaukee?

A question that needs to be answered is: *Why Milwaukee?* This question is specifically referring to why so many Jews settled in Milwaukee, particularly during the second wave of migration after 1970. Milwaukee has one of the largest populations of Jews in the country, but it also has one of the highest *concentrations* of Jews in the country: "The largest concentrations…reside in New York, Los Angeles, Chicago, Boston, Miami, Philadelphia, San Francisco, Atlanta, Milwaukee, Madison and Kansas City."[88] However, answering *Why Milwaukee* is a difficult question to answer, and my educated supposition is that the answer is a combination of multiple factors.

The first answer is, because there was already a Jewish community in Milwaukee,[89] and both for Jewish immigrants from the Russian Empire and new Jewish immigrants from the FSU, they wanted to settle where there were already established communities both of Jews and Jews of Eastern European descent.[90] The second answer is family reunification.[91] Jewish immigrants

[87] Anne Dressel.
[88] Cohen & Wiatrak, "Jews from Former Soviet Union Share Struggles and Joys."
[89] Cohen, *Jews in Wisconsin*.
[90] Cohen.
[91] Cohen & Wiatrak, "Jews from Former Soviet Union Share Struggles and Joys."

from the FSU wanted to live where they already knew someone, even if it was just one cousin, and families already living in the US could sponsor them to come.[92]

The third answer is, Milwaukee's prominent Jewish non-profit organizations were proactive and willing to do the difficult and expensive work of resettling families in Milwaukee. Organizations, such as the Milwaukee Jewish Federation (MJF) and Jewish Family Services (JFS) also had structures in place to proactively act to accommodate the second wave of Jewish immigrants from the FSU.[93] Structures, such as a MJF's Resettlement Program, and a great deal of lessons-learned from resettling holocaust survivors immediately after WWII.[94] These organizations also planned, financially for example, for immigrants from the FSU, helping facilitate the migration process. According to a 1976 report from the MJF Resettlement Program, to accommodate 18 families for the fiscal year 1976-1977, it would cost $3,283 per family,[95] with a staggered cost based on level of self-sufficiency of the families.[96] Including the staff cost as well, the total projected funds required from 1976-1977 for resettlement was $63,900.[97] This included finding an apartment, clothes, food, utilities, medical expenses, education, and miscellaneous costs. This cost increased each year, and additional costs, such as funds towards free medical care at institutions such as the Sinai Samaritan Medical Center (from $100,000 to $200,000 in 1989[98]) were also budgeted.[99] Organizations, such as MJF, JFS, and the Sinai Samaritan Medical Center were not only proactive in estimating costs of resettling this group of

[92] Cohen & Wiatrak.
[93] "Resettlement Program."
[94] "Resettlement Program."
[95] "Resettlement Program."
[96] "Resettlement Program."
[97] "Resettlement Program."
[98] "Sinai Samaritan Medical Center Inter-Office Memorandum."
[99] "Sinai Samaritan Medical Center Inter-Office Memorandum."

immigrants, but were also proactive about applying for grants, such as Federal Block Grants,[100] and grants through various foundations, to support their resettlement mission.[101] Finally, local families, called "Anchor Families"[102] were also able to sponsor immigrants in collaboration with MJF, meaning, the sponsoring family and MJF would cost-share regarding the immigration expenses.[103] Thus, the answer to the question *Why Milwaukee*, is not straight forward, but these reasons constitute a reasonable set of explanations to this question.

Organizations

Known originally as the Hebrew Relief Society, Jewish Family Services was founded in 1867,[104] and the Milwaukee Jewish Federation was founded in 1902,[105] to serve the growing Jewish population in Milwaukee.[106] These two non-profits are the largest Jewish serving organizations in Milwaukee, however they do differ. MJF focuses on the Jewish community, emphasizing education, philanthropy, social justice, outreach, Israel/overseas work, and developing young leaders.[107] MJF also oversees other programs, such as JMM.[108] JFS is principally a social service organization and serves all of Milwaukee without emphasizing one religious or ethnic group.[109] JFS's primary services are social services, case management, mental health and counseling services, support of the Jewish community, and housing.[110] As I previously mentioned, JFS does not focus on one religious or ethnic group, however they do offer

[100] "Local Soviet Refugee Resettlement - Proposed Budget 1991-1992."
[101] "The Faye McBeath Foundation Final Report on The Medical Translator Component of the Soviet Resettlement Program."
[102] "Local Soviet Refugee Resettlement - Proposed Budget 1991-1992."
[103] "The Faye McBeath Foundation Final Report on The Medical Translator Component of the Soviet Resettlement Program."
[104] "Jewish Community | Jewish Family Services Milwaukee."
[105] "History | Milwaukee Jewish Federation."
[106] "Jewish Community | Jewish Family Services Milwaukee"; "History | Milwaukee Jewish Federation."
[107] "About MJF | Milwaukee Jewish Federation."
[108] "Jewish Museum Milwaukee."
[109] "About JFS | Jewish Family Services Milwaukee."
[110] "About JFS | Jewish Family Services Milwaukee."

specialized services for Jewish people and immigrants from the FSU.[111] They offer culturally-sensitive services for survivors of abuse, dental services for holocaust survivors, Jewish community case management, community outreach, education, and support for Jewish women, social services for Russian speakers (i.e. ESL classes, restitution for holocaust survivors, medical interpretation, assistance with SSI, disability benefits, food stamps, and other translation services), supportive housing for seniors, and SHOFAR (Safeguarding Healthy Families and Relationships).[112] MJF and JFS are two of over 75 Jewish organizations in Milwaukee.[113] For this paper, MJF and JFS are the focus as historically they have played a prominent role in the resettlement of Jews from the FSU in Milwaukee, and this is evident in my archival research. Other organizations will be discussed as they appear in the archives for this period.

1970s (1974-1979)

The JMM archives for resettlement and immigration to Milwaukee from the FSU begin in 1974. In 1974, a letter sent from the executive director of Jewish Family and Children's Service, to the Assistant Director of the Jewish Welfare Fund of the Jewish Federation, called for the Jewish Community of Milwaukee to respond to support 15-20 families being resettled from the FSU.[114] In the letter, the executive director notes, "with the current work demands, it is impossible for the present staff to devote the time needed. Refugee resettlement, as you know, is time consuming, demanding and complex. The Russian families, particularly, are having a difficult time."[115] He goes on to write there is need for increased funding and staff, $15,000 to,

[111] "Jewish Community | Jewish Family Services Milwaukee."
[112] "Jewish Community | Jewish Family Services Milwaukee."
[113] "Milwaukee Jewish Community"; "Community Organizations | Jewish Museum Milwaukee."
[114] Ralph Sherman, Executive Director, Jewish Family and Children's Service, "Letter to Mr. Norbert Fruehaf, Assistant Director, Jewish Welfare Fund, Jewish Federation."
[115] Ralph Sherman, Executive Director, Jewish Family and Children's Service.

"get started."[116] The letter precipitated a series of letters internally within MJF and between organizations, discussing how to plan for these new refugees[117].

In 1976, an internal document of the Resettlement Program of MJF detailed several important particulars of how the discussion had progressed since the initial 1974 letters. First this document explains that they expect the number of refugees from the FSU to continue to increase; and second, they note detailed planned costs of resettling families.[118] The document also revealed that from July 1975- July 1976, 44 refugees from the FSU had arrived.[119] MJF had also begun to track how many refugees began English language tutoring, participated in a UWM summer English language program (which MJF paid for), received community resources, and how many would be participating in specialized courses in the fall. The document also detailed that MJF helped with school enrollment for minors, providing books for students, as well as tools and work clothes for adults, depending on the job.[120] While the 1970s established the Milwaukee community's commitment to serving and preparing for refugees from the FSU, funding and support continued to increase in scale and complexity in the 1980s.

1980s

Support for refugee families from the FSU continued through the 1980s; however, due to the financial strain of resettlement, in the 1980s the MJF sub-committee on Soviet resettlement had a ceiling on the number of refugees they could resettle annually in Milwaukee, that number being 25 individuals.[121] During this time, MJF prioritized family reunion, and encouraged

[116] Ralph Sherman, Executive Director, Jewish Family and Children's Service.
[117] I use the terms refugee, immigrant, and newcomer, in accordance with how they appear in the documents in the JMM archives.
[118] "Resettlement Program."
[119] Rose Kulakow, "Refugee Report July 1, 1975 Thru July 28, 1976."
[120] Rose Kulakow.
[121] "Report from Sub-Comittee on Soviet Resettlement."

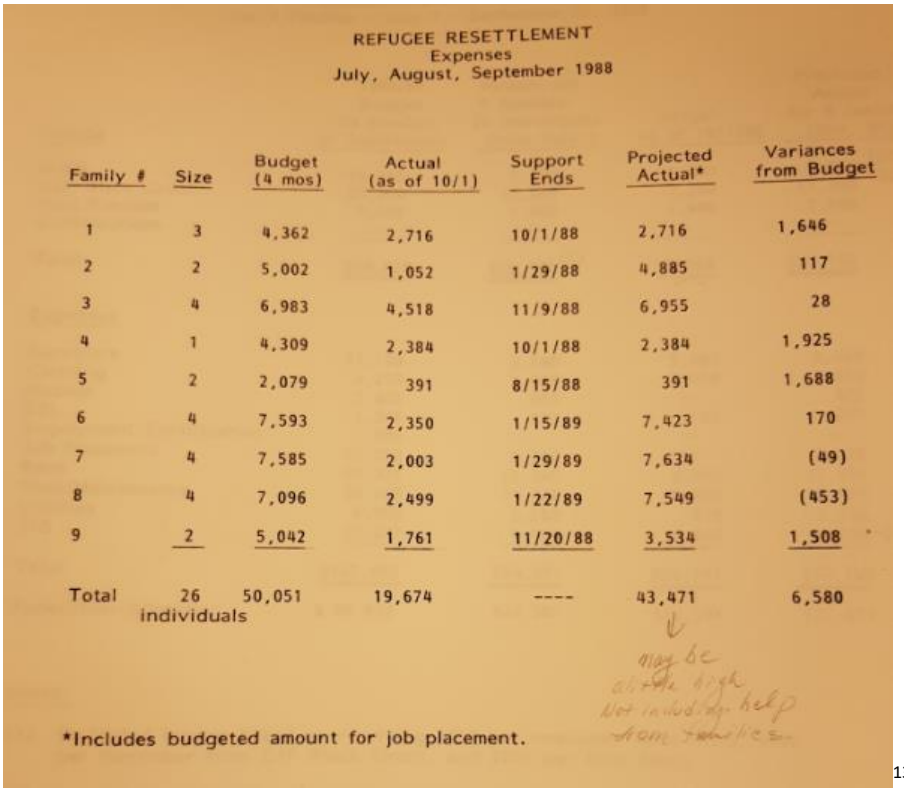
"resettlement of non-family reunions in Israel"[122] it order to relieved financial cost to the Milwaukee community. However, in 1987, while MJF still proposed a ceiling, although they note it was a flexible ceiling at 25 people per year, they did recommend the following motion: "The Federation will accept any newcomer requesting admittance to Milwaukee"[123] This recommendation, from the Sub-Committee on Soviet Resettlement noted several sociostructural changes prompting the change in recommendation: (1) "A significant Russian population have now established themselves in Milwaukee and are in a better position to help with the resettlement of newcomers. While many of these are not first degree relations, they are committed to giving the newcomers the needed support."[124] (2) The availability of funds from a Federal Block Grant for refugees, and (3) they argue that other cities were accepting non-first degree relative immigrants, and allowed any newcomer to resettle in those cities.[125] This motion was adopted.

During this time, in addition to the MJF resettlement program assisting with finding an apartment for newcomers, and providing furniture, clothing, the apartment deposit, food for the kitchen, a medical emergency grant, telephone installation, and a one-time moving allowance,[126] the federation also assigned 'primary contacts' or 'host' families (also referred to as Anchor families) that shared financial responsibility with the newcomers. 'Host' families at this time were primarily responsible for making apartment payments (listed at $350-525 per month in 1987).[127] The MJF sub-committee was also clear that they expected MJF and the host families to

[122] "Report from Sub-Comittee on Soviet Resettlement."
[123] MJF, "Report from Sub-Committee on Soviet Resettlement."
[124] MJF.
[125] "Report from Sub-Comittee on Soviet Resettlement."
[126] "Letter to Berry Chrustowski, Douglas Cohen, Elaine Appel, Igor Shvarts, Barbara Stein, and Rena Waxman, from Janet Greenbaum, Chair of the Sub-Committee on Soiet Resettlement."
[127] "Report from Sub-Comittee on Soviet Resettlement."

assume responsibility for four months before they expected the newcomer family to "begin supporting themselves."[128]

In a subsequent budget proposal for 1988, compiled by JFS, they note that the initial costs of resettlement for five families were $22,105.[129] After the initial costs, maintenance costs were listed at $49,588, making the total cost of resettlement in the first couple of months for five families $71,693 in 1988.[130] This budget includes tuition for at least two individuals to attend English language classes at UWM.[131] In a subsequent document showing refugee resettlement expenses for 1988, the actual budget is compared to the projected budget:



REFUGEE RESETTLEMENT
Expenses
July, August, September 1988

Family #	Size	Budget (4 mos)	Actual (as of 10/1)	Support Ends	Projected Actual*	Variances from Budget
1	3	4,362	2,716	10/1/88	2,716	1,646
2	2	5,002	1,052	1/29/88	4,885	117
3	4	6,983	4,518	11/9/88	6,955	28
4	1	4,309	2,384	10/1/88	2,384	1,925
5	2	2,079	391	8/15/88	391	1,688
6	4	7,593	2,350	1/15/89	7,423	170
7	4	7,585	2,003	1/29/89	7,634	(49)
8	4	7,096	2,499	1/22/89	7,549	(453)
9	2	5,042	1,761	11/20/88	3,534	1,508
Total	26 individuals	50,051	19,674	----	43,471	6,580

may be ... not including help ... families

*Includes budgeted amount for job placement.

[132]

[128] "Report from Sub-Comittee on Soviet Resettlement."
[129] "Proposed Budget for Resettlement."
[130] "Proposed Budget for Resettlement."
[131] "Proposed Budget for Resettlement."
[132] "Refugee Resettlement Expenses, July, August, September, 1988."

Interestingly, MJF and JFS also spent a significant amount of time learning, in terms of policy, budget, and number of individuals resettled, from other cities accommodating large influxes of immigrants from the FSU. The main comparative cities, according to the JMM archives, were Minneapolis, Hartford, Pittsburgh, St. Louis, Atlanta, Cincinnati, and Houston.[133] For example, in 1988, Minneapolis anticipated 101 resettlement requests, Hartford anticipated 100+, Milwaukee anticipated 80-90, Pittsburgh anticipated 50, and St. Louis anticipated 40-65.[134] Furthermore, in terms of eligibility requirements in 1987, Atlanta welcomed all newcomers and provided support for basic needs for two months, Minneapolis set a limit of 25 newcomers and provided support for up to six months, St. Louis allowed first degree relatives while noting some flexibility and provided support for three months, Cincinnati welcomed all newcomers with no ceiling on the number they would accept and provided support for four months, Pittsburgh welcomed only first degree relatives and provided support for three months, and Houston welcomed all newcomers and provided support for three months.[135] Learning from other cities informed Milwaukee's approach to eligibility requirements, and length of time to support families.

Finally, and importantly, in 1989, MJF created an overall plan called, "Passage to Freedom: Community Mobilization on Behalf of Soviet Jewry."[136] This campaign had several goals: (1) Raise $900,000 for resettlement for FSU immigrants both in Milwaukee and overseas. (2) Gain greater community support and resources for resettlement, including the mobilization of the Russian-speaking community in Milwaukee. This second goal also sought to elicit a sense of

[133] "Survey of Communities' Resettlement Policies"; "Resettlement Comparison of Other Cities."
[134] "Resettlement Comparison of Other Cities."
[135] "Survey of Communities' Resettlement Policies."
[136] "Overall Plan 'Passage to Freedom' Community Mobilization on Behalf of Soviet Jewry."

urgency in the Milwaukee community about resettlement, framing it as a humanitarian effort.[137] Finally (3) "To coordinate service delivery systems throughout [their] agencies in order to ensure the best service for the Russians in the most cost-efficient manner."[138] This campaign is important because it represents the beginning in a shift in how the established Milwaukee community and the newcomer community from the FSU engaged with each other.

In summary of the 1980s, documentation of meeting notes and budgets dominated the JMM archives. However, the "Passage to Freedom: Community Mobilization on Behalf of Soviet Jewry"[139] in 1989 represented a shift in approach and programming by FSU-serving organizations in Milwaukee. In the 1990s, as the second wave of immigration from the FSU reached its apex, while costs were still noted, much of the focus from MJF and JFS, according to the archives, shifted to programming for this group. The 1990s are also when the voices of immigrants from the FSU begin to emerge in documents from the JMM archives.

1990s

In 1990, on the precipice of the crest of the second major wave of Jewish migration from the FSU to Milwaukee, 10% of Milwaukee's Jewish population was comprised of recent immigrants from the FSU,[140] and an additional 391 immigrants from the FSU arrived in Milwaukee in 1990.[141] Letters, memos, and service plans at this time detail the increases in services planned to accommodate hundreds of immigrants from the FSU arriving annually, a significant increase from just 20-50 annually during the 1970s and 1980s. The 1989 plan for

[137] "Overall Plan 'Passage to Freedom' Community Mobilization on Behalf of Soviet Jewry."
[138] "Overall Plan 'Passage to Freedom' Community Mobilization on Behalf of Soviet Jewry."
[139] "Overall Plan 'Passage to Freedom' Community Mobilization on Behalf of Soviet Jewry."
[140] "Remarks and Greetings on Behalf of the Milwaukee Jewish Federation."
[141] "The Faye McBeath Foundation Final Report on The Medical Translator Component of the Soviet Resettlement Program."

1990 from MJF, called "Resettlement Service Plan"[142], included not only covering the costs of resettlement, but also case management with a JFS caseworker, ESL training at MATC, providing ESL tutors for older adults, a one year scholarship at Jewish day schools, and greater assistance with job placement.[143]

Moreover, at this time, to respond to the growing needs of this community, MJF created the Acculturation Committee subcommittee called the Newcomer Packet Subcommittee.[144] During the subcommittee's first meeting, members discussed the materials they thought should be included in the newcomer packet for arriving families from the FSU.[145] These materials included, a directory of Jewish communal services in Russian, a welcome letter in Russian, a map of Milwaukee, a list of discount and resale shops in Milwaukee in Russian, and finally, driving instructions and rules in Russian.[146] In a subsequent meeting, the Newcomer Packet subcommittee, renamed the Newcomer Packet Ad Hoc Committee, created 16 points of action, expanding upon the list of materials from their first meeting, and adding tasks such as translating additional materials into Russian. Some of the new materials to include in the Newcomer packet included: Bus outlets and schedules, newcomer "entitlements" (i.e. Camp Scholarships, Day School Scholarships, Synagogue Membership, and Jewish Community Center Membership[147]), library services, ESL classes, local laws about children being unattended and parking violations, Jewish community services, Jewish fact sheets, a Jewish calendar and glossary, American

[142] "Resettlement Service Plan Outline - 1989/1990."
[143] "Resettlement Service Plan Outline - 1989/1990."
[144] "Minutes: Acculturation Committee Newcomer Packet Subcommittee."
[145] "Minutes: Acculturation Committee Newcomer Packet Subcommittee."
[146] "Minutes: Acculturation Committee Newcomer Packet Subcommittee."
[147] "Minutes: Soviet Newcomer Outreach Committee Newcomer Packet Ad Hoc Committee."

practices regarding etiquette, how to use coupons, and "explain[ing] concepts of Rummage Sales and Warehouse Sales."[148]

It should also be noted that between 1989 and 1990, the Acculturation Committee of MJF changed its name to the Community Outreach Committee. This was because immigrants from the FSU expressed that they did not like the word 'acculturation.'[149] As explained in the meeting notes, "it sounds as if the community is trying to make 'cultured persons' out of those who have no culture…From this point on the Acculturation committee will be known as the Community Outreach Committee."[150] During this time, there was also interest in learning more about the wants and needs of the growing immigrant community from the FSU. A number of projects were proposed to facilitate learning from this group and the integration process. For example: a bilingual newsletter, bilingual flyers for events, focus groups to gather input, translators at major events, and a welcoming committee.[151]

The Community Outreach Committee strove to support Jewish immigrants from the FSU, writing: *"The Jewish community's ultimate mission in resettling Soviet Jews in Milwaukee is to help them lead richer Jewish lives as members of the Jewish community, reclaim their lost Jewish heritage and to fully reunite with the Jewish people. We believe the collaborative approach based on a partnership between agencies, synagogues, schools and organizations, will yield positive results."*[152]

The Committee sought to achieve their goals through several avenues, which included sensitizing not just new immigrants, but also the existing Jewish community in Milwaukee, as

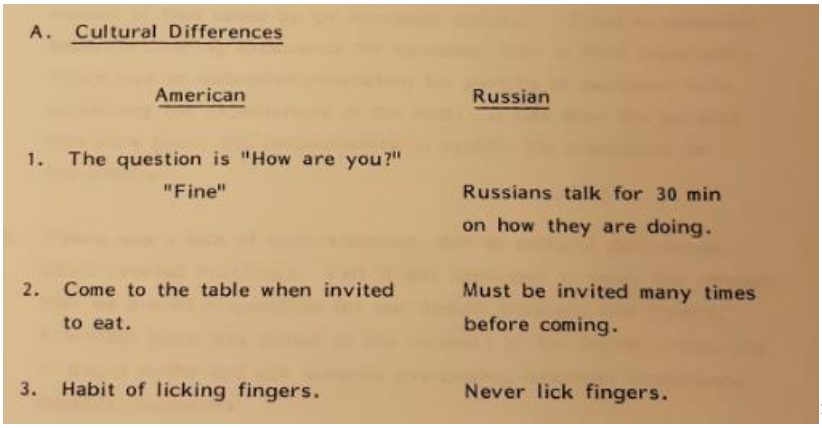
[148] "Minutes: Soviet Newcomer Outreach Committee Newcomer Packet Ad Hoc Committee."
[149] "Minutes: Community Outreach Committee: Update - Mary Zilist, Chair."
[150] "Minutes: Community Outreach Committee: Update - Mary Zilist, Chair."
[151] "Minutes: Community Outreach Committee: Update - Mary Zilist, Chair."
[152] "Mission Statement for Communtiy Outrearch Committee."

well as developing programs as needs and interests arose, and clarifying communication between groups and agencies.[153]

Thus, in 1990, 12 leaders of Milwaukee's Jewish community who served immigrants from the FSU attended a "Soviet Resettlement Workshop" in Washington, D.C., put on by the Jewish Welfare Board (later renamed the Jewish Community Centers Association of North America[154]).[155] The notes from the workshop detailed a series of question and answers to depict cultural differences between immigrants from the FSU and Americans, as well as a summary of services other US cities were providing for newcomers.[156] For example, in a workshop with Misha Galperin, he wrote that, "There is a general distrust of mental health persons [among FSU individuals], especially in a clinical setting. The mental health person should go and be a part of on-site areas where other things are going on."[157] This comment reflects the peer-reviewed literature on the subject – immigrants from the FSU tend to be wary of mental health services.[158] However, there is some debate among local service in Milwaukee providers as to whether immigrants from the FSU are wary to seek services due to the punitive nature of mental health services in the FSU,[159] linguistic challenges (the phrase in Russian for 'psychological trauma', is directly borrowed from English '*психи трамва'*), or both.

[153] "Mission Statement for Communtiy Outrearch Committee."
[154] "Collection: National Jewish Welfare Board, Records | The Center for Jewish History ArchivesSpace."
[155] "Notes from Resettlement Workshop: JWB Bi-Annual, Washington D.C."
[156] "Notes from Resettlement Workshop: JWB Bi-Annual, Washington D.C."
[157] "Soviet Resettlement Workship - Misha Galperin."
[158] Casimir et al., "Perceived Insomnia, Anxiety, and Depression among Older Russian Immigrants"; Van Son and Gileff, "Relying on What They Know."
[159] Duncan and Simmons, "Health Practices Among Russian and Ukrainian Immigrants."

Parts of the workshop touched upon the more comical side of cultural differences. For example, under the category of cultural differences, it was noted that Americans have a "Habit of licking fingers", while Russians, "Never lick fingers."[160]



A. Cultural Differences

	American	Russian
1.	The question is "How are you?" "Fine"	Russians talk for 30 min on how they are doing.
2.	Come to the table when invited to eat.	Must be invited many times before coming.
3.	Habit of licking fingers.	Never lick fingers.

[161]

Galperin also discussed the particular vulnerability of teens and their need for integration and social support. He noted, "They are in double jeopardy. They face issues of belonging, changing allegiances, 'Who am I?' They face ethnic identities, such as 'You're not Jewish, you're Russian.'…They also most often become the family spokesperson as their English is better."[162] In response, local organizations in Milwaukee, such as MJF, tried to advertise summer camps for children and young adults. In a 1990 list of "Summer Program Availability for Soviet Newcomers", there were five options: (1) Lubavitch Camp, which included Russian-speaking counselors on-site; (2) the JCC (Jewish Community Center), which had four different options, two, three, and four week camp, day camp and overnight camp, for a wide range of ages; (3) the Children's Outing Association for preteen boys and girls; (4) the Shorewood Village Recreational Program, which included ESL; and (5) Whitefish Bay Summer Playground

[160] "Notes from Resettlement Workshop: JWB Bi-Annual, Washington D.C."
[161] "Notes from Resettlement Workshop: JWB Bi-Annual, Washington D.C."
[162] "Soviet Resettlement Workship - Misha Galperin."

Recreation.[163] Religious programs to teach recent immigrants about Judaism were also very common. For example, in 1993, the Kesher program,[164] sponsored by the Milwaukee Association for Jewish Education and the JCC, not only taught Jewish teachings, but also covered topics such as, "Being Jewish in the 90s" and "Being a Jew in the USSR."[165] Kesher continued for several years and was also described in a Russian newspaper, *Зеркало*.

166

«ЗЕРКАЛО» №22(68) ноябрь '96 стр. 21

ПРИГЛАШАЕТ "КЕШЕР"

Спросите любого малыша или подростка, посещающего Программу "Кешер", что он делает в воскресное утро. Можете не сомневаться, что вы услышите конечно более интересное чем избитое "смотрю телевизор" или "сплю до полудня".

Программа "Кешер" - это прекрасная возможность для многих детей из семей недавних эмигрантов из СССР/СНГ в непринужденной обстановке познакомиться с еврейской культурой и искусством, музыкой и танцами, народным творчеством. Детям помогают расширить знания не только о жизни еврейской общины Милуоки, но и о традициях наших общин в разных уголках мира. Ну и, конечно, они научатся немного говорить на иврите. Дети с увлечением занимаются изготовлением предметов еврейского обихода и изделий с еврейской традиционной символикой.

Детей разного возраста от 4 до 16 лет доставляют автобусом на занятия, а по их окончании развозят по домам. Занятия начинаются в 9:15 и заканчиваются в 11:45, с перерывом на скромный ланч.

Вот как некоторые родители оценивают качество и значение этих занятий:

Светлана АВРУНИНА, мама десятилетней Юлии, посещающей программу в течение трех лет: "Юлия с нетерпением ждет воскресенья. Она получает большое удовольствие от занятий. Теперь у нее много друзей. Отличная программа для детей, особенно по изготовлению предметов с еврейской традиционной символикой". Каждое воскресенье Юля приносит домой какую-нибудь поделку, сделанную собственными руками и с увлечением рассказывает о том, что она узнала на занятиях."

Эдуард Бялый, папа семилетней Саши: "Программа "Кешер" особенно важна для еврейских детей из семей недавних эмигрантов. Они даже дети, порой даже не знают, что они евреи, возможность многое узнать о своем народе. На мой взгляд, эту программу должен посещать каждый ребенок."

Ирина МОСКОВИЧ, мама двенадцатилетней Лены, посещающей Кешер с самого первого занятия: "Лена получает огромное удовольствие, посещая занятия, и всегда узнает на них много нового и интересного. К тому же программа совершенствуется и обновляется ежегодно."

Программа основана пять лет тому назад и сегодня объединяет почти пятьдесят ребят. Финансируется программа несколькими спонсорами Еврейской Федерацией Милуоки, Милуокской ассоциацией еврейского образования и Еврейским общинным центром.

ЕСЛИ ВЫ РЕШИЛИ ЗАПИСАТЬ РЕБЕНКА В ПРОГРАММУ, ПОЗВОНИТЕ:

967 –8174
(Таня Арбит, по-русски)
962 –8860
(Shulamit Halpern, по-английски)
167

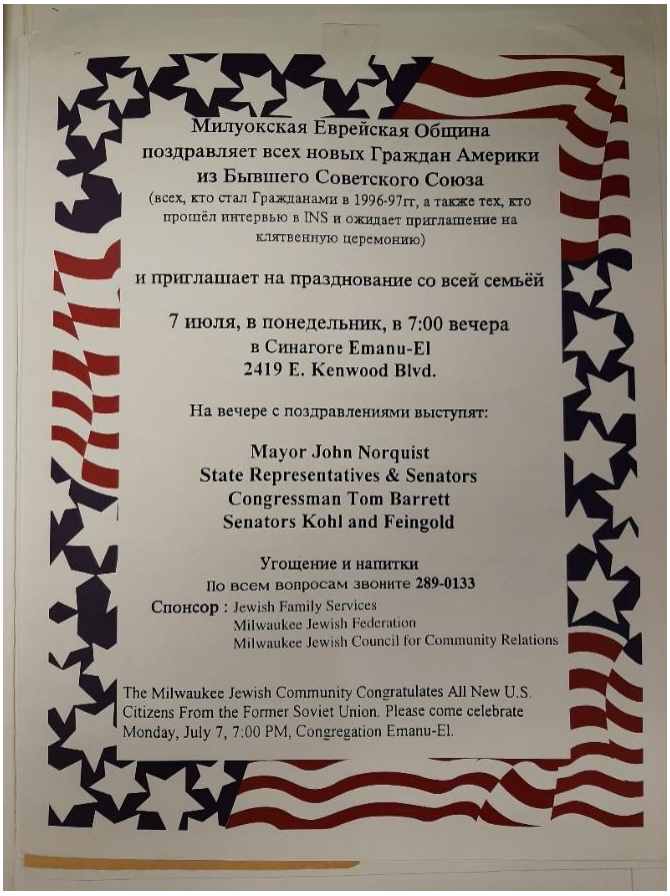
Despite this provision of specialized services, and well-attended activities such as Kesher, it was deemed insufficient by older adult immigrants from the FSU. On July 3rd, 1997, 37 residents of the Golda Meir apartment signed a letter, asking for their support not to be cut, which said:

"*We are living in the subsidize Golda Meir House. Majority of us are old and very old infirm people who can't learn foreign language in extent of speaking and understanding them fluently. Therefore, we can't visit doctors, social security and other services without translators,*

[163] "Summer Program Availability for Soviet Newcomers."
[164] "Kesher News. A Program Sponsored by the Milwaukee Association for Jewish Education and the Jewish Community Center of Milwaukee."
[165] "Kesher News. A Program Sponsored by the Milwaukee Association for Jewish Education and the Jewish Community Center of Milwaukee."
[166] *Photo: Students of Kesher*.
[167] "Приглашает Кешер."

and we can't survive without them! So, we strongly urge you not cut a quantity of the translators in the Resettlement Department. Please, help us! We hope only you!"[168]

While immigrants from the FSU began to be more vocal about their needs, the greater Milwaukee community also began to recognize the presence of this growing group. For example, MJF organized citizenship celebrations, inviting both the mayor and local representatives. The Russian-English flier below is one example of an invitation for a citizenship ceremony:



[169]

Countless groups, subgroups, committees, and subcommittees were formed at this time to support immigrants from the FSU, and some were also run-by immigrants from the FSU. The

[168] Golda Meir Residents, "Letter from Golda Meir Residents to Richard H. Meyer the Executive Vice President of the Milwaukee Jewish Federation," n.d.
[169] Milwaukee Jewish Federation, "Милуокская Еврейская Община поздравляет всех новыхй Граждан Америкии."

Milwaukee Branch of the American Association of Jews from the Former Soviet Union was supported in its inauguration in 1997 by many local organizations: The Milwaukee Jewish Council for Community Relations, JFS, MJF, and Congregation Emanu-El B'ne Jeshurun.[170] The goals of the group were to, "involve immigrants in U.S. social and political life...protect immigrants interests and rights…participate in preserving Jewish culture and traditions…[and] organize leisure activities for association members and their children."[171] According to one of the leaders of the Milwaukee Branch of the American Association of Jews from the Former Soviet Union, Edward Darglots, they "wanted to work with the Jewish federation because they're Jews and we're Jews."[172] Their inaugural meeting took place at Congregation Emanu-El B'ne Jeshurun in 1997.[173] This was an active group. In the late 1990s 30 of the 400 members of this group traveled to Washington, D.C. to advocate for immigrants after meeting with local WI representations, Tom Barrett, and representatives for Senators Russel Feingold and Herb Kohl.[174]

As noted by Cohen, German-Jewish immigrants to Milwaukee and Eastern European Jewish immigrants to Milwaukee traditionally lived in different parts of the city and were involved with different branches of Judaism, Reform versus Orthodox.[175] Thus, the support of MJF in supporting all Jewish immigrants is reflected back the immigrants also working with MJF, supporting the notion that connections of Jewish identity were more important than geographic origin or sect of Judaism practiced. This is especially interesting considering many Jewish immigrants from the FSU were unfamiliar with Judaism at the time of emigration.[176]

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[170] Paula Simon, Executive Director, "Invitation to Congressman Tom Barrett to Attend the Inaugural Meeting of the Milwaukee Branch of the American Association of Jews from the Former Soviet Union."
[171] Nadine Bonner, "Russian Newcomers Looking to Form Self-Help Association."
[172] Nadine Bonner.
[173] Nadine Bonner.
[174] Nadine Bonner.
[175] Cohen, *Jews in Wisconsin*.
[176] Anne Dressel, "In Their Own Words, The Jewish Women of Byelorussia."

In summary, the 1990s represented a time of great influx and activity among recent immigrants from the FSU, the Milwaukee community, and FSU-serving organizations such as MJF and JFS. Furthermore, the 1990s also represented a shift in engagement: the Milwaukee community was more involved with this group of immigrants, and this group of immigrants was more vocal, advocated for their needs, and organized their own organizations. Evidence of this advocacy and organization still exist, and I would argue that the FSU immigrant soul of this group continues to be evident, especially in Shorewood, WI.

2000s

By the 2000s, the large wave of Russian-speaking Jewish immigrants from the FSU had ended, although migration has not ceased from the FSU to Milwaukee.[177] During this second wave, between 1976 and 1997, over 3,582 families were resettled in Milwaukee by MJF and JFS.[178] In fact, 20% of the Russian-speaking households in Milwaukee and Ozaukee counties were in Shorewood.[179] The Russian-speaking immigrant population in Shorewood grew faster and larger than any other place in Milwaukee county.[180] By 2000, there were 101 Russian-speaking students in the Shorewood school system, compared to five in Milwaukee Public Schools and 11 in Whitefish Bay.[181] Shorewood is home to a Russian grocery store, Russian-language section at the public library, a weekly Russian-speaking social group at the library, and its older adult immigrant community from the FSU was even highlighted in the 2019 movie, *Give Me Liberty*.[182] While the JMM archives end in 1999, other sources identified Milwaukee as a popular destination for immigrants from the present day Russian Federation. When searching

[177] "About JFS | Jewish Family Services Milwaukee."
[178] Rory Linnane, "Tracking the History of Russian-Speaking Families in Shorewood."
[179] Rory Linnane.
[180] Rory Linnane.
[181] Rory Linnane.
[182] "Give Me Liberty (2019) - IMDb."

for information on immigration to Milwaukee in Russian, the most common results are websites and blogs promoting Milwaukee as one of the best cities for Russian immigrants (ex: "The Best American Cities for Immigrants in 2019" - "Лучшие города США для иммигрантов в 2019 году*"*).[183] While the pace of migration to Milwaukee has changed, there is still a great need for services from organizations such as MJF and JFS.

Some services, which were no longer needed after the large wave ended, were thus dissolved, such as MJF's Resettlement Committee and Program. However, there are still over 75 Jewish organizations in Milwaukee,[184] and JFS and MJF are still prominent organizations serving the Milwaukee community, and particularly the 5,000 immigrants from the FSU.[185] I myself have volunteered with JFS for several years teaching ESL to a group of older adult immigrants from the FSU, and see that they have many unique needs and face some isolation due to a lack of English language proficiency. During focus groups I conducted in 2019, one woman said: "There are 23 theaters in Milwaukee, and I can't go to any. I can only go to the music ones, because music is a universal language. But I want to learn English so I can go to the other theaters."[186] The sentiments from the focus groups as well as the size of this group underscore the continued need for services among this population, as well as the importance of studying this history. Immigrants from the FSU are alive and vibrant in Milwaukee at all ages, and non-immigrants from the FSU in Milwaukee should know Milwaukee's role in this narrative. Thus, I hope this paper has illuminated some of that arc of history, specifically the importance of the history of Jewish immigrants from the FSU to Milwaukee.

[183] "Лучшие города США для иммиграции"; "Лучшие Города США Для Иммигрантов в 2019 Году | Rubic.Us."
[184] "Milwaukee Jewish Community"; "Community Organizations | Jewish Museum Milwaukee."
[185] "Russians."
[186] This resident has since passed away.

As Emanuel Ringelblum said, "Let the world read and know."[187]

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[187] "'Let The World Read And Know' The Oneg Shabbat Archives | Yad Vashem."

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