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The IIH supports the production and dissemination of rigorous, non-partisan, and non-ideological research on immigration issues across a broad diversity of disciplines and perspectives, and the application of this research to local, regional, and national policy issues.

KEY FACTS

- Latina immigrant women have endured the strongest economic and health impacts of the pandemic,[1] while also fearing the possibility of their own or a loved one's deportation.
- This has severe consequences for their health and wellbeing and for how they navigate access to care.

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Latina Immigrant Women's Health and Access to Healthcare in the Heartland, before and during the Pandemic

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Introduction

We investigate the spillover effects of immigration and public health policies on Latina immigrant women's health and their access to healthcare in Kansas. Studies have shown that the fear of deportation negatively impacts undocumented immigrants' health, and the health of their family members.[2] However, geography matters a great deal. Latino immigrants in urban and rural areas experience deportability differently, have access to vastly different resources, are dissimilarly impacted by physical constraints of their respective environments, and their health needs may also differ. Within these different contexts, immigration enforcement actions, such as raids, apprehensions, detention, and deportation ripple to also affect the health of immigrants' loved ones, including U.S. citizen family members.[3] Drawing on research in urban and rural Kansas, we highlight an important matrix between legal status and geographical location. While immigration policies extend a gradation of rights and

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protections to immigrants and their families based on a variety of legal statuses which provide more or less anchoring in U.S. society, this gradation is experienced differently in small towns and in large cities. Thus, legal status in tandem with a significant expansion of immigration enforcement and policing, translates into a variety of local contexts where immigrants' health deteriorates while it also limits their access to formal health care.

Background

The Illegal Immigration Reform and the Immigrant Responsibility Act (IIRIRA) of 1996 formalized immigration enforcement *within* communities across the United States through programs such as the 287(g). Such programs, including successive versions such as Secure Communities, have permitted the involvement of local law enforcement in the apprehension of immigrants inside the country. Thus, in the past twenty-five years, local law enforcement agencies often have acted on behalf of immigration enforcement to apprehend and detain immigrants whom they suspect of being undocumented. Each administration in the past twenty-five years has amplified this architecture of enforcement.[4] Building on this legal infrastructure, President Trump's Executive Orders No. 13767 and No. 13768, which he signed in his first week in office, enhanced these collaborations and encouraged the apprehension, detention, and deportation of anyone "suspected" of violating immigration laws, regardless of actual immigration status or criminal conduct.[5] Given extant policies, anyone who is in the country without immigration status is technically violating immigration law, even if they are not engaged in criminal activities. This leaves undocumented immigrants at risk of deportation when spending time in public spaces or conducting everyday activities such as grocery shopping or driving to work. Each administration in the past twenty-five years has amplified this architecture of enforcement. This enhancement of policing in the interior of the country has been facilitated by the twin processes of the racialization of legal status whereby Latinos are strongly associated with an undocumented status, coupled with the racial profiling of undocumented immigrants.[6] These processes allow a lawful tactic to apprehend and detain people who are "suspected" of being unauthorized, regardless of how long they have lived in the U.S. or if they have ever committed a crime. Indeed, the racialization of legal status and racial profiling have impacted Latino communities so deeply that a spillover effect has been created; regardless of documentation or citizenship status or place of birth, Latinos of any generation experience some of these effects.[7] Thus, immigration laws and enforcement practices contribute to create a hostile context that undermines immigrants' and their loved ones' health.

Importantly, whereas in the past small rural towns at times might have fallen out of immigration authorities' radar, today ICE (Immigration and Customs Enforcement) can be found raiding workplaces or knocking on people's doors in rural towns and in large cities, as is the case in Kansas.

In parallel, public health policies have narrowed the possible options and assistance that immigrants have available to treat their ailments. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) worked in unison to take away the possibility for immigrants (including immigrants with undocumented or with liminal statuses) to receive federally-funded subsidized healthcare and other health-related benefits, including nutrition programs, housing aid, or cash assistance.[8] And in 2010, the Affordable Care Act specifically excluded undocumented immigrants from accessing subsidized healthcare.[9] While access to health insurance varies by immigration status,[10] undocumented immigrants are largely uninsured compared to immigrants with other immigration statuses.[11] This reflects gaps in access to subsidized insurance programs and expenses associated with private insurance markets. The effects of the COVID-19 pandemic reflect the graded effects of legal status, as undocumented immigrants are disproportionately affected, yet government relief packages under both the Trump and Biden administrations have left these migrants out of government financial support, even when they continue to hold "essential worker" jobs in service and food production and "frontline" jobs in the health care sector, especially in cities.

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Latin American immigrants are not the only group affected today by immigration laws and public health policies. However, because racial profiling practices link illegality to "Mexican" and "Hispanic" or "Latino" immigrants more broadly, the brunt of these policies falls on Latin American immigrant communities. Latin American immigrant women, especially those who are poorer, darker skinned,



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or are of Indigenous background,[12] are particularly affected as they are also targeted either directly or indirectly, when their partners are deported and the women become the sole breadwinners of their households. Deportations of Latino men, which constitute the overwhelming majority of deportations,[13] leave the women on their own, trying to manage gendered mothering expectations and bearing the financial burden of the household alone.[14] Given gender ideologies and household gendered asymmetries, immigrant women are often responsible for providing or organizing childcare, taking care of their children's school and medical appointments, and/or caring for other family members when they get sick. And Indigenous women face an added layer of deep-seated racism, both from US society and immigration enforcement agencies that target them [15] and from within Latino communities as well.[16] And given the amplification of interior immigration enforcement in recent decades, immigrant women now experience deportability if they spend time in public spaces or public institutions (including schools or healthcare facilities [17])[18] and thus, their strategies to find care and to care for their health (and their family's) pushed many outside of the formal healthcare system into insecure, temporary, and even harmful strategies.

Methods and Data

We rely on ethnographic participant observation conducted between 2016 and 2020 (and ongoing in 2021 via limited, virtual and telephone communication) in rural and urban Kansas as well as interviews with 40 Latin American immigrant women to investigate: (1) policies that affect women's health and (2) how women manage their health. Ethnographic participant observation took place in parks, churches, libraries, restaurants, court

houses, general stores, and grocery stores; at holiday events and parades, family gatherings, birthday parties, weekend barbecues, and hang outs on front porches; and during health care-related activities. We volunteered at health clinics and hospitals, we attended "wellness community gatherings" in rural Kansas, where medical providers met to discuss the community's health concerns. We took detailed notes during events and encounters or immediately after they ended. The interviews were conducted in Spanish, recorded, and later transcribed verbatim. Interviewees gave verbal consent, and in the instances when they did not feel comfortable with the recording, we took detailed notes during the interview. To maintain informants' confidentiality, we use pseudonyms throughout this brief. We recruited participants through multiple points of entry and then snowball sampling as part of two larger projects: (1) focusing on Latin American mixed-status families (PI is Gómez Cervantes), and (2) investigating relations between immigrant newcomers and established residents in rural Kansas (PI is Menjívar). Both projects were approved by our respective universities' IRBs and were conducted simultaneously. We analyze the data using an inductive analysis approach to uncover the main themes presented below.

Interview participants lived in rural and urban areas of Kansas and were from: Mexico (22) and Guatemala (16), one was from El Salvador and one from Honduras. The women's immigration statuses in urban areas included naturalized citizens (2), Lawful Permanent Residents (1), DACA (5), and Temporary Protected Status (TPS; 1), whereas the rest were undocumented (16). Almost all the women in rural Kansas were undocumented (14), and one was naturalized. Most informants were mothers (32), married or cohabiting in heterosexual relationships (27), and worked outside the home (33).

What are the consequences of amplified interior enforcement and exclusionary health policies on Latina immigrant women?

The consequences of amplified interior enforcement and exclusionary health policies on Latina immigrant women are threefold: fear of deportation, limited mobility and mistrust of medical institutions. We now discuss each in turn.

1. Fear of Deportation

Latina immigrant women are afraid of spending time in public spaces, including those that are vital for their lives

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and their families' survival, such as healthcare institutions, because they may be at risk of possible apprehension and deportation. What women fear the most is the possibility of being separated from their children, many of whom are U.S. citizens. This regular fear, present in urban and rural areas given expanded interior enforcement, impinges on the women's mental wellbeing, as it is a form of chronic stress.[19] This fear of family separation then leads to isolation, as women stay at home and avoid unnecessary time outside (even pre-pandemic). This new phenomenon has been observed in large US cities [20] as well as in rural Kansas. Yareni, an undocumented Mexican-Tlapaneco woman in urban Kansas, told us: "*Estamos encerrados*" *We are locked inside*. Thus, immigrant women avoided spending time outside of their homes unless it was absolutely necessary, such as going to work or grocery shopping. This leaves women, and their families, isolated and prevents them from building links to community institutions.[21]

2. Limited Mobility

Kansas is a vast and mostly rural state; public transportation in rural areas is nonexistent and in urban areas it is limited and unreliable. Community health officials in rural areas often shared that lack of transportation is a huge obstacle for most rural residents to obtain routine or emergency healthcare. However, for Latina immigrant women who are undocumented an added layer makes mobility a risk: exclusion from driver's licenses due to their undocumented status. In Kansas, like in many other states, driving without a license is punished with a misdemeanor, yet undocumented immigrants are ineligible for driver's licenses. And immigrants with misdemeanors, including for not possessing a driver's license are at higher risk of detention (and deportation). But given the lack of public transportation in rural Kansas and unreliable transportation in urban areas and the vast distances to travel, undocumented immigrants must drive (or rely on someone else to drive them) to conduct routine, daily activities such as going to work, grocery shopping, or to a health clinic. Undocumented immigrants then find themselves between a rock and a hard place: they must drive in order to provide and care for their family but doing so places them at risk of being separated from their family members indefinitely. In our studies, a few Latina immigrant women had to risk driving, as was the case of Sofia, an undocumented Mexican-Tlapaneco woman living in a small urban area in Kansas. She explained that following her husband's deportation she "has to drive" to work or take her daughter to medical appointments or childcare. Sofia is the main and only provider for her three-year-old daughter (who is a U.S. citizen), and after her husband was deported, not driving meant that she would be unable to conduct the daily activities needed to care for her child. However, given

exclusionary and punitive policies, every time she drives, she is fully cognizant that she puts herself at risk of apprehension and deportation. In other instances, immigrant women rely on others from their community for rides. Yet, these rides can often be extremely expensive and create exploitative relationships. For instance, Flor, an undocumented Guatemalan-Mayan woman in rural Kansas, was charged \$40 for a 1-mile-long car ride to the doctor for a prenatal appointment.

3. Mistrust of Medical Institutions

Amplified interior immigration enforcement also has created a mistrust of medical institutions amongst Latina immigrant women. In particular, immigrants worry that healthcare providers can share their personal information with immigration enforcement agencies, which would then leave them at risk of deportation. And this is the case in urban and rural areas in our studies. Although medical spaces are in theory "safe" spaces from ICE, media reports during the Trump administration showed ICE agents apprehending immigrants en route to, or outside medical institutions.[22] This, in addition to changes to the Public Charge rule in 2019, which added inadmissibility determination to the use of federally-funded programs among immigrant families,[23] has exacerbated women's apprehension of visiting medical providers. Additionally, their past experiences with uninsured, lower-quality medical care have led them to mistrust US healthcare institutions more broadly. Ofelia, who ended up seeking care at a rural Kansas hospital after months of experiencing abdominal pain, was only given over-the-counter medicine to treat her ailment, was stuck with a \$300 medical bill, and remained in pain. These experiences are then shared with their friends and family members, which then enhance the community's mistrust of healthcare providers.

How has COVID-19 affected Latin American immigrants in rural areas?

Latinos in the United States are experiencing some of the highest rates of COVID-19 infection, hospitalization, and death rates.[24] They are likely to hold "essential jobs" in spaces with high infection rates, face a history of chronic conditions, and/or lack adequate information regarding the pandemic.[25] Additionally, healthcare providers in rural areas (and in states like Kansas in urban areas as well) have limited resources to provide adequate language translation, creating additional barriers to communicate adequately with non-English speakers. Given the conditions created through the comingling of immigration and public health policies described above, undocumented immigrants are largely uninsured, meaning that accessing healthcare is extremely

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expensive. At the first COVID-19 outbreak in the rural community in our study, where Nina, an undocumented Guatemalan-Mayan woman lives, she shared that she fears the possibility of being sick with the virus and worried about whether the local healthcare provider where she got tested was telling her the truth. She had two tests and the provider gave her conflicting results, so she was uncertain if she was sick. She worried she could get her children sick by bathing, cooking for, or feeding them. Two weeks after obtaining a positive COVID-19 test, Nina's employer called her to return to work. She was not feeling 100% well, but not poorly enough that would warrant her a costly visit to the emergency room. She asked for a "couple" of more days to regain her strength, but her employer told her that if she did not return on the given day, she would be fired. Like Nina, many immigrant women are providers to their families, and cannot afford to miss work, even when they are sick.

A Call to Action

The combination of immigration policies that criminalize immigrants' behaviors and everyday activities and public health policies that exclude them from accessing healthcare harm Latina immigrant women's health in at least three ways: directly, by creating a toxic environment of fear that makes them ill; by hindering Latina immigrant women's ability to care for their families or build links to their communities; and by pushing them to informal strategies to seek care. Importantly, this predicament has immediate and long-term consequences for immigrants' health. The COVID-19 pandemic has exacerbated these conditions. Following, we outline the actions federal and state governments can take to address these issues.

Federal Policies

1. The federal government should amend existing public health policies to open access to subsidized health insurance to all residents regardless of immigration status. Access to adequate health care is a human right and everyone, regardless of legal status or nationality, ought to be able to exercise this right. This would bring the United States in line with other wealthy countries and with universal principles and rights. At a more practical, immediate level, immigrants' health should be protected for public health reasons. Immigrants in any legal status work in essential, frontline jobs with regular and daily exposure to the public where virus contagion is high.
2. Furthermore, immigrants hold jobs in local economies around the country, often keeping those economies

afloat as well as the national economy. Importantly, the amount of revenue that immigrants contribute to federal and state governments through taxes [26] already contributes to subsidize the safety-net programs (including healthcare) that immigrants are excluded from. Amending the Affordable Care Act to allow immigrants in any legal status to access the subsidized healthcare that they already contribute to would help them improve their health and treat their ailments, including sicknesses contracted through the pandemic. The costs of healthcare (especially Covid-related) for uninsured immigrants can devastate entire families in the United States and across borders given that many immigrant women are also responsible for the financial wellbeing of their families in their home countries.[27] Given that hospitals in the past have used deportation as a strategy to avoid the high cost of long-term patient care when immigrant patients cannot pay their bills,[28] it is extremely important to support undocumented immigrants' access to health insurance and secure pathways to finance and treat their health in a post-pandemic future.



3. The federal government should include undocumented immigrants and those in semi-legal statuses in COVID-19 relief efforts, including direct financial assistance. Latina immigrant women have been severely affected by the pandemic, including experiencing job instability or loss and getting sick, in addition to dealing with the fear of deportation of themselves and/or their loved ones. COVID-19 relief would support immigrant women who are breadwinners and also responsible for childcare. This aid would trickle to their families and children, many of whom are U.S. citizens.
4. It is crucial that the federal government ends 287(g) agreements and similar programs that enhance interior immigration enforcement across the country. The mass

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deportations during the Obama administration taught us that these initiatives rely on racial profiling practices that unjustly target Latino communities,[29] yet the Trump administration re-instituted and expanded 287(g) through executive orders. The Biden administration revoked the Trump administration's executive orders, but it has not created any provisions or taken any actions that would end localized immigration enforcement operations across the country.

5. Healthcare infrastructure in rural areas has been in decline for decades which has left people vulnerable especially during the pandemic.[30] It is vital for the federal government to provide assistance to rural healthcare, including infrastructure, technology, and medical providers. Rural healthcare support also should include assistance to immigrants including those who are uninsured.

State Policies

State lawmakers can also make significant changes to address the health and healthcare of Latina immigrant women and other immigrants in their communities.

1. Individual states and local policing agencies can refuse to sign on to 287(g) programs. Local police are not constrained by law to apprehend or detain immigrants; it is up to the localities to do so. Some federal programs such as 287(g) are voluntary, so state and localities should consider disengagement from them.
2. Providing access to driver's licenses would improve Latina immigrant women's (and others in their communities') living conditions significantly. States should follow the lead of the fifteen states [31] that already allow undocumented immigrants access to driver's licenses. This would lessen immigrants' chances of apprehension, detention, and deportation when driving their children to school, to a clinic, or going to work.

Access to driver's licenses should also include protections from racial profiling on the basis of "suspicion" of immigration status while driving, which would be alleviated by ending localized immigration enforcement so policing agents are no longer in charge of apprehending undocumented migrants. This would help immigrant women, especially undocumented women, build links to institutions in their communities, as they did in the past when interior enforcement was not as intense as it is now. This policy change could also bring important revenue to the state in taxes, registration fees, and driver license fees.[32]

3. Since PRWORA gave individual states authority to decide eligibility for subsidized safety-net programs, individual states can open subsidized healthcare and nutrition programs to immigrants (across statuses) and their families. Importantly, undocumented and semi-legal immigrants are already contributing to the funding of these programs through taxes,[33] but they continue to be excluded from these resources.
4. Finally, rural healthcare providers must find ways to diversify their staff and healthcare practices to address the healthcare needs of immigrant populations. Initiatives such as *Promotoras de salud* [34] can help bridge immigrant communities' trust with healthcare providers.

To learn more about the health impacts of immigration policy on immigrant women, read our complete publication: Gómez Cervantes, Andrea and Cecilia Menjívar. 2020. "Legal Violence, Health, and Access to Care: Latina Immigrants in Rural and Urban Kansas" *Journal of Health and Social Behavior* 61(3):307-323

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This issue brief is also available in Spanish.

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